A critical exploration of staff experiences and roles following a student death by suicide within two United Kingdom Higher Education Institutions

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Abstract

Wider networks of people are affected by a suicide death than originally thought. These networks include people whose job-role brings them into contact with the death by suicide of another person, for instance, staff members in Higher Education Institutions (HEIs). The impact of student suicide within United Kingdom (UK) HEIs is unexplored and the experiences of staff members following a student death by suicide are unknown. Postvention encompasses activities or support designed to facilitate recovery after suicide. To meet the needs of people in wider networks, it is necessary to understand their experiences. Postvention support offered to staff members within UK HEIs currently lacks a context-specific evidence base.

This thesis asks: How is a student suicide experienced by staff members within a UK HEI and what are the features of that experience? Do staff members undertake specific postvention roles following a student suicide, if so, what kinds of role, and are there any staff needs attached to delivering them? Two studies address these questions. Firstly, a qualitative research synthesis explores the experiences of health, social care, and education professionals following the death by suicide of a client, patient, service user, or student. Secondly, a two-phase, mixed-methods study, explores the experiences of staff members across a range of job-roles in two UK HEIs following a student suicide. Data were collected by electronic survey (n=19) and semi-structured interviews (n=10). Survey data were analysed to give descriptive statistics; open text survey data and interview data were subject to a constructivist grounded theory analysis. A social constructivist paradigm positions this research within the field of critical suicidology.

Novel findings demonstrate that HEI staff experience perceptions of impact that are more diverse and intense than expected and can include a sense of being bereaved. Staff members undertake a broad range of tasks, from crisis response to the long-term support of students who are bereaved by the death. A complicated sense of entanglement and tension sits

between the doing of tasks and the experiencing of feelings. Personal traits shape help-seeking and experiences of support. A ‘sense of community’ within the HEI nurtures the concept of ‘belongingness’ and the construction of perceptions of closeness to the student who died. These concepts may explain the heightened perceptions of impact experienced by staff members. Findings can be applied to the development of postvention support for staff in UK HEIs, and to the provision of community based postvention to wider networks.

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'A distinction in research is between research which is concerned with verification

and research which is concerned with discovery.

In the former type, theory serves as a framework to guide verification.

In the latter, theory is the 'jottings in the margins of ongoing research',

a kind of research in which order is not very immediately attained,

a messy, puzzling and intriguing kind of research

in which the conclusions are not known before the investigations are carried out.'

(Gherardi & Turner, 1987, p. 12)

Chapter 1

Introducing the researcher: Introducing the thesis

1.1 Introducing the researcher

I would like to open this thesis by sharing the personal experiences that have shaped my understanding of suicide. My research is about the experiences of people who are impacted by a death by suicide in the context of their job role. I have experienced two such instances in my working life, that I share with you here, followed by my reflection on other suicide deaths that I had experienced and my entry point as the researcher of these studies.

1.1.1. The death by suicide of my boss.

When I was 26 my boss took his own life. He was a businessman with a chain of retail outlets; I was deputy manager at one of his shops. He was also a husband and the father to two young children. His office was above our shop, so I was used to seeing him every day, sometimes he would sit and chat with us over lunch. He was kind, friendly, interested; I'd worked for him for nearly three years and I enjoyed having him as my boss. When we were told the news of his death we were shaken and bewildered, and later, maybe we felt angry as well. After he died the chain of shops were immediately taken into administration and our jobs were at risk if a buyer could not be found. Nobody asked us how we were or what it was like for us. Nobody offered us any support. Looking back to that experience, even after 26 years have passed, still leaves me feeling unsettled.

1.1.2 The death by suicide of our service user

By the time I was 45 I was working for a family support project. We facilitated supervised contact for children in statutory foster care with their birth parents. I was lead practitioner. It was part of our service to facilitate a final contact between children and their birth parents

when a child had been placed for adoption. This would usually be the last time that birth parents and their children would see each other. One of my colleagues facilitated such a contact; it was the end of a case that she had been supervising 3 or 4 times a week for maybe 6 to 9 months. The following day, the child's birth mother died by suicide. My colleague, who had got to know this woman well through working with her frequently for months, was devastated. Other colleagues who had also facilitated the contact or who were used to seeing the mother in the building were shocked, upset, confused. As a project we all felt the sombre and deep impact of what had happened. We talked a lot, we shared our feelings, we cried together. Supervisors made space to give extra support, counselling services were available and offered, we used team meetings, supervision, lunch breaks, all as forums for talking, sharing, learning, grieving and moving forward.

What we were doing, without knowing it, was providing postvention support to our colleagues, and to ourselves.

1.1.3 Experiences in learning

I bring academic knowledge and professional experience to this study. I completed my first degree as a mature part-time student and graduated with a first-class honours degree in Human Geography from the Open University. This learning gave me a grounding in social science. I learnt new ways of thinking, of understanding the world and the people in it, and most importantly, I learnt to ask questions, to be curious and to interrogate information. After graduation I changed my career path and undertook a two-year skills training in counselling. I worked in social care in the child protection sector. I received ongoing professional development over twelve years of employment in the third and public sectors that further informed my views and understanding of people, families, communities, and social settings. In 2014 I embarked on a part time MSc in Counselling Psychology which helped me to develop a theoretical underpinning to much of the work that I had been engaged in over the previous

decade. I learnt more about theories of human development and mental ill health; theories and models of practice; and psychological and therapeutic approaches to working with mental ill health. This gave me a knowledge base that sat within the broader social, political and economic learning I had undertaken at undergraduate level. I bring to this PhD an academic background in social science and psychology; a professional background of working with counselling skills in social care and mental health settings; and a working knowledge of people, teenagers, young adults and families situated in social and cultural contexts of inequality, disadvantage and struggle.

The one thing that unites this diverse and eclectic background is me. My view of the world has been shaped by my academic and professional focus on people in social settings; in their homes and communities; and in the context of their families, neighbours and peer groups. I am interested in understanding how and why different people might have different responses to the same circumstances; and how and why social settings appear to shape and impact upon people's abilities, choices, and behaviours. It has also informed my understanding of the roles of wider contexts such as political and economic factors in shaping the lives, choices, and behaviours of individual people, families, and communities. In undertaking this study, I am curious to hear and learn about the realities of my participants; to work alongside them to develop or construct an understanding of the meanings they attach to their experiences and; to ensure that this inquiry be rooted in the natural settings in which the study participants operate. In doing so, I aspire to create new knowledge from their experiences so that real world outputs can be created from that knowledge to inform or improve the experiences of future others. Thus, completing the research and practice cycle.

First and foremost, however, I am human. I have experienced the suicide deaths of other people. When I reflected on my personal experiences with suicide I was surprised to find that I know of five people who have died by suicide, and a sixth person who I believe died by suicide.

I shared the stories of two of these suicide deaths at the beginning of this chapter, the others I do not need to share in such detail, but some factors around these deaths and my experiencing of them remain relevant to my role as the researcher exploring the impact of suicide. Four of these people who have taken their own lives I have known through my place of work; two colleagues, one boss, one service user. The fifth person was the brother of a friend and the sixth was the member of an online support network. In two cases the cause of death has not been publicly shared, which is why there is a small level of doubt for me around one of them. I respect that not knowing is maybe necessary to support the wellbeing of the closer networks around those who have died.

My experiences to some degree situate me alongside those of my participants. I am not a bereaved family member or a very close friend. I am a colleague, a professional, a member of the wider, often unseen, network of people that surrounds the person who has died. I am exposed to, affected by, but not necessarily bereaved by the deaths by suicide of six human beings. I bring this experience with me into my research in the form of empathy, compassion, and curiosity to discover more about the experiences of others whose job role has bought them into contact with a death by suicide.

When I reflect on the two deaths that I shared at the beginning of this introduction I realise that their stories are about so much more than my personal experience. These are deaths that happened within contexts of social, economic, and cultural norms and expectations. I later learnt that my boss took his own life due to financial worries and fears for his family's future. The early 1990's was a challenging time for small businesses. I might hypothesise that feelings of shame or guilt played their parts in his decision-making. His wife told me that he had taken a very brave choice. By taking his own life he ensured that the family home and wealth would not be lost and also that his business went in to administration rather than liquidation, a process which eventually secured the future of his shops and of our jobs.

I do not know the reasons that the child's mother took her life. But her circumstances were desperately sad, her personal background and life experiences created a complexity of chaos within which she wasn't able to provide the security and stability that her child needed. Despite opportunities to make change, she did not have the capacity to do what was necessary to secure the child's future with her. Her death happened within the contexts of socio-economic, circumstantial and psychological disadvantage as well as statutory and legal processes that informed both her child's future and her own. So, in reflecting, I am left to wonder if it might prove helpful to frame these deaths by suicide within a context other than that of an individual tragedy. By thinking about circumstances, about stories of economic downturns, cultures of pride and success, about stories of disadvantage and deprivation, about legal processes, can we open the door to a broader narrative around suicide? And can we then extend that broader narrative to grow our understanding of the experiences of people who are impacted by suicide?

1.2 Introducing the thesis

There were an estimated 793 000 suicide deaths worldwide in 2016, this indicates an annual global age-standardised suicide rate of 10.5 per 100 000 population (World Health Organisation, 2019). The likelihood of anybody experiencing the death by suicide of another person in any given year is approximately one in twenty people (4.3%); the likelihood during a lifetime is one in five people (21.8%) (Andriessen et al., 2017). There is a possibility that some of those people will experience a suicide death connected to their place of work or their job role. This thesis presents a critical exploration of the experiences of people whose job role brings them into contact with the death by suicide of another person. I undertook two distinct studies that are reported in this thesis. In the first, a systematic review in the form of a qualitative research synthesis, I explore the experiences of a range of health, social care and education practitioners following the death by suicide of a client, patient, service user or

student. In the second, a two-phase, mixed-methods study, I focus on the experiences of staff members across a range of job roles in two United Kingdom (UK) Higher Education Institutions (HEIs) following the death by suicide of a student. I outline the underpinning rationale and methodology for both studies in this introductory chapter.

In the following sections I will introduce three topics that underpin this research. Firstly, postvention, which I will introduce as a concept and define. Secondly, the experiencing of the impacts of suicide; I will briefly explain who might be affected by a suicide death and how the impact might be felt or perceived. Finally, in terms of what happens after a student death by suicide; I will introduce the topic and context of student suicide to clarify why research that explores the aftermath of such an event is needed. I will set out the methodological approach, research questions, aim and objectives, together with an outline of the two studies, their relationship with each other and their potential contribution to knowledge. Finally, I will explain the structure and organisation of the rest of the thesis to close this chapter.

1.2.1 Postvention

At the heart of this thesis sits the concept of postvention. A term first coined by clinical Professor of Psychiatry, Edwin Shneidman, in the late 1960s, (Leenaars, 2010). Professor Shneidman used the term to describe the kinds of things that happen to support a person after a suicide attempt or after someone close to them had died by suicide (Shneidman, 1975). More recently, postvention has been described by Andriessen (2009, p. 43) as being 'activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide and prevent adverse outcomes including suicidal behaviour'. There is an increased risk of suicide amongst those who are exposed to suicide (Maple et al., 2017; Hill et al., 2020) and it is thought that postvention support may lessen that risk (Jordan, 2017). Postvention might take a clinical or a public health approach toward meeting the needs of those who are bereaved or affected (Andriessen & Krysinska, 2012). For example, provision may include a diverse range of

support interventions largely targeted at families and those closest to the person who has died by suicide. These might include support groups, grief counselling, outreach, and online support; services may be focused on specific settings, shaped to meet the needs of specific groups or be community based; they may be initiated by the bereaved themselves, by grief or other charitable organisations, or by public sector and health providers (Andriessen et al., 2019a).

1.2.1.1 Who is affected?

Far wider networks of people are affected by a suicide death than originally thought, these networks extend beyond family members and close friends (Berman, 2011; Cerel et al., 2018a). For people in wider networks around the person who died, perceptions rather than relationships appear to shape the level of impact felt and the ways in which that impact is experienced (Cerel, et al., 2013). Identification as a survivor is unrelated to the relationship to the deceased, rather it is informed by perceptions of psychological closeness to the person who died (Cerel et al, 2013).

Further research by Cerel et al., (2017) explores the concepts of perceived closeness and perceived impact as a factor in determining the symptomatic outcomes of a suicide death on an individual. Data were collected from 807 participants of a telephone survey of 1,736 adults in Kentucky, USA. Findings revealed that higher levels of impact are felt amongst wider family networks, social, and work networks, and amongst those who came into contact with the decedent due to the nature of their death, as well as amongst close family members. That is, perceptions of impact can be as high for those in wider networks as for those amongst close family members. Additionally, all three of these groups of survivors included people who reported high levels of perceived closeness. Perceptions of greater closeness and impact were related to higher incidences of depression, anxiety, PTSD, and prolonged grief (Cerel et al., 2017).

To explain the different kinds of impact that people may perceive after a suicide death, Cerel et al. (2014) developed a 'continuum of suicide survivorship' model (Figure 1).

The model describes the range of impact a suicide by death may have; it proposes that impacts of suicide in the general population range from 'exposed to', through 'affected by' to 'bereaved by' a suicide death, with those who are 'bereaved by' experiencing either a short or a long term bereavement process (Cerel et al., 2014). The model is described as a 'nested model'. This means that each subsequent category represents a subset of the larger category within which it is nested. For instance, those affected by a suicide are also included in the broader group of those who are exposed to a suicide. The model includes 'anyone who knows or identifies with someone who dies by suicide' and employs a typology of relationships to the person who died to describe who will sit in each of the subsets (Cerel et al., 2014, p. 594). For instance, those who perceive themselves as exposed might include those who are part of the same community, be that a neighbourhood, workplace or educational setting, as well as first responders and those who discover the body of the person who died; those who are affected might include those who have experienced a previous bereavement by suicide, but who would not be considered bereaved by this suicide, for instance witnesses, housemates, close friends, colleagues, team members, first responders and those who might discover the body of the deceased; and the suggested cohorts who may experience a short-term bereavement include family members, therapists, friends and close work colleagues; whilst those who might experience a long-term bereavement include, family members, close friends, and therapists (Cerel et al., 2014).

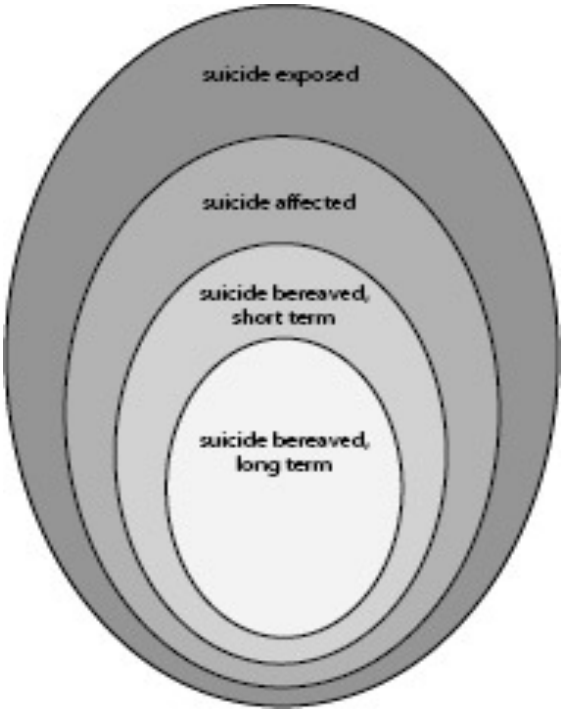

Figure 1: The continuum of suicide survivorship (Cerel, et al., 2014)

This is currently the only theoretical model that seeks to explain the range of potential experiences, beyond that of bereavement, following a death by suicide. Thus, the continuum acknowledges that people in wider networks, beyond family and close friends, may be impacted. This range of experiences and acknowledgement of wider networks made the model appealing to me in the context of my research topic and population. As such, I identified it as a useful tool in supporting the participants of my study to describe their personal perceptions of impact following a student death by suicide, and I included adapted descriptors from the model in an e-survey (detailed in section 4.5.5.1) completed by the study participants. So, instead of using the tool as a predictive model, whereby I might have assigned my participants to particular subsets according to their relationship to the student who died; rather, I used it as a means to understand the participants own perceptions of the impact they experienced and as a tool by which I could interpret their experiences. As I will report in the Discussion chapter (Chapter 6) of this thesis, my inductive enquiry from participants first-hand accounts of the experience of student suicide did not always align with the model. I found that

the somewhat prescriptive nature of the typology attached to the model did not adequately capture the experiences of my participants. Some participants perceived their experiences to be more impactful than the model might suggest (eg. To be affected by rather than exposed to; or to feel bereaved by rather than affected by a student death by suicide). These findings led me to question the prescriptive nature of the typology and some of the assumptions that the model calls upon regarding the circumstances that might lead to individuals being assigned to a particular subset. Based on the findings of my research I suggest that the model proved helpful as a tool to support individuals in self-identifying their perceptions of impact; however, to be used as a predictive tool it requires further expansion.

It seems clear then, that further qualitative research around peoples' experiences following a suicide will generate a better understanding of how people make meaning of these events; how this relates to their identification with the suicide death and the effect this identification has; and how they perceive themselves to be impacted and how they develop these perceptions (Maple et al., 2019). I will be seeking to understand more about how people reflect and relay their experiences through their accounts by undertaking a constructivist grounded theory analysis (Charmaz, 2014) of the data that I collect. That is, I will adopt an inductive and interpretative engagement to understand what the data is showing or telling me about participants' experiences and the meanings that they attach to their experiences. As we learn more about the experiences of wider groups, so the continuum of suicide survivorship, a relatively recent model, can be expanded to include wider networks that are impacted by suicide. For instance people who have diverse kinds of relationship or no previous relationship with the person who died (Maple et al., 2019) and those with no previous knowledge of the person who died, known as 'zero responders' (Burns et al., 2019). In addition, our understanding of the role, purpose and provision of postvention, currently, a narrowly defined and under-researched topic (Andriessen et al., 2017; Maple et al., 2017), will also expand. As such, the support needs of practitioners, zero responders and staff members can be met.

1.2.2 Student Suicide

There is a sparse body of literature that explores the topic of student suicide in the UK. This section will bring together what we know to date, starting with a small group of studies that report on rates of student death by suicide at Oxford and Cambridge Universities. Student death by suicide at the University of Cambridge, UK, was measured during the 10-year period from 1948 – 1958 (Rook, 1959). Findings reported suicide deaths to be higher in the undergraduate population than that in other universities and in the general population (Rook, 1959). The author speculates that the high standards of the selection process may be biased toward selecting students with higher likelihood of dying by suicide (although no clear line of argument or evidence for this is presented); or, that various pressures of student life at Cambridge (such as the pressure to attain at a high level, the practice of independent study, and financial worries) might differentiate the student experience from that at other institutions and be more challenging for young students to manage (Rook, 1959). Longitudinal studies undertaken at Oxford and Cambridge universities during the 1990s and 2000s suggest that the rates of suicide amongst the Oxbridge student population were in line with those in the age related population (Collins & Paykel, 2000; Hawton et al., 2012). It might be that these three studies in combination indicate that suicide rates amongst students at Oxbridge universities have reduced over time from being greater than, to being in line with, the age-related general population. However, on the basis of just three studies, and given the length of time between the studies when no research was undertaken, such a statement remains speculative. There has been no similar research undertaken at other universities within the UK, so, it is difficult to form a wider sense of meaning or understanding about the rates of student suicide beyond the site-specific findings that are published in these studies. This sparsity of knowledge and the resulting challenges in contextualising or generalising research findings typifies student suicide research.

Recently, two studies have drawn on national data sets to investigate current similarities or differences between student and non-student populations regarding self-harm and suicide attempts and deaths. A 2019 study used data from three UK National Psychiatric Morbidity Surveys (2000, 2007 and 2014) and found that the prevalence of suicide attempts appeared lower amongst students than age-related non-students in England (McManus & Gunnell, 2019). The second study, used Office for National Statistics mortality data and Higher Education Statistics Agency data for England and Wales (Gunnell et al. 2020). An analysis of that data suggest that incidences of student suicide per 100,000 whilst increasing, were less than half of those in the age related general population (Gunnell et al., 2020). These findings are strikingly different to those from the Oxbridge studies, possibly because they are drawn from a far wider population, however it remains difficult to conclude that these differences indicate a trend toward declining rates of student suicide in HEIs, due to the multitude of differences in methodology and data sources. There has, however, been a reported decline in the rates of suicide in the student population evidenced in the United States (US) in the years that span from 1920 – 2004, with the rates being about half that of the age and gender related general population since 1960 (Schwartz, 2004). Reasons for the decline over time may be linked to a decreasing proportion of male students over the decades; and due to the ban of firearms on campuses in recent decades (Schwartz, 2004). The decline in the proportion of male students may also be a factor in the UK, although this has not been identified as such in any of the UK based studies. The issue of firearms however, due to cultural and legislative differences between the UK and US, would seem irrelevant.

We know that at least 95 higher education students died by suicide in England and Wales in the year ending July 2017 (Office for National Statistics, 2018). It is difficult however, to establish an accurate figure for the number or rates of student suicides that occur within HEI's in the UK. This is due in part to the combining of higher and further education students within the statistics; the identification of part-time students as being of 'employed' status (Stanley et

al. 2007; Mallon et al. 2009; Hawton et al., 2012), the use of open or narrative verdicts by coroner's offices (Gunnell et al., 2013) and a lack of clarity around student status at the time of death if a suicide occurs during a planned leave of absence due to ill health for instance (NUS Disabled Students, 2016). Given these challenges, the figure above is likely to be an underestimation of the true number of student deaths by suicide. Indeed, with small and disparate pockets of knowledge it currently remains a challenge to develop a cohesive and informative story around the numbers and rates of student death by suicide in UK Universities. This presents an understandable problem for those who work in UK HEIs and who wish to call on data to inform policy and procedural directives around the prevention, intervention and postvention of student suicide.

A limited literature has attempted to grow an understanding of student suicide by looking at factors that are unique in the student population (Stanley et al., 2007). For instance, the unique experiences of transition that include for many students, leaving home and moving to a new geographic area; leaving established peer and support networks and having to develop new ones; experiencing the differences in teaching and learning methods between school and universities (Mallon et al., 2009). Experiences of transition continue throughout students' university experience as they return to their 'childhood' home during prolonged breaks over the Christmas period and the summer months (Mallon, et al. 2009). Individual traits such as perfectionism, for instance, that might be encouraged or exacerbated by cultures of achievement and performance measures may also impact on student suicide (Bell et al., 2010). However, this remains an under-researched area and to date there have been no comparison studies to explore differences in causal factors between students who die by suicide and suicide in the age-related general population.

Studies to date have explored incidences of student suicide (Gunnell et al., 2020) and potential explanatory factors for student suicide (Stanley et al., 2007; Mallon et al., 2009 & Bell et al.,

2010). There have not been any studies that explore the impacts of student suicide within or beyond the HEI on peer groups, other students, HEI staff or the family of the student who died. Nor has there been any research regarding the ways in which those impacts are experienced and the meanings that individuals affected by a student suicide may attach to their experience. There have also been no studies that explore the perceived needs of people impacted by a student suicide and as such any postvention support that is currently offered or provided within UK universities has been designed and is being delivered without a context specific evidence base. Likewise, in the US a review of the literature around college student suicide examines risk factors and predictors of suicide; treatment and prevention of suicide, including prevention programmes; and obstacles to the prevention of college student suicide, however, there are no papers included in this review that address the impact of college student suicide on peers, on college staff, or on family networks (Schwartz & Friedman, 2009).

1.2.3 Methodology

My personal reflection

My journey toward a methodological paradigm was influenced by my experiences prior to undertaking a PhD and by my academic learning during the PhD. My view of the world has been shaped by my academic and professional focus on people in social settings; in their homes and communities; and in the context of their families, neighbours and peer groups. I am interested in understanding how and why different people might have different responses to the same circumstances; and how and why social settings appear to shape and impact upon people's abilities, choices, and behaviours. My understanding of the roles of wider contexts such as political and economic factors in shaping the lives, choices, and behaviours of individual people, families, and communities has grown through my professional experiences and my studies.

I struggled enormously at first with the concepts of ontology and epistemology, feeling that these were very high-brow ideas and that I was 'just' a practitioner who had somehow stumbled into this unknown world of big words and big ideas. It was in reading, and getting lost in the ideas of other academics that I started to see a place where I felt comfortable. The following extracts from my research journal illustrate my experiencing of this process.

03 January 2017:

'It seems that this is what lies at the beginning of it all … the task of uncovering my own personal research paradigm. The only comfort being my certainty that it is already all within me – maybe in a different language or format – waiting to be translated through this new academic language that currently feels elusive and high-brow.'

25 August 2017:

'Reading Ian Marsh (2010), and considering alternative narratives around suicide – and noticing how dominant the 'medical' or 'psycho-pathological' model is. I realise that coming from a social science / social care background I am well placed to consider alternatives.

I read Marsh, and I know that I need to re-visit the idea of coming from a social constructionist view of how things are – and what that means in terms of what I am bringing to this project – and how that might shape my approach in terms of understanding contexts – asking questions – hearing stories and analysing data. It feels that through opening and reading this book I have, at last, found my own position and recognised that I can bring something to – not just my own study – but the current knowledge growth in suicidology – I can develop my voice from my own background, experience and values. Rather than feeling that I don't 'belong' in any camp – being

neither a psychologist nor a health professional – I see now that I have my own camp, one that is rooted in a social constructionist view of the world – that sits comfortably with my own views, values and beliefs and that will allow me to experience a sense of congruence between myself and my project that has been somewhat absent until now.'

A methodological framework

The social dimension of suicide is not a new idea, Durkheim published a sociological perspective on the topic in 1897, highlighting social, economic and cultural factors associated with the incidence of suicide (Bantjes & Swartz, 2017). However, in recent decades suicide and suicidology in both research and practice have been underpinned by three particular assumptions; that suicide is pathological, that suicidology is science, and that suicide is individual (Marsh, 2010). A pathological model of suicide cites psychiatric illness or mental disorder as being the cause of suicide, this idea has become dominant within modern suicidology, thus informing and narrowing the kinds of solutions that are sought (Marsh, 2016). Whilst pathology speaks of the cause of suicidality, the scientific model of suicide speaks of the kinds of knowledge that is called upon to shape understanding, and inform prevention. Current suicide research favours an objective medicalised approach to understanding and resolving the issue, as this approach dominates, the field of potential learning and understanding narrows as qualitative explorations are excluded from the conversation (Marsh, 2016). Finally, an individual model of suicidal ideation and behaviour locates suicidality as arising from within the person, thus ignoring the cultural and social contexts within which the individual operates, learns, responds and behaves, and the potential for those contexts to shape experience, choices, and behaviour (Marsh, 2016). These three ideas generate an authoritative paradigm of psychopathology in suicidology that focuses on individual risk factors (White, 2017). Marsh (2020) refers to a psychocentric view of suicidality, that dominates in terms of theory, policy and practice. Psychocentrism is a term used to

explain how human problems are seen as pathological and individual, and has been suggested to consist of ten characteristics, including, reductionism, determinism, victim-blaming, positivism and pathological individualism (Rimke, 2016). Such a perspective on suicidality restricts narratives about suicide and limits the questions we ask and the kinds of research we undertake. In turn, this impacts on the kinds of solutions that are developed to respond to suicide, as problems are seen as located within the individual (White, 2012). A focus on targeting prevention interventions toward individuals may overlook the wider social, political and cultural contexts within which suicidal ideation or behaviour exists (White, 2017). A more holistic view might include environmental, historical, biographical, cultural, linguistic and political contexts; however, these are currently excluded from consideration by a 'compulsory ontology of pathology' (Marsh, 2010). To move beyond this narrow viewpoint requires a widening of methodologies and practices 'so as to capture the silences and absences of contemporary suicidology' (Fitzpatrick et al., 2014, p.319).

Personal reflection

It has been an important, and very personal aspect of this project to reflect on my own thoughts and ideas around suicide. To test those ideas, to stretch them and to try to articulate them in meaningful ways. It is about knowing my topic, and knowing my personal position with regards to the topic. In the early months of this PhD journey I found that I had more questions than I was able to find answers for:

14 April 2017:

'I come from a place of wanting to respect and value people's choices. And of wanting to explore deeply the topic of suicide, so that I might be better able to situate those choices. And so, I find myself pondering difficult questions like:

- is it ok to want to die by suicide?

- is it a choice that we should respect when made by others?

- if I feel that I am in support of elective euthanasia, then am I accepting of elective suicide?

- but – is an individual with suicidal ideation operating from a place of rational autonomy?

- who are we to 'save' others?

- what is 'rational autonomy' anyway?

- what about stages of development and the adolescent brain?

- what is it that drives us to want to prevent death by suicide?

- is life sacred?

- is subjectivity helpful or dangerous?

- is suicide prevention a Christian ideal?

- how much are our cultural values and ideals rooted in religious belief systems?'

I found that these questions were not addressed in the literature that I was reading. I was already bumping up against the 'silences and absences of contemporary suicidology' (Fitzpatrick et al., 2014, p 319).

A number of scholars however, are challenging the psychocentric approach. Kral (2019) for instance, outlines a cultural theory of suicide. He suggests that ideas of suicide are culturally rooted and become internalised as a cultural script which is, in turn, normalised by means of contagion (Kral, 2019). He uses the term 'perturbation' to describe the kind of emotional states that might (but usually do not) lead to suicidal behaviour, and identifies the concept of 'lethality' as being the mechanism that does lead the perturbed individual toward the idea and

intentionality of suicide (Kral, 2019). For Kral (2019), it is the cultural script, or idea, of suicide that facilitates the 'lethality'. Abrutyn & Mueller (2018), also recognise cultural influences on suicidal behaviour, specifically in the form of societal regulation which can heighten suicide risks amongst specific groups in society. They argue that there is a role for sociology in suicidology in developing a transdisciplinary approach and broadening knowledge (Abrutyn & Mueller, 2019). Chandler (2020a) also calls for interdisciplinary collaborations between psychologists, sociologists and others, citing socioeconomic inequalities in suicide rates and the challenges that psychological disciplines may have when seeking to explain such disparities. The idea of socio-economic inequalities is played out by Mills (2018) in her claim that austerity policies in the UK post 2008 can be evidenced as a cause of suicide. Such work provides credible challenges to the dominant individual medical model of causality in suicidology and opens the door to new ways of understanding suicide in social and political contexts. To take a more inclusive exploration of the relationship between experiences of distress and social, political, economic and historical contexts would require a psychopolitical approach (Marsh, 2020). For instance, Standley (2020), suggests two alternative approaches toward understanding suicidality; the application of intersectional theory to examine the effects of multiple marginal identities; and a socioecological model to acknowledge the complexity of the individual, social and systemic factors that affect development and wellbeing in young adults. Together, these scholars present a case for the application of diverse disciplines such as sociology, politics, economics, cultural studies and historical studies, alongside the currently dominant application of psychology, in the field of suicidology.

These emerging debates regarding contextual ideas and discourses will likely inform future suicide research. Currently, these ideas are being pursued in the interest of broadening our understanding of suicidal ideation and behaviour, so as to better inform preventative models and policy. However, postvention and the experiences of those who are exposed to, affected by or bereaved by suicide have not yet been discussed in this conversation. It is already

established that there is a place for sociology in the study of dying, death and bereavement as these phenomena occur in social contexts (Thompson et al., 2016). The processes of grieving and loss occur in community and cultural spaces where meanings are developed as much between people as they are within them (Neimeyer et al., 2014). The personal experiences of the bereaved are shaped within cultural, political, and religious contexts by the stories of other bereaved people, and by public accounts of loss (Neimeyer et al., 2014). These contexts are, of course, present and relevant for people who are exposed to or bereaved by suicide just as they are for those who are affected by other means of death. Critical suicidology draws attention to the inequalities that generate higher rates of suicide in some communities than others (Mills, 2018; Kral, 2019). Additionally, it is known that exposure to suicide increases the risk of suicide through the mechanism of contagion (Kral, 2019). Suicide affects far more people than those who die by it (Cerel, 2018). Indeed, in a rare nod to those who are bereaved by suicide, Button, (2016) states that 'a decent political society' (p 278) might feel compelled to prevent not just deaths by suicide, but also the subsequent loss and suffering of those who are affected by suicide. Despite Button's acknowledgement, it feels that there are spaces in the critical suicidology conversation, still, 'silences and absences' (Fitzpatrick et al., 2014, p319), where postvention might be acknowledged or add to the conversation. I believe there is space to consider those who are affected by suicide and to include lessons that might already be learned from the study of postvention. For instance, Button and Marsh (2020) talk about a re-imagining of suicide prevention from a social justice perspective, by engaging ideas of collective responsibility to generate 'a collective, relational and political endeavour' toward addressing the harmful aspects of social life. In extending this argument onwards, such a re-imagining might embrace the experiences of those who are affected by suicide loss, and bring a social, cultural or political insight to our understanding of their experiences, be they family members or those included in the wider networks around the person who died.

It follows then, that future research will benefit the field of suicidology by taking broader, inter-disciplinary approaches toward exploring not only suicide and suicidality, but also, the impacts of suicide. In response to this idea I will endeavour to draw on the social, cultural and political contexts within which the studies and participants' experiences reported in this thesis are situated. My aim being to develop a more critical understanding of post-suicide experiences and postvention needs amongst those who experience a suicide because of their job-role. In order to address the gap in knowledge regarding the impact of student suicide, to add to knowledge regarding wider populations, and to inform further development of the continuum of suicide survivorship (Cerel, 2014), I am utilising an inductive qualitative approach designed to promote the development of theory throughout this doctoral study. To embrace the call for a sociological perspective in the field of suicide research and to apply the approach of critical suicidology to postvention studies, I am situating this research within the perspective of a social constructivist paradigm.

I have given due consideration to the methodological processes that are informed by my philosophical roots to create a study that is congruent and robust throughout (Appleton & King, 2002). In describing the five fundamental principles of constructivism, Guba and Lincoln (1982) start with ideas of reality and its elements. First, a constructivist view is that there are many realities and many interpretations. Validity is given to each person's experiences and to the context in which those experiences occur (Guba & Lincoln, 1982). Many realities can be incorporated into developing the construction(s) that research produces (Appleton & King, 2002). My focus in this inquiry is to learn about the interpretations and realities that participants have constructed around a shared experience. Second, is the concept of causality; it is thought to be too simplistic an explanation for the complexity of what is actually happening in social situations where multiple influences are present and experienced in many ways (Guba & Lincoln, 1982). My aim in this thesis is not to seek or to generate ideas around causality, rather to explore the complexity of connections that participants perceive between

and across different aspects of their experience. Study findings will be constructed from the data without any specific hopes or expectations attached with regard to what the findings might show or demonstrate.

The third principle states that unique contexts result in the absence of generalisation. Generalisation is a post-positivist concept (Guba & Lincoln, 1982). Constructivism asserts that it is a simplistic idea as the diversity in social settings do not accommodate for sweeping generalisations (Erlandson et al., 1993). Value is instead given to the unique nature of settings, actions, and interrelationships that bring meaning to data and interpretations (Guba & Lincoln, 1982). By reporting the findings of my research in depth with thick descriptions (Geertz, 1973), the potential exists for others to recognise similarities between their own situation and that which I have reported, so that they have confidence to transfer findings across settings. The fourth principle addresses the relationship between the researcher and phenomena under study. Meanings are constructed through multiple interactions between individuals; therefore, study findings are the result of interaction between myself and the study participant(s) 'it is precisely their interaction that creates the data which will emerge from the inquiry' (Guba & Lincoln, 1989, p. 88). More than that, perceptions and expectations are formed through the interactions that take place between myself and a participant. These are influenced by our own value systems, which, for the participant, may shape their expectations and perceptions around the use of the data generated. Finally, the fifth principle addresses the impact of values on the inquiry process. I acknowledge that my personal values have influence and the potential to shape the area of inquiry and the theoretical paradigm and methodology adopted for the study. Values are also ingrained in the study setting that together with the beliefs of all groups represented in the study, will contribute in shaping constructions (Lincoln, Lynham & Guba, 2013).

These five principles (Guba & Lincoln, 1982) inform the approach I have taken in this thesis and provide a framework for all elements of the studies. A constructivist paradigm seeks to gain understanding through interpretation of participant's perceptions. The idea of multiple realities underpins a relativist ontological approach, in that each person constructs their own subjective meanings and understandings socially and experientially. I take a subjectivist viewpoint to inform the inquiry. People construct their own meanings from their lived experience. During a research study a transactional process occurs as I, the researcher, and the study participant(s) interact to co-create findings. Methodologically, a constructivist paradigm takes the form of a hermeneutic, or interpretive inquiry within a dialectic approach; my aim being to generate constructions on which there is substantial consensus (Lincoln, Lynham & Guba, 2013).

1.2.3.1 Research questions

I have designed this study to critically examine the experiences and perceptions of a cross section of staff working within UK Higher Education Institutions (HEIs) where a student suicide has been a recent event; I pose two research questions to underpin the study:

- How is a student suicide experienced by staff members within a UK HEI and what are the features of that experience?
- Do staff members undertake specific postvention roles following a student suicide, if so, what kinds of role, and are there any staff needs attached to delivering them?

To fully explore these questions I have identified the following aim and objectives:

1.2.3.2 Research Aim

To critically examine the experiences and perceptions of staff working within a UK HEI where a student suicide has been a recent event (between 2 years and 9 months prior to the study), in order to:

a. Identify how a student suicide is experienced by staff members within a UK HEI and highlight the features of that experience
b. Explore whether staff members undertake specific postvention roles following a student suicide, if so what kinds of roles, and are there any staff needs attached to delivering them?
c. Undertake a critical exploration of the experiences of a cross section of UK HEI staff members following a student suicide
d. Understand whether staff members feel they need postvention support, whether support is offered, how the support is experienced, and whether existing postvention models suit the needs of a UK HEI community context.

1.2.3.3 Research Objectives

- To undertake a synthesis of existing qualitative data to explore the experience of suicide for staff members working across a range of health, social and educational contexts.
- To ascertain the range of staff within UK HEIs who identify themselves as having been impacted by a student suicide, and to explore the range of impacts and needs as identified by these staff.
- To ascertain the formal roles which are undertaken by staff members following a student suicide. To understand who undertakes these roles, and whether there are any specific needs attached to delivering them.
- To explore the perceptions and experiences of a cross section of UK HEI staff members following a student suicide.
- To understand if UK HEI staff members have postvention needs following a student suicide, whether postvention support was offered to them and whether it was suited

to their needs. To inform a critical exploration of the application of current postvention models within a HEI community of practice context

This aim and the objectives serve to provide a clear framework to the two studies I have undertaken:

1. A Qualitative Research Synthesis that explores the experiences of health, education and social care practitioners following a client, patient, service user or student death by suicide
2. A mixed-method two-phase study that explores the experiences of UK HEI staff members following a student death by suicide.

I have set out the relationship between the research questions, the related aims and objectives, and the studies in the thesis map in Figure 2 below:

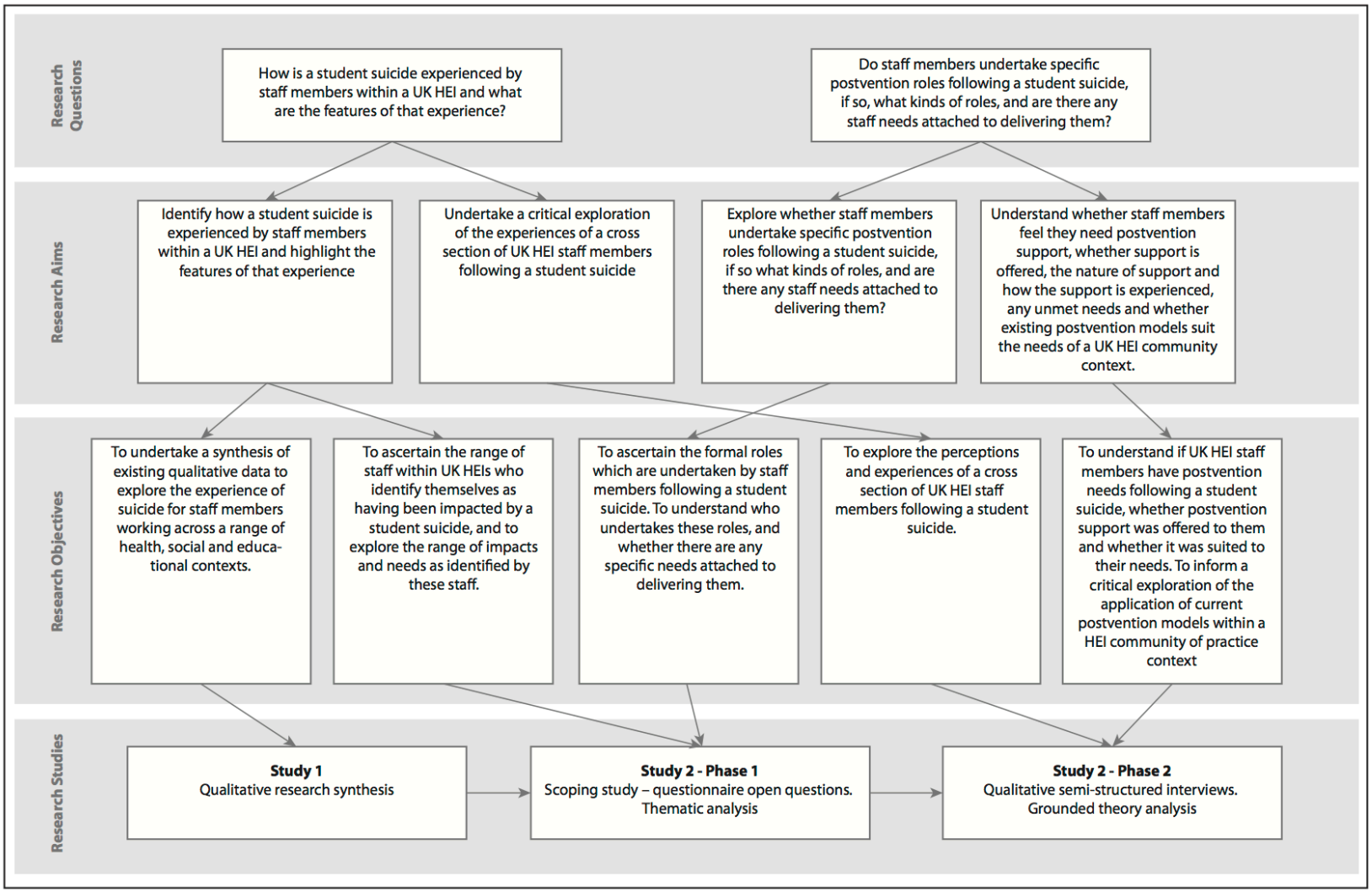

Figure 2: Thesis Map

1.2.3.4 Expected or planned original contribution to knowledge

I believe that this PhD will make the following contributions:

- Study 1: A critical examination of the literature around impacts of suicide on different groups of workers. An interpretative review of the literature will lead to the development of a theoretical framework within which to situate key themes or patterns
- Study 2 – Phase 1: An empirical understanding of the types of impact that a student suicide has on different groups of staff within HEI's and of the different roles and responsibilities those individuals perceive themselves to undertake following a student suicide.
- Study 2 – Phase 2: A critical exploration of the impacts of a student suicide upon staff members with HEI's with a particular focus on their experiences and perceptions. As an inductive study an emerging theoretical framework will be identified from the data during the process of analysis.

The findings of this PhD will articulate the experiences of health, social care and education practitioners, and, for the first time, those of HEI staff members following the suicide of a client or student. I will demonstrate that participant experiences are embedded in the social and cultural contexts within which suicide occurs and participants operate. I have designed the studies in this thesis to generate theoretical understanding of experiences, some of which are previously unexplored. As such, I intend that the findings will contribute to knowledge generation about the impact of suicide on wider networks of people who are exposed to and affected by a suicide because of their job-role. My findings will inform directions for future research in the topics of impact of suicide; student suicide; and postvention. Finally, I hope

that these findings will provide an evidence base from which postvention support for staff members in UK HEIs can be developed and delivered.

1.2.4 Organisation of the thesis

The thesis is titled 'a critical exploration of the experiences of staff at two UK Higher Education Institutions following a student death by suicide. In this section I will explain the organisation of the thesis across seven chapters, and highlight the critical nature of the enquiry and research contained herein.

Chapter 1: An introduction to the thesis: The chapter that you have just read outlined the range of influences that have shaped this body of research. Starting with my personal experiences with suicide in the workplace and an introduction to myself as the researcher. The two key areas of research that underpin this thesis, the concept of postvention, and the topic of student suicide both illustrate that research in this area is sparse and to date has failed to address a number of important questions. Cerel's (2014) model, the continuum of suicide survivorship, is the only theoretical model to address experiences of people who are impacted by a suicide death; I explain how it has shaped my thinking and how my findings have challenged the model. Critical suicidology challenges suicide research to take broader socio-cultural and political approaches to situating and understanding suicide, however postvention is currently absent in the critical suicidology conversation. To address this absence, I have applied a critical paradigm to my research which is underpinned by a social constructivist methodology. Together, the research, theory and paradigms outlined in this chapter, underpin my stated research questions, aim and objectives. I closed this chapter with a statement of the expected contribution of the research, and this overview of the organisation of the thesis.

Chapter 2: Literature Review: To explore the research context I undertake a narrative review of the literature regarding the impact of suicide, the impact of student suicide, and

postvention. Through this review I provide an overview of the current knowledge and theoretical context within which this thesis is situated. I also demonstrate that postvention literature does effectively engage with qualitative methodologies. However, the focus on the experience of bereavement serves to silence the experiences of those in wider networks around the person who died, which means their needs are often overlooked in the provision of support interventions. I also highlight the problematic issue that practitioners are often situated as the providers of postvention, which can render invisible any needs that they may have for support.

Chapter 3: Qualitative Research Synthesis: In this chapter I report the first study in this thesis. A systematic review of the literature in the form of a qualitative research synthesis through which I seek to understand what is already known about the lived experience of suicide and postvention needs of practitioners who experience suicide because of their job-role. This is an empirical and theoretical review of qualitative literature that synthesises evidence from 12 published research articles. The findings of this review demonstrate that studies have not engaged critically with the impact of broader socio-cultural contexts, however in bringing this literature together it is clear that such contexts do shape practitioner experiences.

Chapters 4: Methodology & Methods: The second study in this thesis, a two-phase mixed-methods enquiry that explores the experiences of staff in two UK HEIs following a student death by suicide is presented across Chapters 4, 5, and 6. In chapter 4 I present the methodological approach taken to the second study; I discuss ethical dilemmas including my own role and positionality in undertaking this study, and explore the issue of voice. I present the methods of data collection (e-survey n=19 and semi-structured interviews n=10) and the methods of analysis.

Chapter 5: Findings: In this chapter I present the findings from both phases of study two data collection in three sections; descriptive findings from survey data; staff experiences of

undertaking tasks following a student death by suicide; a grounded theory developed from qualitative interview and open-text survey data. The grounded theory that I constructed from participant data describes experiences via a core category 'bearing witness', which encompasses six further categories; 'responding to a student suicide'; experiencing a student suicide'; 'needs and fears'; 'experiences of support'; 'human stories'; and 'cultural stories'. My aim in presenting the grounded theory findings is to share with the reader the experiences that participants shared with me, whilst explicitly showing how these quotes worked to frame participants' experiences and situated them within broader cultural, social and political contexts.

Chapter 6: Discussion: I discuss and contextualise the findings reported in Chapter 5 according to current relevant literature and theory. Discussion encompasses staff members perceptions of impact; experiences of undertaking tasks following a death a by suicide; experiences of pro-activity; help-seeking and social supports; perceptions of closeness and belonging; and the HEI as a community and as a socially situated institution. I call on the study findings to critique Cerel's (2014) model, and to expand ideas around the concept of 'perceptions of closeness' (Cerel, 2017**)**. I acknowledge and discuss the strengths and limitations of the study.

Chapter 7: Conclusion: To close the thesis I present methodological conclusions pertaining to social constructivism in postvention research and the place of postvention in the critical suicidology conversation. I propose that postvention has a place and a role to play in the critical suicidology conversation, firstly in demonstrating that qualitative methodologies are currently engaged with and contributing to knowledge in suicidology; secondly as a means of engaging postvention researchers with broader contextual socioeconomic and political contexts. I set out the implications and recommendations for research; for the design of postvention interventions and for postvention provision in HEI settings. Finally, I draw together

the findings of studies one and two to present a clear outcome from the research I have undertaken and to conclude the thesis.

Chapter 2

A Narrative Review of the Literature

2.1 Chapter Overview

In this chapter I report a narrative review of the literature. My aim being to locate the studies I report in this thesis within the context of relevant literature. In this review I explore two topics. Firstly, the impact of death by suicide on those left behind. This includes those who are exposed to suicide because of their job role such as health, education and social care professionals, first responders, and those who work in HEI settings. Secondly, I explore the concept of postvention, specifically, identified need, provision, and known effectiveness of postvention to those who need support following a death by suicide, including a student death by suicide.

2.2 Literature Searches

I conducted literature searches over the course of four years, commencing in October 2016. I employed four resources to search for and source relevant literature for this review; library and database searches, database alerts, social media, and article reference lists.

2.2.1 Library and Database Searches

I conducted literature searches between the dates of October 2016 and May 2020. Initially I undertook broad searches using the University of Worcester online library search Summon, or Google Scholar. Subsequently, I undertook focused literature searches using the following databases, PsycInfo; Medline; SCOPUS; ERIC; and CINAHL. Search terms included, but were not limited to, ‘student suicide’, ‘postvention’, ‘death by suicide’, ‘suicide bereavement’, ‘suicide loss’, ‘impact of suicide’, ‘after suicide’, ‘suicide survivor’, ‘suicide in university’, and ‘higher

education suicide'. I used these and similar terms alone and in combination in title and abstract searches to narrow and refine searches as necessary.

2.2.2 Database Alerts

I created and utilised database alerts from October 2016 until the submission of this thesis, on 30th September 2020, to ensure that I noted and screened new publications. I set up alerts within SCOPUS, Google Scholar, Mendeley and ResearchGate. In addition, I created alerts to highlight new work by key authors in the field or by topic terms such as those utilised in database searches above.

2.2.3 Social Media

I used twitter as an academic tool; I followed twitter accounts belonging to key researchers, authors, research labs, research organisations, suicide prevention and postvention organisations, HEIs, and other academic and research bodies. Specifically, I followed accounts that engaged with research or service provision in the areas of suicide prevention, intervention or postvention; student mental health and wellbeing; mental health in HE; HEI support services and HE organisations and campaigning bodies. As a result, my twitter feed highlighted new research publications and reports that were relevant to this review.

2.2.4 Article reference lists

I screened the reference lists of relevant articles for further work by key authors or pertaining to key topics. In addition, I searched for articles that had cited key relevant papers.

2.3 Impact of death by suicide on those left behind

2.3.1 Those who are suicide bereaved

The impact of a death by suicide on those who are left behind is explored in the literature through focusing on the experiences of those closest to the person who has died. For instance,

study authors have defined their participant groups as parents bereaved by suicide (Maple et al., 2010; Maple et al., 2007; Owens et al., 2008; Ross et al., 2018; Törnblom et al., 2013); close family members bereaved by suicide (Begley & Quayle, 2007; de Groot, 2013; Hunt et al., 2019; Oexle et al., 2019; Spillane et al., 2017); family members and close friends bereaved by suicide (Bellini et al., 2018; Bottomley et al., 2018; Castelli Dransart, 2013; Chapple et al., 2015; Gall et al., 2014); and adults who identify as being suicide bereaved (including the additional relationships of romantic partner, significant other, loved one, acquaintance, and community member) (McKinnon & Chonody, 2014; Miklin et al., 2019; Mitchell & Terhorst, 2017; Oexle et al., 2018; Scocco et al., 2017; Wojtkowiak et al., 2012). Across these studies there appears to be no consistency in the definitions of the groups being studied, for instance, a 'close family member' might equally be defined as a 'family member' or as an 'adult bereaved by suicide' by different study authors. There is, however, a common thread that unites these groups of participants across all of the above-mentioned studies. It is the exploration of the experiences of those who identify as being 'bereaved' following a death by suicide. As such, it is the experiences of those bereaved by suicide, as opposed to those who are exposed to or affected by suicide (Cerel et al., 2014), that inform our current knowledge and are explored in the following four sections.

2.3.2 Traits of suicide bereavement

Ordinary grieving has been described as taking two forms; acute grief and integrated grief (Zisook et al., 2014). Acute grief describes the initial, more intense stage of yearning, longing and sadness, this acute process includes consuming thoughts and memories of the deceased, and may also include anxiety, guilt and anger (Zisook et al., 2014). In addition, the bereaved may experience joy, warmth and pride in remembering and reminiscing about the deceased (Zisook et al., 2014). Integrated grief describes the moving forward from the intensity of acute grief, toward the process of acceptance and envisioning a life without their loved one (Zisook

et al., 2014). Studies have found that the bereavement process following suicide includes some of these 'ordinary' symptoms as well as a range of additional experiences, such as blame and emptiness (Cerel et al., 2017); depression, post-traumatic stress disorder (PTSD), and suicidal ideation (Shields et al., 2015). Shame, (Törnblom et al., 2013); burdonesomeness (Talseth & Gilje, 2017); intrusive thoughts and memories, hopelessness (Bellini et al., 2018); and a search for understanding or answers were also evidenced. There is risk of possible trauma if the death is witnessed or the body discovered (Knieper, 1999); and physical and psychosomatic symptoms such as increased experiences of pain and physical illnesses together with poorer general health have also been recorded (Spillane et al., 2017). With evidence of so many grief responses it is no surprise that the experience is described as a complicated grieving process (Knieper, 1999; Bellini et al., 2018; de Groot, 2013) and it may be further complicated by the responses and behaviours of wider networks and within the community. For instance, lack of understanding on the part of others, or the sense of 'differentness' around the death (van Dongen, 1993) may lead to awkwardness or restraint in social interactions, and a sense of difficulty in interactions with authorities (Knieper, 1999). It may only be when the death by suicide is expected, that is, it follows previous attempts at suicide or has been spoken about by the deceased prior to their death, that the bereaved seem better able to develop an understanding of the suicide and experience less searching for explanations (Wojtkowiak et al., 2012).

2.3.3 Comparing suicide bereavement to bereavement by other circumstances

A comparison of the bereavement processes of immediate and extended family members and friends who were bereaved by suicide to those who were bereaved by other circumstances was undertaken (Bailley et al., 1999). It was found that in a sample of 350 participants, that those bereaved by suicide experienced more frequent feelings of rejection and of responsibility, and more total grief reactions, there were also evidence of trends indicating

increased levels of shame and perceived stigmatisation (Bailley et al., 1999). The same study found that those bereaved by suicide also experienced more 'unique reactions', to those bereaved by other causes (Bailley et al., 1999). Unique reactions are defined as those reactions that are outside of the experience of those bereaved by other causes, for instance, the perceived need to conceal the circumstances of the death or sensitivity to the cause of death being cited in official reports or the media (Barrett & Scott, 1989). Some of these findings were echoed in a more recent comparison study that looked at the experiences of young adults bereaved by the suicide of a close friend or relative, compared to those bereaved by other sudden deaths (natural and unnatural); those bereaved by suicide were found to score significantly higher on scales for stigma, shame, guilt and responsibility (Pitman et al., 2016b). One UK study of 3432 suddenly bereaved adults (bereaved by suicide n=614) found that adults bereaved by suicide had a higher probability of attempting suicide than those bereaved by sudden natural causes, however there was no evidence of an increased risk when compared to those bereaved by sudden un-natural causes (Pitman et al., 2016a). The same study found that the effect of suicide bereavement on suicide attempt or ideation was similar whether the bereaved was blood-related to the deceased or not (Pitman et al., 2016c). It is not yet known whether the increased probability of suicidal ideation and behaviour are a short- mid- or long-term effect. These studies evidence that those who are bereaved by suicide have different grief experiences to those bereaved by other means; and that there is an association between suicide bereavement and suicidal ideation or behaviour for those who are blood-related to the person who died, and for those with no familial relationship, such as friends. There are then, unique impacts attached to the experience of being bereaved by suicide.

2.3.4 The search for meaning

The search for explanations and understanding shapes a further aspect of experiencing the loss. Adults bereaved by suicide respond differently to those bereaved by other causes in

relation to their process of meaning making (Bottomley et al., 2018). Using the Meaning of Loss Codebook (Gillies et al., 2014) to understand the experiences of suicide bereaved adults it was found that different or additional processes of meaning making were at play (Bottomley et al., 2018). Some of these were labelled as, 'building comprehension of the loss', 'destigmatisation of the deceased', 'advocacy', 'identification with others', and 'ongoing impact' (Bottomley et al., 2018). For suicide bereaved parents the meaning making process is an ongoing one (Ross et al., 2018). It is also a process that appears to be complex and is integral to processing and the ability to move forward (Castelli-Dransart, 2013). The development of stories and constructions may be used in sense- and meaning-making processes as tools for survival that serve the bereaved in both social and personal contexts (Owens et al., 2008). Indeed, meaning-making may occur within a challenging context as the suicide bereaved and wider community 'struggle to interact with each other in a beneficial way' (Shields et al., 2015, p. 426). Given this complexity, the nature of the meanings that the bereaved attach to their experience and to the context of the death may make them more or less vulnerable in their bereavement processes (Miklin et al., 2019). When meaning-making processes lead to a heightened awareness of suicide as a real rather than an imagined event it may generate the idea of suicide as a potential option or choice in resolving life's challenges, thus leading to an increased risk of suicidality (Miklin et al., 2019). However, meaning-making might alternately heighten awareness of the impacts of the suicide on others and create a robust idea of suicide as never being an option (Miklin et al., 2019).

2.3.5 Suicide bereavement within personal and social contexts

Wider contexts may further shape the experience of the suicide bereaved as the interactions, beliefs, perceptions and behaviours of families, communities, and social processes affect the bereavement experience. For instance, relational factors, such as the bereaved person's life experiences with the deceased and their perceptions of social interactions and social unease

on the part of their selves and others after the death, impact on the bereavement process for family members (Begley & Quayle, 2007). An example being that the responses and behaviours of professionals such as first responders may influence experiences of bereavement following a suicide (McKinnon & Chonody, 2014). Perceptions of stigma experienced by the suicide bereaved following the death have been associated with increased psychological distress (Scocco et al., 2017) and are shown to complicate the emotional responses of the bereaved (Pitman et al., 2016b). Stigma attached to suicide may impact the relationships of the bereaved and their ability to seek help as well as denying them the opportunity to tell their stories, further adding to the complexity of the grieving process (Peters et al., 2016). These experiences may lead to a perception of being silenced, which inhibits the meaning-making process (Gall et al., 2014). For parents bereaved by suicide, silencing can be experienced as being imposed on them by others, as well as being self-imposed, and can heighten the sense of being isolated (Maple et al., 2010). The perception of a suicide death as being a 'private trouble' as opposed to other sudden traumatic deaths such as death by terrorism or a plane crash which are perceived as a 'public issue', differentiates experiences and opportunities for openly grieving, with the suicide bereaved feeling shut down and having to contain their feelings, again being silenced and driven into secrecy (Chapple et al., 2015). Secrecy in bereavement has been associated with further grief difficulties such as feelings of suicidality and negative mental health outcomes (Oexle et al., 2018). Experiences with social supports also affect experiences of bereavement. Social and family support, such as the willingness of others to talk about the suicide, or public displays of respect for the deceased such as attendance at the funeral, can support the bereaved persons process of 'learning to be ok' (Hunt et al., 2019). Social and family support has also been associated with decreased grief, depressive symptoms and suicidality and with increased personal growth (Oexle et al., 2018). However, when support structures are absent, for instance in work and educational settings,

there is potential for the bereaved by suicide to leave jobs or educational courses in the aftermath (Pitman et al., 2018a).

2.3.6 Impact on wider networks

All of the impacts reported so far have been evidenced in studies whose participants identify as being closest to the person who died and experiencing a process of bereavement following the death. However, there is evidence that others in wider networks are also affected by a suicide death. A survey of 293 people accessing a 'surviving suicide' intervention in the US found 41 unique relationships with the person who died; close familial relationships such as son, brother and husband were the more frequently reported (235 instances of 323 or 73%); in addition were wider family networks such as cousin, stepson and uncle, and friends (73 instances of 323 or 23%); and a range of other relationships, for instance, patient, client, neighbour, co-worker and acquaintance were also reported, albeit in far smaller occurrences (13 instances of 323 or 4%) (Honeycutt & Praetorius, 2016). Exposure to suicide for wider networks may lead to different kinds of impact and responses, for instance, rather than an experience akin to bereavement, it may be that individuals are affected by shock, trauma symptoms, and experiences of PTSD (Maple et al., 2016). Whilst attention focuses on those who are closest to the person who died, wider networks, such as adolescent peer groups for instance, may feel overlooked or may experience feelings of guilt for their grief (Bartik et al., 2013). However, the heightened risk of suicidality in those who are exposed to a suicide death remains, regardless of whether they were blood relatives of the deceased or part of the wider network around the person who died (Pitman et al., 2016a). This may in part be due to the perceptions that individuals have around their closeness to the person who died (Cerel et al., 2017).

2.3.6.1 Impact of suicide on professional workers

Practitioners in health, social care, and education job-roles may experience a death by suicide of their patient, service user, client or student. In some professions, the likelihood of such an experience is high. For instance, in a survey of 120 GPs, 86% encountered at least one patient suicide in the previous ten years (Halligan & Corcoran, 2001); of 247 consultant psychiatrists 68% experienced a patient death by suicide (Alexander et al., 2000); 55% of a sample of 531 psychiatric nurses encountered at least one patient suicide (Takahashi et al., 2011); of 89 psychiatric trainees, 43% experienced one or more suicides (Yousaf et al., 2002); for teachers, nearly 36% of a sample of 145 were exposed to at least one student suicide (Kõlves et al., 2017); and in a sample of 697 social workers, 33% experienced exposure to suicide in the course of their job (Jacobson et al., 2005). To contextualise those statistics, a recent meta-analysis of population-based studies showed that exposure to suicide in the general population is 4.31% for past-year prevalence and 21.83% for lifetime prevalence (Andriessen et al., 2017). In comparison to the general population, health, social care, and education practitioners experience an increased risk of exposure to death by suicide at least once during their working lifetime.

The effects of such rates of exposure have been evidenced amongst health, social care and education practitioners following a death by suicide. For instance, these may include feelings of professional doubt and fear of legal consequences (Castelli-Dransart et al., 2017), as well as a sense of responsibility for the death (Gaffney et al., 2009). In addition, emotional turmoil and stress reactions (Castelli-Dransart et al., 2017), and severe distress (Wurst et al., 2013) have been reported. For some mental health professionals, post-traumatic responses such as intrusion, avoidance, and hyper-arousal have been reported as being so severe and persistent that they fell within a clinical range (Castelli Dransart et al., 2014). Teachers reported that they felt impacted both in their personal life (76% of 145 teachers) with experiences of low mood

and poor sleep, and their professional life (85.7%) by heightened awareness of suicide risk, increased use of existing protocols, and changes to practice when encountering potentially suicidal students (Kõlves et al., 2017). In addition, over one third of the teachers reported decreased self-confidence (Kõlves et al., 2017). The severity of responses to a patient death by suicide has been linked to the interplay of mental health professionals sense of closeness to the patient; level of exposure to the suicide; and experiences of support and training (Castelli Dransart et al., 2015). Feelings of responsibility for the death and concerns for the bereaved family are also thought to influence adjustment and coping after a patient suicide (Gaffney et al., 2009).

The literature reviewed here suggests that professional workers do experience diverse impacts following a death by suicide encountered because of their job-role. Distinct impacts are reported in their professional lives to those experienced in their personal lives, evidencing that the effects of suicide exposure affect these workers in both public and private contexts. Health, social care, and education professionals may perceive themselves to be exposed to or affected by a suicide. However, the kinds of effects experienced are distinct from those described in the literature pertaining to the experience of bereavement by suicide for close family and friends.

2.3.6.2 Impact of suicide on first responders and those first on the scene

In addition to the wider networks who knew the person who died, there are also people who come into contact with a suicide death that have no knowledge of the deceased, such as those who work in the emergency services. Frequency of exposure is likely to be higher for these groups, for instance of a sample of 61 US firefighters it was found that the average lifetime exposure to suicide was 13.1 exposures (Kimbrel et al., 2016). The same study found that cumulative exposure to both attempts and death was positively correlated with suicidal behaviour (Kimbrel et al., 2016). Similarly, female firefighters who experience exposure to

suicide during their careers may experience more severe psychiatric symptoms and increased suicide risk compared to their counterparts with no exposure (Hom et al., 2018). In addition to increased suicidality, high levels of occupational exposure to suicide for law enforcement officers led to a significant association with PTSD and other mental health symptoms (Cerel et al., 2018b). Rail workers are another group who experience suicide deaths because of their jobs. A systematic review of the impact of suicides and other critical incidents on railway personnel found that some workers experienced diagnosable traumatic reactions following an incident; whilst others were affected to an extent that may not meet diagnostic criteria, but even so had a profound effect on their lives (Bardon & Mishara, 2015). Contact with the corpse and perceptions of the victims vulnerabilities were amongst the factors that increased negative reactions for railway workers (Bardon & Mishara, 2015). The impact of responding to suicide deaths for ambulance staff includes ongoing salient memories of the events they have witnessed; feelings of being haunted by events; interference with sleep; and feelings of personal distress and vulnerability (Nelson et al., 2020). Ambulance staff are often the first at a scene and may become involved with tasks that are beyond their usual job role. For instance, negotiating with a person in crisis; informing people of the death of a loved one; preserving a potential crime scene; and exposure to the intense reactions of bereaved individuals (Nelson et al., 2020). The impact of these kinds of tasks has been captured in a focus group study of 35 first line responders (Nilsson et al., 2017). The study revealed that they experienced feelings of inadequacy when faced with the emotional responses of suicide bereaved people; they felt unable to offer solutions as they doubted their own capacity and lacked supportive guidelines; they reported feeling torn between different responsibilities; and they shared that they used emotional shutdown as a means for preservation (Nilsson et al., 2017). However, despite these challenges, first responders are identified as playing a critical role for those who are bereaved by suicide during the immediate crisis stage of the aftermath (Norton, 2017). The behaviour of

first responders can reduce risk and promote healing for family, friends, the wider community and others who are present at a suicide death (Norton, 2017).

2.3.7 Impact of suicide within HEI settings

Having established that a death by suicide has impact on people beyond family and friend networks, it is necessary to understand if this is also the case for wider networks within the context of a HEI setting following a student death by suicide. This is important in order to situate the subsequent research in this thesis within existing knowledge. There is a current lack of literature that explores the impact of student suicide on individuals within the university or college community, however, it is known that students do experience exposure to suicide deaths (Cerel et al., 2013). Of 117 college students 65% knew someone who had attempted or died by suicide, of those, 21% identified as being a suicide survivor, that is, they felt personally affected by the suicide (Cerel et al., 2013). Whilst Cerel (2013) did not set out to explore the effects of those exposure experiences, a cross-sectional study of staff and students at 37 UK Higher Education establishments, concluded that bereavement by suicide is a specific risk factor for subsequent suicide attempt among young bereaved adults (Pitman et al., 2016a). Neither of these studies however report on the specific incidence of exposure to or impact of a student suicide amongst student peers or staff members in HEI settings. Therefore, the impact of a student death by suicide on HEI staff members remains unknown.

2.4 Postvention

There is an increased risk of suicide amongst those who are exposed to suicide (Maple et al., 2017; Hill et al., 2020) and it is thought that postvention, whilst providing support, may lessen that risk (Jordan, 2017). In this section I will take a broad view of what postvention support might look like and what kinds of postvention guidance and support are available, in order to understand what might be accessible for UK HEIs. It is also relevant to explore what we know

about the effectiveness of postvention interventions; who of those exposed to, affected by or bereaved by suicide might need postvention support; and what kinds of postvention support they need. Finally, I will review what we currently know about postvention in the context of student suicide.

2.4.1 What does postvention support offer?

Postvention approaches can be delivered via clinical or public health routes to meet the needs of those who are bereaved or affected by a suicide (Andriessen & Krysinska, 2012). The aims of postvention are to aid recovery, support the grieving process, and to limit adverse outcomes such as the risk of suicidal ideation and behaviour in those exposed to suicide (Szumilas and Kutcher, 2010; Andriessen & Krysinska, 2012). In assessing what kinds of postvention provision are available, a review found that programmes primarily fall into three main groups; school-based programmes; family-focused programmes; and community-based programmes (Szumilas and Kutcher, 2010). School-based programmes included in the review consisted of three elements; supportive counselling for close friends of the person who died; psychological debriefing-type interventions for the whole school population; and crisis/gatekeeper training for staff members (Szumilas and Kutcher, 2010). Family-focused postvention programmes were found to include outreach at the scene for survivors of a suicide death; support groups for partners and parents of the deceased; support groups for other adult survivors and support groups for child and adolescent survivors. Community based postvention was found to include media reporting guidelines around suicide and suicide attempts and multi-component interventions that include schools, media and health service systems (Szumilas and Kutcher, 2010). In general, provision may include a diverse range of support interventions largely targeted at families and those closest to a person who has died by suicide (Andriessen et al., 2019a). Interventions may include support groups, grief counselling, outreach support, and online support; services may be situated in specific settings, shaped to meet the needs of

specific groups, or be community based; they may be delivered by the bereaved themselves, by grief or other charitable organisations or by public sector and health providers (Andriessen et al., 2019a). National guidelines in the UK, US, and Australia all advise that interventions be delivered according to the level of impact (Andriessen et al., 2019a). For instance, universal interventions for people with low levels of grief might include interventions such as leaflets, books and signposting; those for people who are experiencing moderate to severe grief reactions might include psycho-education, peer support, facilitated group support, help-lines and counselling; interventions for those who are experiencing complex grief or mental health problems as the result of a suicide bereavement might be supported by one to one psychological help such as psychotherapy (Andriessen et al., 2019a).

2.4.2 Is postvention effective?

There is inconsistent evidence for the effectiveness of postvention models and interventions (Linde et al., 2017; Andriessen et al., 2019a; Andriessen et al., 2019b). A systematic review of seven intervention studies found that there is some evidence of benefit (Linde et al., 2017). Four of the seven studies reviewed explored the effectiveness of bereavement groups; two looked at interventions based on cognitive-behavioural approaches and one offered a writing therapy intervention (Linde et al., 2017). Five of the seven interventions were found to be effective in reducing grief intensity. Bereavement groups proved effective in lowering the intensity of uncomplicated grief; writing interventions lowered suicide-specific aspects of grief; and cognitive behavioural interventions evidenced helpfulness for those who had high levels of suicidal ideation (Linde et al., 2017). More recently, a further systematic review of eight studies (including one study included in Linde et al., [2017]), and twelve postvention guidelines sought to find out which postvention models have been shown to be effective in reducing distress for families, friends and communities following a death by suicide (Andriessen et al., 2019a). The findings of this review were inconsistent; five of the eight studies provided some

evidence of effectiveness such as improvement in grief scores, improvement in mental health scores, and reported decreases in suicidality. However, other measures of the same outcome variables reported mixed results regarding grief, mental health, and suicidality, both within and across studies (Andriessen et al., 2019a). Components that appeared to provide some level of effectiveness included providing support according to the level of grief, involvement of trained volunteers/peers, and focusing the interventions on the grief, as opposed to crisis response models (Andriessen et al., 2019a). A further systematic review that assessed the effectiveness of interventions looked at controlled studies of grief, psychosocial, and suicide-related outcomes (Andriessen et al., 2019b). Eleven relevant studies were found and the review concluded that, whilst there was some evidence of the effectiveness of interventions for uncomplicated grief, the same was not the case for interventions for complicated grief. In addition, it was found that supportive, therapeutic and educational approaches that involve the social environment, such as the wider community, and are delivered in sessions by trained facilitators showed promise (Andriessen et al., 2019b). Reviews of school-based and family-focused postvention programmes found no protective effects in terms of the number of suicide deaths or attempts (Szumilas and Kutcher, 2010). However, school-based postvention programmes delivered an increase on a self-efficacy rating scale for a group-based psychological debriefing and educational session aimed at close friends of the deceased (Szumilas & Kutcher, 2010). Despite this, the review authors recommend that psychological debriefing should not be used with adults or youth, and that school-based programmes should avoid the participation of all (Szumilas & Kutcher, 2010). This recommendation is informed by findings from one school-based programme that reported serious negative effects following the delivery of a psychological debriefing programme when two students died by suicide, six were hospitalised and thirty suicide gestures or attempts were recorded in the six months following the intervention (Szumilas and Kutcher, 2010). In community-based programmes, outreach at the scene of the suicide was found helpful in engaging survivors to attend a

support group; and in family focussed programmes, for spousal survivors, contact with a nurse-led group counselling postvention programme helped to reduce psychological distress, and parents bereaved by suicide experienced mixed effects of a group treatment programme for bereavement by violent death of a child (Szumilas and Kutcher, 2010).

The overall methodological quality of studies in this area are described as weak (Andriessen et al., 2019a; Andriessen et al., 2019b) or low, (Linde et al., 2017). It seems clear therefore that additional methodologically robust evaluation is needed to assess the effectiveness of postvention guidance and provision (Andriessen et al., 2019b; Linde et al., 2017). With findings of inconsistent evidence within and across studies (Andriessen et al., 2019a) for the effectiveness of diverse postvention interventions, and with some evidence of potential serious harm (Szumilas & Kutcher, 2010), it seems that there is little clarity regarding the effectiveness of postvention interventions, or the suitability of specific interventions for specific needs or groups. In all, the evidence around the effectiveness of postvention guidance and interventions is limited, patchy and inconsistent. Interventions reviewed are diverse in terms of aims, target populations, sources and means of delivery which make comparison and conclusion very difficult.

The authors of all of these reviews critique the effectiveness of interventions and the methodological approach of studies that set out to measure their effectiveness. They also categorise the nature of the interventions, but they do not critique the nature of the interventions. Most of the interventions measured in these reviews take the form of psycho-therapeutic approaches to working with (complex) bereavement due to suicide, thus focusing the support on the individual person who is experiencing loss and grief (Linde et al., 2017; Andriessen et al., 2019a; Andriessen et al., 2019b). It has been argued that 'highly structured, standardised and pre-determined' interventions designed as preventative measures to suicide are not always effective (Fitzpatrick et al., 2014, p.14); rather, that support might do better to

focus on the diversity and multiplicity of meanings that suicide has for people within communities (White, 2012). Whilst these authors were not writing with postvention in mind, it is credible that their arguments are relevant in terms of reviewing postvention interventions. It might, therefore, be pertinent to move beyond measures of effectiveness just at an individual level, and in addition, seek to ascertain how interventions propose and act to address wider socially and culturally embedded meanings of suicide. In this way, addressing the factors that may lead to the complex experiences of shame, stigma, guilt and silencing experienced by those who are impacted. Of course, support and interventions can only be designed in response to what is currently known about the impact of suicide. So, whilst postvention research continues to focus on personal experiences of loss and grief following suicide, it is clear that this will remain the sole focus for support. If postvention research were to develop a broader, more critical focus to encompass social, cultural and political impact of suicide, likewise the focus of response might also expand beyond its current 'narrow' remit (White, 2012, p46).

Most of the studies included in these reviews apply to interventions and guidelines accessed by or intended for close family members and those who are bereaved (Andriessen et al., 2019a; Andriessen et al., 2019b; Linde et al., 2017). In addition, throughout all of these reviews the language used by the reviewers refers to those who are bereaved by suicide, with little or no acknowledgement of those who are exposed to or affected by a death by suicide. Therefore, whilst national guidelines acknowledge the wider networks who may be impacted, it appears that they are overlooked at the point of intervention delivery. If there are interventions available for wider networks they currently remain undocumented in the academic literature. The very recent publication of a study protocol to evaluate a postvention programme for professionals after a client or user suicide is cited to be the first mixed method evaluation of postvention support for professional workers (Leaune et al., 2020).

2.4.3 Who needs postvention support and what kinds of support do they need?

People who are bereaved by suicide have reported the need for pro-active offers of support (Pitman et al., 2018b; Shields et al., 2015) from diverse sources (Pitman et al., 2018b) that should be repeated regularly (Shields et al., 2015). Ten bereaved adults took part in a group discussion that aimed to explore the views of people bereaved by suicide regarding the development and evaluation of support services (Pitman et al., 2016c). They expressed the need for specific targeted support such as immediate support from a sudden death liaison worker and, later, proactive support from their GP and suicide support services (Pitman et al., 2016c). Additionally, in a survey of 166 bereaved by suicide family members and loved ones 94% of them stated a need for support; however only 44% of them received support and only 40% of those who did receive professional support felt satisfied with it (Wilson & Marshall, 2010). Aspects of support groups that were found to be helpful included companionship, mutual understanding and comfort with a sense of belonging and feeling of validation and hopefulness (McKinnon & Chonody, 2014). Timing of availability of services is important; those whose most recent loss to suicide was less than 12 months found that support resulted in significantly less likelihood of risk of suicidality, fewer experiences of loss of social support, and less loneliness compared with people bereaved by suicide who had not accessed a support service (Gehrmann et al., 2020). Support after a suicide death does not only come from formal postvention interventions. Informal support may include that received within family and peer networks. Indeed the strongest protective factor following suicide bereavement was found to be support from family and friends (Callahan, 2000). However, people bereaved by suicide are less likely to receive informal support than those bereaved by other kinds of sudden death and are more likely to experience a delay in receipt of informal support (Pitman et al., 2017).

It is not just those who are bereaved following a death by suicide that need support. A number of studies report on the support needs of professionals who are exposed to or affected by a

suicide. Amongst 152 GPs affected by a patient suicide, 62% stated that they would access a support system if one were available (Halligan & Corcoran, 2001). A survey of 90 psychiatrists found most of them sought some kind of support following a patient death by suicide (Erlich et al., 2017). Qualitative survey responses from 79 mental health professionals outlined a range of suggestions for the provision of support, these included debriefing, counselling, the option to take time off, informal support from a manager, and further training (Murphy et al., 2019). In responses to an open text question about support, 145 teachers who were exposed to a student death by suicide, the majority mentioned counselling as well as professional support, others mentioned training, a crisis plan and 'not ignoring the incident', and a greater understanding about the impact of a student suicide on teachers (Kõlves et al., 2017).

2.4.4 Accessing postvention support

A qualitative study that explored the experiences of 14 bereaved adults found that they experienced inconsistencies in being connected with support services or being provided with information regarding services; with written material appearing out of date and irrelevant to needs (McKinnon & Chonody, 2014). Additionally, the impacts of their bereavement hindered their ability to search out support services, and those in rural areas particularly struggled to access support over great distances (McKinnon & Chonody, 2014). Participants in the same study shared that they did not want to access peer support groups as they did not want to listen to the stories of others and would find sharing their own story difficult; some who attended peer support groups found the experience unproductive and others never returned (McKinnon & Chonody, 2014). Another qualitative study (n=10), evidenced other challenges to accessing support, including a perceived lack of understanding amongst professional services in terms of knowing how to help, fears of stigma and judgement, and not feeling ready to face the issue (Trimble et al., 2012). These findings evidence that those bereaved by suicide need improved access and greater availability of support; the development of proactive support

networks; and professionals who understand and recognise the pain and strong feelings that come with suicide bereavement (Trimble et al., 2012).

Accessibility of postvention to those who need it may be a factor in determining the effectiveness of the model. For instance, two models of postvention are described by Cerel & Campbell (2008). One being active, the other passive, where the active model utilised an outreach design to begin as close to the time of death as possible; often engaging at the scene of the suicide by providing immediate support and referrals to all those identified as potential survivors. In contrast, passive models of postvention support rely on the survivor to seek them out and make the first contact. A comparison study of active and passive models of postvention found that an active model was associated with survivors presenting sooner for treatment and more likely to attend survivor support group meetings and to attend more meetings (Cerel & Campbell, 2008). Increased availability of support, this time in the form of an intervention supported by text messaging was found to decrease symptoms of depression (Spino et al., 2016). Internet support groups were also found to be helpful particularly as they could offer access to support around the clock, and gave users the opportunity to invest more time with the support; this was found to be particularly helpful for users who experienced a greater sense of stigma and felt unable to access support in their personal communities (Feigelman et al., 2008).

Challenges to accessing support were also evident in wider networks of those who were exposed to or affected by a suicide. Of 152 GPs affected by a patient suicide, whilst 62% stated that they would access support if available, only 20% of them actively sought support (Halligan & Corcoran, 2001). A survey of 90 psychiatrists found that only 9% of them had accessed a postvention procedure or toolkit following a patient suicide, despite 72% of the sample experiencing one or more patient suicides (Erlich et al., 2017). Likewise, only 17.7% of 179 mental health professionals were offered formal support after a service user suicide (Murphy

et al., 2019). When support is received it may not meet needs; 27.1% of 145 teachers felt that they needed more support than they received following a student death by suicide (Kõlves et al., 2017). In the absence of postvention support, one strategy for coping after a suicide may be making changes to practice; just over half of 90 psychiatrists reported some level of change in their clinical practice such as requesting increased supervision; increased use of assessment tools; and stopping accepting patients who may present with risk of suicidality (Erlich et al., 2017). In addition, support may be sought beyond the professional domain; teachers most frequently turned to family members or their partner (65.3%) compared to 30.6% who sought support from the school counsellor (Kõlves et al., 2017).

2.4.5 Postvention guidance for United Kingdom Higher Education Institutions

Given the kinds of experiences of impact and trauma outlined previously it seems likely that staff in HEIs who undertake first responder roles or who know a student who dies by suicide may need support to understand and manage their emotional responses and to mitigate any potential trauma impact. HEIs require guidance with regard to providing postvention support to their students and staff members to ensure that provision is accessible to the people who need it and is offered in a form that meets their needs. To develop and implement appropriate postvention support, it is important to better understand the differential experience and impact of suicide on specific sub-groups (Andriessen et al., 2017).

Within the UK, Public Health England (PHE) (2016a), offer guidance to locality and health and wellbeing boards around including postvention within a local suicide prevention strategy. If localities have followed this guidance it means that there may be community level provision available to HEI staff following a student suicide. Guidance is underpinned by Cerel et al's. (2014), continuum of suicide survivorship model which accommodates all people who are exposed to, affected by or bereaved by a death by suicide. The guidance outlines a pathway of care and support that starts from the first contact with emergency services or first responders;

through to referral routes for specific postvention support packages from local providers; to primary care interventions or mental health services. A hierarchical model of support identifies that those who are 'affected', such as first responders and teachers, by a suicide death, as well as those who are bereaved, will need support at different levels. This suggests that those in wider networks are provided for within the model. However, the case studies included in the guidance to demonstrate good practice in postvention support, all state that their support is available to those who are 'bereaved' by suicide, with some offering support to family members only. This suggests that whilst guidance is inclusive of those who are exposed to and affected by a death by suicide, that in fact, community provision is not set up to meet the needs of those in wider networks, focusing instead on those closer to the person who died and who are bereaved by a suicide death.

Public Health England also provide a downloadable leaflet entitled 'Help is at Hand' (Public Health England, 2016b). The leaflet is aimed at members of the public who are exposed to a death by suicide. It is an information pack that talks about feelings, about processes following a death by suicide, and about the kinds of relationships that people may have had with the bereaved. It also includes information about how to help someone who is bereaved by suicide (this includes a section on helping 'my student') to move forward from a suicide bereavement; and signposting for further support which takes the form of national helplines such as Samaritans and two bereavement support organisations, one of which is specifically aimed at bereavement by suicide. There are some sections of the resource that may prove helpful to staff in HEIs; for instance, a section on dealing with the media; and a section for people who have been affected by the suicide of an acquaintance or stranger, university staff are included in the list of people who may sit in this category. The leaflet is therefore positioning the HEI staff member as both the provider of support to others, and as the person who may need support.

In addition to guidance and resources offered by PHE, there is also more targeted guidance offered specifically to schools, colleges and HEIs (Samaritans, 2020a); to secondary teachers and staff in schools and colleges (Papyrus, 2018); and to HE leaders in UK Universities (UUK et al., 2018). All three sets of guidance position university staff members as the providers of postvention support, with students and family members being those who need supporting. Guidance is offered to staff in the form of advice and support for creating a suicide safer school, college, or HEI (Papyrus, 2018; UUK et al., 2018) including a draft policy (Papyrus, 2018) or guidance for the creation of a postvention team (UUK et al., 2018). A framework approach that aims to understand student suicide, mitigate risk, intervene when necessary, and respond appropriately when a death occurs is suggested by UUK (2018). Guidance covers the use of appropriate and safe language following a suicide or suicide attempt; suggestions for building community connections as sources of support; intervention if a child or student is talking about suicide or engaging in suicidal behaviour; and advice on talking about suicide with school children and students (Papyrus, 2018). Advice and support are also offered on what to do following a student's suicide or attempt; informing and supporting students; communicating with the media; how to mark remembrance; how to manage social media (Papyrus, 2018). Additional suggestions are made for supporting students and others around them, including information on expected responses and why people might die by suicide (Samaritans, 2020a). Again, the HEI staff member is positioned as the provider of postvention support to others.

In terms of recognising that HEI staff members may also require postvention support, guidance from Samaritans (2020a), does not acknowledge that HEI staff may experience emotional or traumatic responses to a student suicide and no guidance around support for staff members is offered. Professional workers are often seen in terms of being the providers of support following a suicide rather than being affected by the suicide and in fact needing support themselves (An Fhailí et al., 2016). However, the emotional impact on staff is mentioned in

passing by Papyrus (2018), and suggested strategies to manage the impact include talking with colleagues, seeking support from professionals, and having a debrief at the end of the day to discuss how things have gone and identify any concerns regarding specific students. The guidance from UUK (2018) is the most comprehensive and targeted package for HEIs and it does acknowledge that staff may need support as well as students, but it does not differentiate how this support might be provided, that is, staff needs may be different to student needs, and staff may wish to seek support in different places, which is not acknowledged. Training programmes are suggested for staff members (UUK, 2018), but the suggested programmes either focus on suicide prevention and intervention, rather than postvention; or on giving professionals the skills to support others who are bereaved after a suicide death.

Guidance is also available from the US (Higher Education Mental Health Alliance [HEMHA], 2014) aimed at US colleges and universities that are affected by or want to be prepared for a student death by suicide on campus. Like the UUK (2018) guidance, provision of postvention hinges on the creation of a postvention committee and a protocol. Guidance includes suggestions for provision of support interventions via group discussions and support sessions with individual clinical support for those that need it. This guidance includes a protocol for when the student who died was a counselling centre client and includes guidance around legal concerns accordingly. The guidance acknowledges that first responders, residential staff, and academic and support staff who knew the student who died are all potentially within high risk groups following the suicide. Suggestions are made for strategies to support these staff members such as group discussions and strategies to foster mutual support, there is acknowledgement that responders and committee members are not immune to emotional difficulties or even traumatic responses. The use of a debriefing process is suggested as a means of identifying the right time to end the postvention protocol and to identify any gaps that have come to light as a result of the student death (HEMHA, 2014).

Guidance from beyond the Higher Education sector may provide a starting point in thinking about how staff needs might be met within HEIs. For instance, a ten-point action plan for supporting staff in the case of suicide by a colleague, customer, business partner, or a family member of an employee identifies three key phases for support and response (Carson J Spencer Foundation et al., 2013). The first phase, 'acute', being the immediate response phase. The second phase is 'recovery', which is about short-term support to ensure adequate resources are available to support grieving, coping and cognitive processing. Finally, the third phase, 'reconstructing' is about preparing for the longer-term impacts and transitioning from postvention to prevention. Throughout the plan, resources, guidance and checklists are included alongside templates for memos and a decision making flow chart (Carson J Spencer Foundation et al., 2013). Whist this guidance has not been prepared with HEI staff in mind, it does place the needs of staff members at the centre of a postvention response and support framework.

Likewise, guidance for other sectors may also have relevance. For instance, Samaritans (2020b) offer guidance for supporting rail workers who witness death or serious injuries or who are involved with the emergency response following a suicide or attempt on the railway. The experiences of rail workers who respond to a suicide might have commonality with experiences of first responders on HEI campuses. The guidance acknowledges that trauma is a likely outcome of workers' experience and offers a one-day 'Trauma Support Training' to managers to improve support to those working in high risk roles; Samaritans also produce two booklets, one that aims to prepare railway staff for what to expect and one to provide information and guidance on seeking further support. They also offer a post-incident support service to railway stations following a suicide.

There is very little attention paid in the academic literature to postvention in the context of a student suicide. A suggested model takes guidance from approaches in US High Schools and

accordingly suggests an approach based on a 'death response team' (Streufert, 2004). An outline offers support to a University in setting up such a team. This includes considerations to be taken such as; how to respond to a death by suicide as well as other kinds of deaths; approaches toward liaising with family members; ensuring the safety of other students; and setting up survivor support groups. Community wide considerations include communication with the media and the arrangement of memorials is advised. Documentation is acknowledged and training needs for staff are suggested. Whilst this all may seem helpful the model is aimed to respond to deaths by various means and this may result in some specific sensitivities related to a death by suicide being overlooked. Another paper that addresses postvention responses on campus is a commentary piece about student suicide on US campuses (Westefeld et al., 2006); the authors suggest a range of tasks for staff aimed at supporting the 'survivors' of the suicide, that is, the family and other students. The paper recommends that US colleges should have a clear postvention team and response plan in place ahead of a suicide occurring and that the plan ought to be shaped to suit the particular campus and that it ought to include psycho-education, group work, referral information and opportunities for affective processing (Westefeld et al., 2006). There is no acknowledgement in this paper however that staff may identify amongst the survivors, or that they may encounter any emotional response to the suicide of a student or to delivering tasks within a postvention programme. The suggested provision is aimed at students and family members of the deceased student.

2.4.6 Seeking an evidence base for postvention provision in United Kingdom Higher Education Institutions

Current guidance and suggested models for provision cite varied levels of underpinning evidence. In terms of basing their guidance in evidence, both the UUK (2018) and Papyrus (2018) guidance call on UK government and ONS statistics around suicide to evidence the need for suicide strategies in education settings, with the UUK guidance also calling on the research

literature around suicide and student suicide. Guidance from Samaritans (2020a) doesn't state whether it is based in evidence from the literature. None of these three UK based sets of guidance appear to have been developed from a specific programme of research, nor is there any evaluation offered as to the effectiveness of the suggested strategies and frameworks. The guidance set out by HEMHA (2014) states that it draws heavily upon two pieces of work; firstly, Cimini and Revero, (2013); a book chapter that outlines the development of a comprehensive campus response to suicide and related risk. Secondly, Meilman and Hall, (2006), a paper that outlines the development and use of community support meetings on university campuses as a tool for managing the aftermath of a student suicide. Neither of these works appear to be underpinned by research evidence, in terms of who might be impacted, how they might be impacted, what their needs might be and how those needs might be met. Additionally, neither of the works discuss any evaluation of their effectiveness in terms of outcomes. Overall, the guidance currently available to UK HEIs around developing postvention responses is not based on any context specific evidence nor has it been evaluated in terms of efficacy. It remains the case that until more is known about the impact of a student suicide on HEI staff, an evidence based postvention response cannot be designed and implemented to meet their needs.

2.5 Summary and Conclusions

Current knowledge of the impact of a suicide death is drawn largely from the literature that explores the experiences of those who identify as being bereaved by the death, usually close family and friends. The focus throughout the reviewed literature is on the individual, and knowledge is constructed based on personal, rather than community, social, cultural or political impacts of suicide. Suicide bereavement is different to bereavement by other circumstances and includes complex grief and experiences of meaning making, silencing, and stigma, and is shaped by social and community contexts and the behaviour of others within those contexts. The reported sense of 'differentness' (van Dongen, 1993), together with

aspects of the bereavement process such as perceptions of stigma, shame, and guilt, appear to root the individual's experience in their awareness of social narratives about suicide. For instance, the acknowledged fear of the cause of death being reported in the media (Barrett & Scott, 1989). Although this is an aspect not widely explored in the literature. There is considerably less known about the impacts of suicide on wider familial and social networks and so it is not yet known if the impacts are similar or different to those of the bereaved. However, it is evidenced that professional workers who knew the person who died, and first responders who did not know the person who died, experience trauma responses and professional impacts that are distinct from the experiences of those who are bereaved. In addition, first responders in particular come into contact with suicide in public and community settings, thus situating their experiences of suicide within a social experience of suicide. This aspect of their experience appears unacknowledged in the literature. There have been calls for more qualitative research in suicidology (Hjelmeland & Knizek, 2010); a significant proportion of the postvention literature that informs this review is qualitative. These studies play an important role in reporting the experiences and perceptions of people who are impacted by suicide, informing our understanding of the topic.

There is an incredibly limited literature that explores the topic of student suicide, with no known studies exploring the impact of a student suicide in a HEI setting on either students or staff. So, currently it is unclear whether the experiences of HEI staff who are first responders and staff who knew the student are similar to those reported above or whether there are further distinct impacts that remain undiscovered.

Currently, postvention provision takes the form of support groups and psychological support. Just as the impact of suicide is studied through personal experiences, so responsive interventions are aimed at the individual. There is an echo here of White's (2012) observation that findings from a narrowly focused literature regarding the causes of suicide have led to

equally narrow prevention interventions. Postvention is delivered through a range of in-person and remote platforms by diverse providers, usually aimed at meeting the emotional needs of those bereaved by suicide, such as family members and those closest to the deceased. Whilst interventions might be delivered at community or school level, the focus is on healing or supporting the individual's psychological and emotional harms through interventions that focus on strategies for change or coping. There is limited evidence for the effectiveness of postvention support, but there are some positive indicators that require further methodologically robust research. The effectiveness of postvention interventions is measured by the experience of positive change to bereavement symptoms. The reviewed literature paid no attention to postvention as a tool for community or social interventions or outcomes. The only evidence of community focused intervention being the provision of media reporting guidelines, often by third sector organisations (Samaritans, 2021). Those who are bereaved feel a need for support, however it seems that often support is perceived as inaccessible or there are other perceived barriers to access. The unacknowledged message here appears to be that individuals require the community to 'reach in' to them during their time of need; thus, posing the question of whether community focused postvention intervention might prove more accessible than the current individual focused interventions that may be available to those who seek them out. Higher Education Institutions are able to refer to public health and specific education and HE guidance to help shape HEI provision of postvention. However, staff members are most likely to be positioned as the providers of support to others, rather than being acknowledged as potentially needing support themselves. Thus, creating the confusing position for staff members of having the dual role of both delivering and needing support. The evidence base for guidance where cited, is taken from the wider suicide literature and suicide statistics; suggested models of provision have not been informed by site-specific research and have not been evaluated. Currently, there is no context specific evidence base to inform the design, delivery and evaluation of postvention with UK HEIs.

Chapter 3

Qualitative Research Synthesis

3.1 Chapter Overview

The review of the literature that I presented in Chapter 2 identified a sparsity of knowledge pertaining to the experiences of HEI staff following a student death by suicide. In response, I undertook the current study in order to explore, synthesise, and interpret the experiences of other groups of practitioners following the death by suicide of a client, service user, patient or student. The purpose of this is to provide a theoretical context within which I might understand the experiences and perceptions of the HEI staff who participate in my second study. Accordingly, in this chapter, I report a systematic literature review taking the form of a qualitative research synthesis (Major & Savin-Baden, 2010). Firstly, I define qualitative research synthesis (QRS) as a method, and explain how this method aligns with my thesis aims. My reasons for undertaking the QRS are set out. I report the methods and findings of the study. I discuss the findings to contextualise them in light of the narrative literature review in Chapter 2, which explored the impact of suicide and the topic of postvention. I also consider the findings in terms of their potential usefulness in informing my second study, which I have designed to explore the experiences of HEI staff following a student death by suicide. Finally, I pay consideration to the strengths and limitations of this study.

3.1.1 Qualitative Research Synthesis

Qualitative research synthesis is a systematic review of qualitative literature. Major and Savin-Baden (2010) describe QRS as being 'an approach that uses qualitative methods to analyse, synthesize and interpret the results from qualitative studies' (p. 10). It is a systematic process of scientific inquiry (Sandelowski & Barroso, 2007) that takes an iterative approach through all stages from searches and inclusion, to interpretation of findings (Major & Savin-Baden, 2010).

Reflexivity is required on the part of the researcher when working with the interpretations within the original studies (Major & Savin-Baden, 2010). Numbers of qualitative studies have increased over the past two to three decades, however qualitative research continues to face the challenges presented by the narrative that it lacks validity, value and is difficult to apply to real world settings (Sandelowski & Borroso, 2007). QRS seeks to challenge such narratives, for instance, the process of synthesising qualitative studies offers a means of making the most of existing research (Major & Savin-Baden, 2010). This will be demonstrated in this synthesis as I bring together a diverse, yet topically connected group of studies with the purpose of generating greater depth of knowledge of the experiences of particular groups to a particular event within a particular setting. Knowledge of the particular, in this instance, the individual, has an important role in practice-based disciplines (Sandelowski & Borroso, 2007). QRS serve a range of uses, the following of which are most pertinent here: it is an effective method for identifying gaps in current knowledge; it provides a means to advance theory building through the synthesis of qualitative data; and it is also an approach that can provide evidence from across a range of studies that is suitable for answering questions for policy makers and practitioners (Major & Savin-Baden, 2010).

3.1.2 Meeting research aims

Andriesson et al., (2017a) call for an increase in theory driven research in the topic of postvention. I have designed this study to develop a theoretical basis from which the thesis as a whole can address the research questions, aims and objectives. The review was designed to explore and synthesise the experiences of health, social care and education workers following the death by suicide of a client, patient, service user or student. The aim being to begin the process of answering one of the two research questions that underpin the thesis: how is a student suicide experienced by staff members within a UK HEI and what are the features of that experience? One objective in addressing this question is to undertake a synthesis of the

qualitative literature. The relationship between the current study and the research questions, aims and objectives is illustrated in Figure 1, chapter 1.

3.1.3 Reasons for undertaking a qualitative research synthesis

The choice of QRS as an approach for this review was informed by the alignment between the philosophy of the QRS, and the underpinning philosophical approach I am taking within this thesis. A QRS focuses on qualitative literature; the kinds of exploratory questions that underpin qualitative studies are aligned with the research questions that underpin this thesis. It is an approach therefore, that will provide informative and relevant findings within the context of this thesis. A QRS also utilises an iterative approach with the aim of not just summarising a body of research but of constructing new meaning from it. The focus in a QRS is on interpretation of data; interpretations undertaken by the primary researchers of the included studies and those made by myself in undertaking the synthesis. The constructions and co-constructions of meanings and an interpretative approach, are integral to a social constructivist viewpoint. Interpretation, meaning-making and the co-construction of meanings are also aligned with the methodological approach that I have adopted for the subsequent study of this thesis; a constructivist grounded theory (Charmaz, 2014). By selecting research methods that embrace similar philosophical underpinnings and similar approaches to working with data I hope that the findings from both studies will come together to answer the research questions in a congruent and coherent manner.

In this review I address the noted absence of research literature regarding experiences of HEI staff members by looking at the available literature pertaining to other groups of workers and creating a synthesis of the data. I will take an interpretative approach to the synthesis (Noblit & Hare, 1988) with the aim of highlighting the nuances between and across a range of professions and job-roles in terms of how a death by suicide is experienced. This may build an understanding of the kinds of factors that affect the experiences of individuals, and provide a

theoretical starting point against which I can begin to understand the findings that emerge from my second study. That is, I am curious to discover whether the impact of a student suicide on HEI staff mirrors the experiences of other staff groups, or if there might be unique, currently unidentified, features. As such, the synthesis will add depth to the body of qualitative literature from which it emerges (Major & Savin-Baden, 2010).

To sum-up, I intend that the current study serve two distinct purposes: firstly, to bring together a body of research literature and synthesise the findings therein to draw out any new knowledge or theory pertaining to the experiences of practitioners following a suicide; secondly, to provide a starting point against which to position the experiences and perceptions of the HEI staff members who participate in the second study of this thesis.

3.1.4 Presenting the findings of the study

The study presented in the current chapter has been published in the International Journal of Environmental Research and Public Health (Causer et al., 2019) (Appendix 3.1). The journal is 'open access' and as such is subject to 'creative commons' which means that there are no restrictions on my sharing or re-using the content of the published study as long as it is accredited accordingly (MDPI, 2020). The published version of this review presents the research and subsequent findings as an autonomous study. To situate the same review in the context of this thesis I present and discuss the research and findings so as to make explicit the role of the review in strengthening the structure of the thesis and as making an integral and important contribution to the process of knowledge generation within the thesis. As such, whilst this chapter may, by necessity, bear some similarities, and make some references, to the published study; it also contains a significant proportion of previously unpublished material, findings and interpretation.

The published version of this study can be found at the following weblink:

https://www.mdpi.com/1660-4601/16/18/3293

3.2 Methods

3.2.1 Formulation of the synthesis question

I constructed an initial search question with the aid of a framework from Major and Savin-Baden (2010); Table 1 demonstrates how I used the question component framework to prompt my consideration of the elements that would construct the question for this review:

Question Component	Question Elements for this Review
Person	Health, Social Care or Education worker
Environment	Within the context of their job-role
Intervention	The death of a client, patient, student or service user by suicide
Comparison	The features of Individual workers experience of the event
Outcome	N/A This study seeks to explore an experience rather than a change.

Table 1: Components of a good question (Major & Savin-Baden, 2010).

The question for this research synthesis is:

'What are the features of the experience of workers in health, education or social care roles following the death by suicide of a client, patient, student or service user?'

3.2.2 Literature Searches

I undertook database searches using PsycInfo, CINAHL, SCOPUS, ERIC and Medline. I purposively selected these databases to screen articles published in psychology, health, nursing and education journals. I conducted and completed the searches in February 2018. I also conducted hand searches of the reference lists of relevant studies. I set up database alerts

to identify subsequently published studies, the alerts remained active until the thesis was submitted on 30th September 2020.

The search terms for all databases were:

Suicide AND [client OR patient OR service user OR student] AND [impact OR effect OR influence OR experience].

Searches limiters were used as follows:

PsycInfo: English Language; Peer Review; Qualitative Studies

CINAHL: English Language & Peer Review

SCOPUS: English Language; Journal Article; Peer Review; Qualitative; Interview

ERIC: English Language; Journal Article; Peer Review

Medline: Additional search terms were used: AND [qualitative research OR qualitative study OR qualitative methods OR interview]. Limiters were: English Language; Journal Article

Details of each search undertaken and number of articles returned are included in Appendix 3.2.

3.2.3 Screening the literature

Noblit and Hare's (1988) definition of qualitative research as being that which seeks to generate understanding of participants' subjective experiences and uses an interpretative framework provided a foundation in determining whether a study be included. The inclusion and exclusion criteria were set out with the aim of generating a purposive body of literature (Major and Savin-Baden, 2010). I paid attention to ensuring that included studies were to some degree homogenous in terms of quality (ie. Were subject to peer review), and reporting of data, findings and interpretation. This was to ensure that data was equally weighted at the

point of synthesis and as such, I decided to exclude grey literature, case studies, and opinion pieces. Inclusion and exclusion criteria are detailed in Table 2.

	Inclusion	**Exclusion**
Publication	Published in a peer reviewed journal Published in the English language	Grey Literature Articles presented as Reports, or presenting advice or action plans for professionals
Methods	Qualitative studies Interviews (in person or telephone) or open-ended survey questions Analysis that pays attention to meanings and themes Mixed method studies if qualitative findings are reported in a distinct section and meet the criteria above	Quantitative data and analytic methods employed Non-empirical case reports and opinion pieces
Research Question / Aim	Studies that explore, investigate or seek to understand the participants subjective experience following the death by suicide of their patient, client, service user or student. Studies with additional aims if the data reported to the above aims is distinct and contributes to the overall synthesis.	Studies that seek to explore participants' views around the topic of suicide, suicidal behaviour or organisational responses to the death by suicide of a client/service user. Studies that seek to explore participants experiences of suicide ideation, suicidal behaviour or attempts (that do not result in a death by suicide)
Presentation of data	Findings reported in a distinct section that identify key themes, concepts, or ideas drawn from the data and illustrated by verbatim quotes. Findings that are reported by the authors in an interpretative style where interpretations are supported by the evidence of verbatim quotes.	Findings that are wholly presented as the author's description or interpretation of the data without any substantiating verbatim quotes from participants.
Participants	Workers in social care, health or education job roles who have experienced the death by suicide	Non-empirical case reports or opinion pieces

	of a patient, client, service user or student. Studies that have more than two participants

Table 2: Search Inclusion & Exclusion criteria

The process of screening involved four stages and is illustrated in the PRISMA diagram in figure 3 (Causer et al., 2019).

1. Duplicate articles were removed; the remaining articles returned by the database searches were screened by title and excluded if the article title specifically indicated that exclusion criteria were met.

2. Abstract screening; all articles that clearly met the exclusion criteria were removed from the search.

3. A detailed examination of the research question or aim, methodology and presentation of data.

These three stages excluded 1865 articles. Leaving 21 articles.

4. Full in depth reading of the text to further clarify that the research question or aim underpinning the study together with the way in which findings are presented would usefully contribute toward answering the synthesis question for this study. Appendix 3.3 details this final stage of appraisal for twenty-one articles.

This removed a final 9 articles, leaving 12 articles that I included in this synthesis. They are, Bohan & Doyle (2008); Christianson & Everall (2008); Christianson & Everall (2009); Davidsen (2011); Darden & Rutter (2011); Kim (2019); Matandela & Matlakala (2016); Saini et al. (2016); Sanders et al. (2005); Tillman (2006); Ting et al. (2006); Wang et al. (2016).

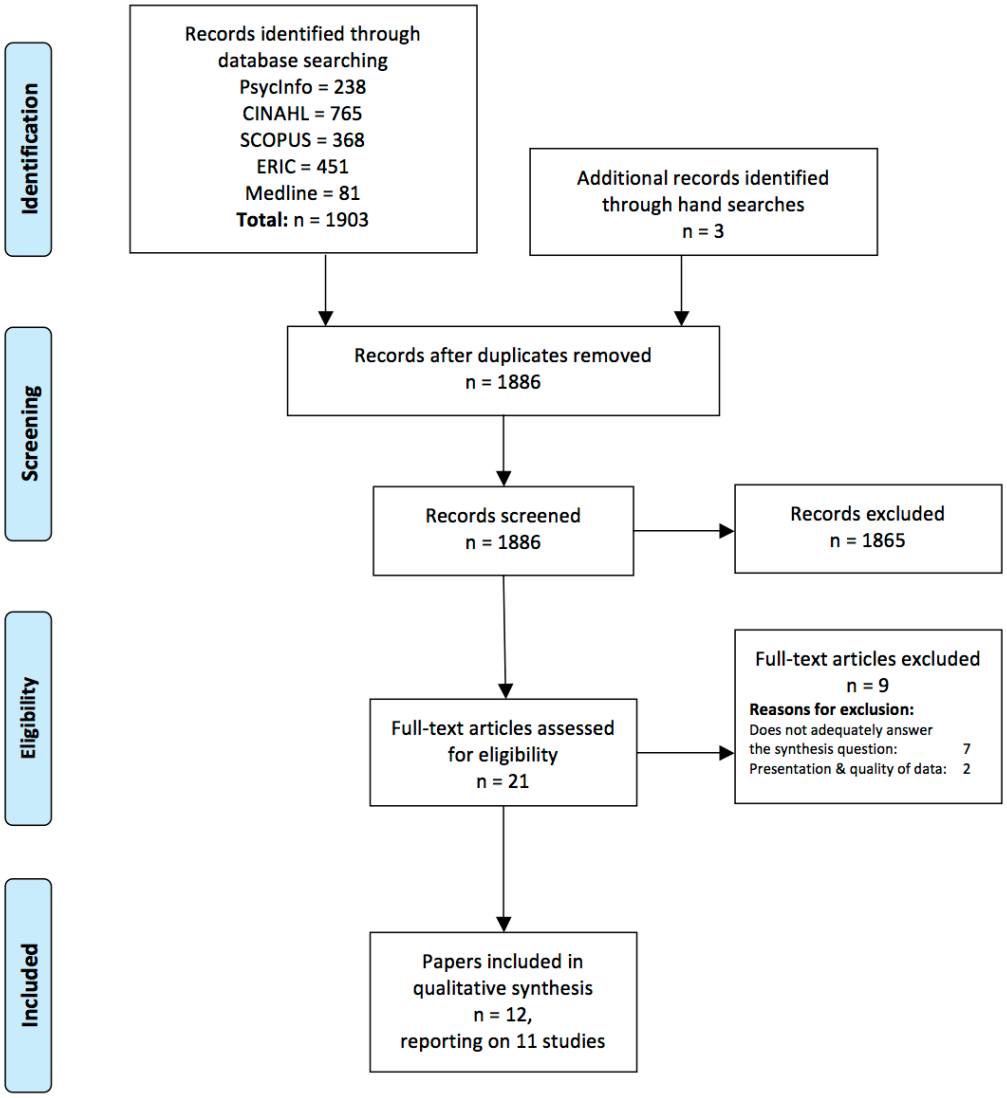

Figure 3: Flow diagram of study retrieval and inclusion processes (Causer et al., 2019). Adapted from the Preferred Reporting Items for Systematic Review and Meta- analyses (PRISMA) flow diagram (Moher et al., 2009).

Details of numbers of articles excluded at each stage are included in Appendix 3.2.

3.2.4 Appraisal of articles

3.2.4.1 Use of an appraisal tool

The use of a quality appraisal tool within a qualitative research synthesis is subject to debate with some authors posing that the diversity of methods within qualitative articles are not

compatible with being assessed by a structured framework (Garside, 2014; Green & Thorogood, 2014). There is also debate around what criteria should be appraised, as the concept of study appraisal originally focussed on quantitative studies, and so the language and criteria used are not directly translatable to qualitative studies (Sandelowski & Barroso, 2007). Pope, Mays & Popay, (2007), suggest that whilst consensus on these matters remains elusive, that the reviewer is helped by the process of appraisal in gaining an overview of the rigour of the studies in the review. Finally, as Garside (2014) highlights, any appraisal process is an appraisal of the published report of the study rather than of the study itself. Despite this, use of a tool does ensure that attention is paid to the methodological rigor of the included studies.

It is important to have clarity around the purpose of utilising a quality appraisal tool. Williams & Shaw (2016) discuss that the inclusion of poorer quality articles may be an option as long as the researcher is mindful that such articles do not ultimately guide the final concepts of the synthesis. Noblit and Hare (1988) argue that 'topic' rather than 'methodological deficiency' (p15) should guide the inclusion of articles. Likewise, Thomas and Harden, (2008) assessed the quality of included articles not by prioritising the quality of the research design of articles, but the ability of the articles to answer the review question. For this study then, I have used the appraisal tool not to exclude literature from the synthesis; rather to assess the quality of included literature. My aim being that this review serve not only to synthesise the data from the articles but also to assess the nature and quality of the literature (Bowen, 2017) in this topic area. The Critical Appraisal Skills Programme (CASP) (2018) qualitative research checklist met this need as it provided a framework within which I was able to begin the process of not just appraising the literature, but also understanding each study within the context of the others. The CASP tool utilises ten questions which are listed below:

1. Was there a clear statement of the aims of the research?

2. Is a qualitative methodology appropriate?

3. Was the research design appropriate to address the aims of the research?

4. Was the recruitment strategy appropriate to the aims of the research?

5. Was the data collected in a way that addressed the research issue?

6. Has the relationship between researcher and participants been adequately considered?

7. Have ethical issues been taken into consideration?

8. Was the data analysis sufficiently rigorous?

9. Is there a clear statement of findings?

10. How valuable is the research?

Each question is accompanied by a set of 'Hints', that aided my response to the question; a downloadable worksheet provides a tool for recording the response to each question as being 'yes', 'no', or 'can't tell' (CASP, 2018). The appraisal is designed such that the first two questions 'screen' the study, and provide an indication as to whether it is worth continuing with the review (CASP, 2018). The questions prompted me to consider how appropriate the methodological aspects of the study are in terms of suitability to the study topic, question, participants and ethical considerations (Long et al., 2020). In addition, the tool is designed to appraise the results of the study in terms of their validity and usefulness. The tool has been subject to ongoing piloting and evaluation and is found to take a generic inclusive approach that is helpful when working with a body of literature such as the studies in this synthesis that include diverse methods, populations and sample sizes (Pearce-Smith, 2018). There are other appraisal tools available for qualitative research; two such tools being the evaluation tool for qualitative studies (ETQS) (Health Care Practice Research & Development Unit, 2009) and the Joanna Briggs Institute (JBI) tool (Joanna Briggs Institute, 2017). All three of these tools appraise studies according to appropriateness of study design; method of data analysis;

reporting of findings; acknowledgement of researcher relationship; and ethical issues (Hannes et al., 2010). However, the ETQS and JBI tools also appraise theoretical framework; believability; and evaluation/outcome. In comparison with the CASP tool, the ETQS utilises far more questions (44 in all) creating a more detailed appraisal (Health Care Practice Research & Development Unit, 2009). This may give a more complex and prescriptive experience for the researcher. The JBI tool, like the CASP tool uses just 10 questions, creating a simpler interface, however, it calls on the concept of congruity throughout, requiring the researcher to assess one aspect of the study alongside another, for instance, 'Is there congruity between the research methodology and the research question or objectives?' (Joanna Briggs Institute, 2017). A review of all three appraisal tools found that the CASP tool may be less sensitive to some aspects of validity, for instance, theoretical and evaluative validity, when compared to the ETQS and JBI tools (Hannes, et al., 2010). The CASP tool, however, has published evidence of the empirical basis of its construction, validity of items and reliability of interpretation as well as guidelines for use (Katrak et al., 2004). I selected the CASP tool for use in this review based on the knowledge that it is well used and well known within the field and it is clearly structured for usability making it particularly accessible to novice researchers (Hannes & Bennett, 2017).

3.2.5 Data Extraction

Data extraction served two purposes; firstly, to inform an overview of the attributes of the included studies; secondly the extraction of data for coding, synthesis and interpretation. The studies that addressed the synthesis question and met the inclusion criteria were eclectic in terms of research question and aims, location of study, participant groups, methodology and quality of reporting. I extracted data to inform an overview of the studies consisting of authors and date of publication; geographic location; participants; study aims or question; methods of data collection; methods of data analysis; key themes or domains that were found. I have

reported the overview in tabular form in Causer et al. (2019), and in full detail in the findings section of the current chapter.

I extracted all data included under the headings of Results or Findings and Discussion for the purpose of the synthesis. This decision was informed by the literature (Major and Savin-Baden, 2010) and by my desire to include not just the described findings and associated evidence of verbatim quotes reported in the studies, but the authors' interpretations and contextualisation of those findings. The inclusion of the authors' interpretations produces the triple hermeneutic that typifies this kind of synthesis (Major and Savin-Baden, 2010). That is, my interpretation of the authors' interpretations of their participants' interpretations of their experiences.

3.2.6 Data Analysis

3.2.6.1 Overview of study attributes

The data that I extracted pertaining to the relevant attributes of each study were tabulated (Causer et al., 2019, Table 1.) and compared.

3.2.6.2 Comparison of themes across studies

To develop an understanding of how the findings of the studies sit alongside one another, I undertook a further reading of the studies with the aim of identifying whether the themes across all studies shared features or differed. This was the first stage of the process of moving from the idea of working with twelve individual papers toward a sense of working with a large and detailed single data set.

My reading of each study was an iterative process and included note taking and reflection. I created a table to organise the themes identified by the authors of each study (Appendix 3.5). Once in table format and again working iteratively between the studies and my notes, I was able to identify and name common groups of themes.

3.2.6.3 Coding, Synthesis and Interpretation

I read each complete study in depth, and made notes made pertaining to the my initial impressions regarding the organisation of the findings; inclusion of verbatim data; style adopted in the reporting of the findings and the discussion section.

I used the following steps in coding: initial coding took a descriptive form, as I progressed through the data some strong codes started to emerge for instance; 'the autonomous client'; 'the un/expected death'; 'the horror'. I noted codes all onto a template (Appendix 3.6). In the second stage of the coding process involved I assimilated similar codes into each other and then identified potential early concepts and themes that described commonality or differences across the studies. This process was iterative as I moved between data, notes, the table of themes referred to earlier and the emerging table of identified codes. The key aim of this stage of the process was to gain a feel of the data as a complete set.

I developed the synthesis through a process of working between the concepts, themes and transcripts whilst returning to the review question. I endeavoured to stay close to the voices of the participants in the studies by working iteratively. This process resulted in three categories of themes and concepts that I describe in the following section. The process of interpretation is explained by Major and Savin-Baden (2010, p.64) as one that seeks to move beyond the comparison and aggregation of the results from the included studies toward one that seeks revelation; develops a third order interpretation and allows movement; this is what I sought to achieve.

3.3 Findings

I will report the findings of this review in four sections; findings from the CASP quality assessment; findings from the comparison of study attributes, findings from the comparison of

themes across the included studies, and finally, an overview of the findings of the synthesis which I have previously reported in full in Causer et al. (2019).

3.3.1 Appraisal of Study Quality

I appraised all included studies for quality using the CASP appraisal framework. I undertook the appraisal in March 2018, however, I appraised Kim (2019) in April 2019. My findings from the appraisal process were reported according to the ten appraisal criteria and were recorded in a table format (Appendix 3.4). I found all of the included studies to be of a good quality when appraised according the CASP framework. All studies clearly stated their aims; in all cases qualitative methodology and research design were appropriate to address the stated aims. Regarding the appropriateness of the recruitment strategy, one study (Tillman, 2006) offered only a vague description of the process of recruiting participants, as being 'the primary researcher approached the subjects', it seems likely that a 'snowballing' or 'existing networks' method was used in this instance, which for a qualitative study is an appropriate method. Two other studies, Sanders et al., (2005) and Ting et al., (2006) used participants selected from a larger sample who in both cases had participated in a larger quantitative study; thus, in these studies a process of purposive sampling was used. Kim (2019), acknowledged the challenges of recruiting participants to the study, which in this case were attributed to cultural beliefs around the shame attached to suicide and to the fear of reputational damage. Methods of data collection were clearly stated and found to be appropriate to address the research question across all studies.

Consideration of the relationship between the researcher and the participants is the item least reported in these studies, with only one study, (Kim, 2019) addressing this issue in making a clear acknowledgement that the researcher shared professional status with the participants. Five of the studies (Davidsen, 2011; Darden & Rutter, 2011; Sanders et al., 2005; Tillman, 2006 & Ting et al., 2006) make no mention of ethical issues or of having gained ethical approval for

the research. With regard to rigor in the analysis of data, all studies with the exception of Bohan & Doyle, (2008), clearly reported in detail any triangulation or checking processes that they employed to validate the research findings; all studies clearly reported their analytic process and described how findings were developed from the analysis.

All of the studies provided a clear statement of findings and included appropriate and adequate discussion of findings in relation to the original research question and to current literature. All of the studies identified useful application of the findings in terms of informing further research; confirming existing research; identifying participant needs; and informing employers and professional bodies of potential to make policy and practice changes that will greater safeguard employees in the future.

In using the CASP framework it was clear that none of the included studies appeared to be of significantly poorer in quality than the others. This helped me in terms of being able to give equal status to the data extracted from each of these studies during the course of the analytic process.

Interestingly, one aspect of the studies that this appraisal process did not address, and which feels significant in terms of the synthesis process, is the length of the published study. The published studies in this synthesis varied in terms of the amount of data extracted from them significantly, with the longest published article producing more than twice the amount of data than the shortest. It was at the forefront of my process to ensure that findings should be represented across studies, and that a significant much reported finding from one study did not become unfairly weighted within the process of synthesis.

3.3.2 Overview of study attributes

The 12 articles included in this synthesis report on 11 distinct studies. Both papers by Christianson & Everall (2008 & 2009), report on the same study, but each paper reports a

distinct set of findings that in both cases are relevant to this synthesis. Christianson and Everall, (2008) was published in a Canadian professional journal and highlights findings that are of specific interest to the profession of school counsellors in Canada such as national professional guidance and training procedures. Christianson & Everall, (2009) was published in a British professional journal and reports more specifically on the emotional impact and processing that the participants experienced.

My overview of study attributes demonstrates that the articles included in the synthesis are diverse in a number of ways and also share some commonalities. The studies were undertaken in seven different countries. This introduces cultural and socio-economic diversity into the data as experiences are influenced not only by personal responses, but also by the setting within which they occur. For instance, it is evident from the studies based in the US (Darden & Rutter, 2011; Sanders et al., 2005; Tillman, 2006; Ting et al., 2006) that the issue of litigation is more prominent in terms of practitioners' experience than in the studies based in Europe. This cultural heterogeneity is considered within the analysis of the data, and evidences a sense of universality of experience in that some findings are present across diverse populations.

The participant groups consist of a range of health, social care & education professions. These occupations bring about varied kinds of relationship and frequency of contact with the deceased. This is evidenced in the data as different kinds of relationship give rise to different kinds of responses. It might be argued that this diversity complicates the synthesis, and if the purpose of this synthesis were simply to evidence homogeneity of experience that would be a valid limitation. However, my aim is to identify similarity and difference across experiences. The diversity of professional groups provides this opportunity. Further, I aim that this synthesis will provide a theoretical starting point for my second study in this PhD. The participants in that study will also occupy a diverse range of job roles and relationships with the student who

has died by suicide; thus, the diversity of participant groups within the synthesis may prove congruent.

The studies include a diverse number of participants; the smallest study has just five whilst the largest study has 198. The numbers of participants seem congruent with the methods of data collection and analysis in each study with the exception of Saini et al., (2016), which undertook 198 face-to-face audio-recorded and transcribed interviews. This is a particularly large number for an interview study, whilst in comparison with the other studies in this synthesis the published paper is a short one, thereby giving less space to findings and participant verbatim quotes. This raises a question around the ability of the verbatim quotes in the article to represent the nuances often present in qualitative interview data, and whether the full diversity of responses is represented in the findings. This particular study differed in a number of ways. Firstly, the study was conducted within the context of a larger ongoing study, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, via which the potential participant details were identified. Secondly, the interviews gathered data for two separate analytic processes, descriptive statistics and a thematic framework analysis. The authors describe the interviews as semi-structured, however it is clear that a number of pre-determined demographic and fact-finding questions must have been utilised. Additionally, the authors refer to transcribing the responses into a 'questionnaire pro-forma' that does suggest a level of structure to the process. I included this study based on the usefulness of the qualitative findings in answering my synthesis question.

All but one study utilised semi-structured interviews either in person or by telephone with the exception, (Sanders et al., 2005), utilising open-ended questions in a survey. The study reports findings in depth with rich evidence provided by verbatim quotes, and contributes to the synthesis by including rich data that evidences the impact of a suicide death over time; a factor that is not explicitly explored in many of the other studies. The two studies that utilised

telephone interviews were conducted in the US (Ting et al., 2006) and Canada (Christianson and Everall, 2008 & 2009). The geographic spread of the participants in both of these articles is a likely and valid explanation for this method of data collection.

The dates at which these studies were undertaken fall within a relatively narrow timeframe with just a fourteen-year span between the oldest and most recent study, the most recent being published in 2019. A significant number of older articles were returned by the database searches, but were excluded from the synthesis according to the criteria listed in this chapter section 3.2.3.

3.3.3 Comparison of themes across studies

The themes reported in the findings or results section of each study were organised across the studies by commonality and difference. Taking an overview of the themes from each study enabled identification of groups of themes across the studies. These are identified in the left-hand column of Appendix 3.5 and are as follows:

- What happened – *experiencing the event*
- Emotional response – *experiencing the feelings*
- Impact on practice – *how do I practice now?*
- Internal responses/self scrutiny – *Am I ok?*
- Responses of others – *do they blame me?*
- Experiences of support – *who will look after me?*
- Self-care/maintenance – *can I look after myself?*
- Training needs – *what do I need?*

This process strengthened my sense of the connections across the included studies and of the differences between them. The processes of synthesis and interpretation will test the validity of these groups of themes and of my first understanding of similarities and differences across

and between the studies. The data as presented by the study authors, therefore, has not been taken at face value (Major and Savin-Baden, 2010).

3.3.4 Synthesis of data

The synthesis of data developed three categories of themes that were evident across all studies. They are, 'Horror, Shock and Trauma', 'Scrutiny, Judgement and Blame', 'Support, Learning and Living With'. My findings from this synthesis are reported in full in a published paper (Causer et al., 2019). Here I report an overview of the three categories of themes in sections 3.3.4.1 to 3.3.4.3 below.

The categories together with the themes and concepts that sit within them, are presented in table 3.

Category	**Theme**	**Concept**
Horror, Shock and Trauma	Witnessing suicide	The horror
		In the moment responses
		Shock and Trauma
	Responses to suicide	Loss and Grief
		Mind and Body responses
	Dealing with suicide	Connections and Closeness
		Absence and Distance
		The dual role
Scrutiny, Judgment and Blame	Thinking about responsibility	Am I responsible?
		The un/expected death
		Professional failure – guilt, reprisal &reputation
		The autonomous Client
	Having to carry on	Aloneness
		Issues of control

		Avoidance strategies
		Hyper-vigilance
	Dealing with others	The organisation and colleagues
		The family
		Cultural and social norms
Support, Learning and Living with	Experiences of Support	
	Learning	
	Living with	

Table 3: Categories, Themes & Concepts (Causer et al., 2019).

3.3.4.1 Horror, Shock and Trauma

The practitioner accounts in all studies in the synthesis include visceral descriptions and recollections of the horror of a death by suicide. The words 'horror', 'horrific' and 'horrified' were repeatedly used across the studies by practitioners and by study authors to describe practitioners' responses to the event. Practitioner accounts evidence that there are multiple aspects of horror attached to their experience. The very idea of suicide is perceived as horrific; there is the horror of the event itself, of being present and witnessing the death in progress and seeing the trauma that suicide has inflicted upon the body; the horror of the recall and imagery of the event; and the horror that a client of the practitioner has made the decision to die by suicide. Ideas and experiences of horror are accompanied by shock responses that for some practitioners take the form of trauma symptoms. This can happen in the moment of hearing the news and over the following hours, days, or even months. These responses are further complicated by feelings of anger, fear and frustration and experiences of disbelief, bewilderment and numbness resulting in a cumulative emotional experience. Additionally, practitioners' responses to suicide can include feelings of loss and grief, as well as physiological and intrusive cognitive responses such as unwelcome thoughts, dreams or imagery.

In having to deal with the aftermath of the suicide, practitioners found that the experiences of horror, shock and trauma continued to shape their thoughts, experiences and behaviours as an ongoing practitioner. Perceptions of closeness and relatedness shaped the kinds of feelings that some practitioners experienced. For others, however, a sense of professional distance led to an absence of emotional responses, and this illustrates that diverse reactions are likely within and across groups of practitioners.

Some therapeutic practitioners experienced a sense of having a dual role as both the healer and the person harmed in the aftermath of a client suicide. Job roles may require them to step into the position of supporting others who are impacted by the event – or their personal traits lead them to take on this task in response to another person who is struggling – whilst at the same time also being impacted by the event and seeking a means of dealing with their own sense of being harmed.

3.3.4.2 Scrutiny, Judgement and Blame

Practitioners experienced complex processes of reflection, examination and scrutiny of the event and of their role and responsibilities in connection with the event. Such processes were evident in self-reflection or self-scrutiny by the practitioner. Additionally, examination, scrutiny and blame of the practitioner by others, for instance, the deceased's family members, team members or managers, occurred across social and cultural settings.

The question of responsibility was particularly pertinent for practitioners. Responsibility toward the client is often integral to health, social care and education job roles, where keeping people alive and ensuring their wellbeing is a core value. As such, the death of a client may trigger practitioners' deepest fears. Practitioners spoke of whether or not they had expected the death, and as such scrutinised their own knowledge of the deceased, often asking, should I have known? Along with self-scrutiny, 'what did I miss?', practitioners also experienced doubt

and self-incrimination, fearing their own responsibility and fearing that others might see them as holding responsibility for the death. As such, ideas of professional failure were palpable, and accompanied by fear of incrimination, accountability and reprisal on the part of others, resulting in the loss of professional reputation. Perceptions of colleagues' behaviour, for instance, that colleagues were judging the quality or methods of their practice, intensified such fears.

Practitioners were able to recognise the limits of their own control over client choices by acknowledging that clients have a degree of autonomy. Although, for some practitioners, a specific aspect of client autonomy, that of not giving the practitioner any clues to their impending suicide, led to a sense of bewilderment, confusion or even anger toward the client for not helping the practitioner to help the client. For others, acknowledgment of client autonomy aided practitioners in formulating an idea around the limits of their professional capacity that felt acceptable to them and this affected perceived levels of impact. The idea of client autonomy also led some practitioners toward a sense of acceptance and compassion toward their clients' actions.

In having to carry on working some practitioners experienced feelings of aloneness in the workplace, for some this is due to being the only colleague with an experience of client suicide which bought about feelings that others are not able to understand. For others, feelings of isolation came about due to experience of trauma symptoms such as dissociation. Practitioners felt powerless in the aftermath of a client suicide as the realisation of the limits to their control over outcomes took hold. For others, the containment of their own emotions, or directing their attention toward the need of others gave them the sense of control that they felt they needed.

Avoidance strategies took different forms, for some, the physical avoidance of location meant they did not experience triggering memories. Whilst others sought the change of

organisational policy so that future 'risky' clients could be referred elsewhere, thus absolving themselves of future experiences of client suicide. Impact on practice took the form of hyper-vigilance, in terms of assessment of patient safety and risk. There are elements of fear, risk aversion and self-doubt all feeding into the practitioners' perception of having or needing to make more frequent or more thorough checks, either with patients who have known risk or who have no record of risk. These efforts may again be about the practitioner absolving them self from future repeat experiences.

The responses and behaviours of others such as colleagues, managers, organisations, the family of the person who died or the legislative process also led to perceptions of incrimination and blame. Indeed, some of the most explicit perceptions of incrimination are experienced through the relationships and interactions that practitioners have with others. For instance, some practitioners anticipated and experienced first-hand the anger and incrimination of family members. Social and cultural norms also added to practitioners' experiences of incrimination or blame. For instance, practitioners in the US particularly evidenced fears regarding the legislative implications of a client death by suicide. This illustrates the most literal experience of fearing incrimination on the part of practitioners and the agencies that employ them. For practitioners in Korea, it is the cultural conceptualisation of suicide as shameful that closed down opportunities to fully explore and process their responses to the event, and led to an internalising of shameful feelings that it was their client who had died by suicide.

3.3.4.3 Support, Learning and Living with

Practitioners' experiences both prior to and after the event influenced and shaped the choices and strategies that they called upon in seeking processes of recovery, acceptance and moving forward. All studies in the review evidenced that participants had wide ranging experiences around being supported and needing to be supported. Support might be accessed formally

through workplace schemes or procedures, other times informally through office 'chats' or personal networks. It was evident that the language of support differed across professional groups with some identifying all workplace support as 'formal', whilst others saw workplace 'peer support' as informal. Support for some practitioners was offered, but for others support had to be sought out. Some practitioners evidenced the experience of no support. This may be due to practitioners receiving no support, choosing not to engage or feeling that they did not need support.

The idea of learning or the identification of training needs was common theme in the discussion sections of the included studies. Gaps in knowledge were identified and training needs were highlighted as recommendations across most of the studies. One study however, went a step further and asserted that practitioners need to feel personally, as well as professionally, prepared for the event of a suicide by means of formal preparatory learning. It is evident that the event often became a catalyst for learning for both practitioners and organisations.

Practitioners did not so much 'recover' from their experience, as they did learn to live alongside the ongoing effects of the experience. Practitioners sought ways to move forward despite the impact of their experience. For some, it may be about letting go, or about utilizing ongoing coping strategies or about learning to live within a different experiential context. For others, it was about needing and making change. Helpful strategies included practical rituals or cognitive processes, taking a break, or thinking about a new job-role or even a career change. Other practitioners drew on existing strengths and strategies to maintain good self-care as they sought to move forward.

3.4 Discussion

This discussion serves to situate this set of findings within the context of the thesis. As such, I will draw connections with the literature that I reviewed in Chapter 2; and will consider my findings in terms of the potential insights they may provide, regarding the experience and perceived impacts of staff in HEIs, for my second study which is presented in Chapters 4, 5 and 6. At the conclusion of the thesis, in chapter 7, I present a broader discussion to draw together the findings from both studies. I also discuss the findings of the current study in Causer et al. (2019) (Appendix 3.1) where I present a more focussed and detailed account exploring the implications of my findings for health, social care and education practitioners.

The synthesis of 12 published papers from 11 qualitative studies demonstrates that the experiences of diverse practitioners include similarity in personal and professional contexts following the death by suicide of a client, patient, student or service user. I constructed three categories of themes, illustrating that experiences of horror, shock and trauma, impact practitioners whilst they are also subject to scrutiny, judgement and perceptions of blame both on the part of themselves and from diverse others. Rather than providing a route toward recovery, practitioners' experiences of support and learning shape the ways in which they live with the impact of a client suicide as they seek to move forward.

An illustrative framework (Figure 4) demonstrates the relationship between my three categories of themes as being an open and over-lapping one. In addition, it illustrates how the mechanisms of incrimination and absolution are integral to the practitioners' experience both in terms of their own perceptions and conceptualisations, and to their experiences in social and cultural settings, such as the work-place, for instance.

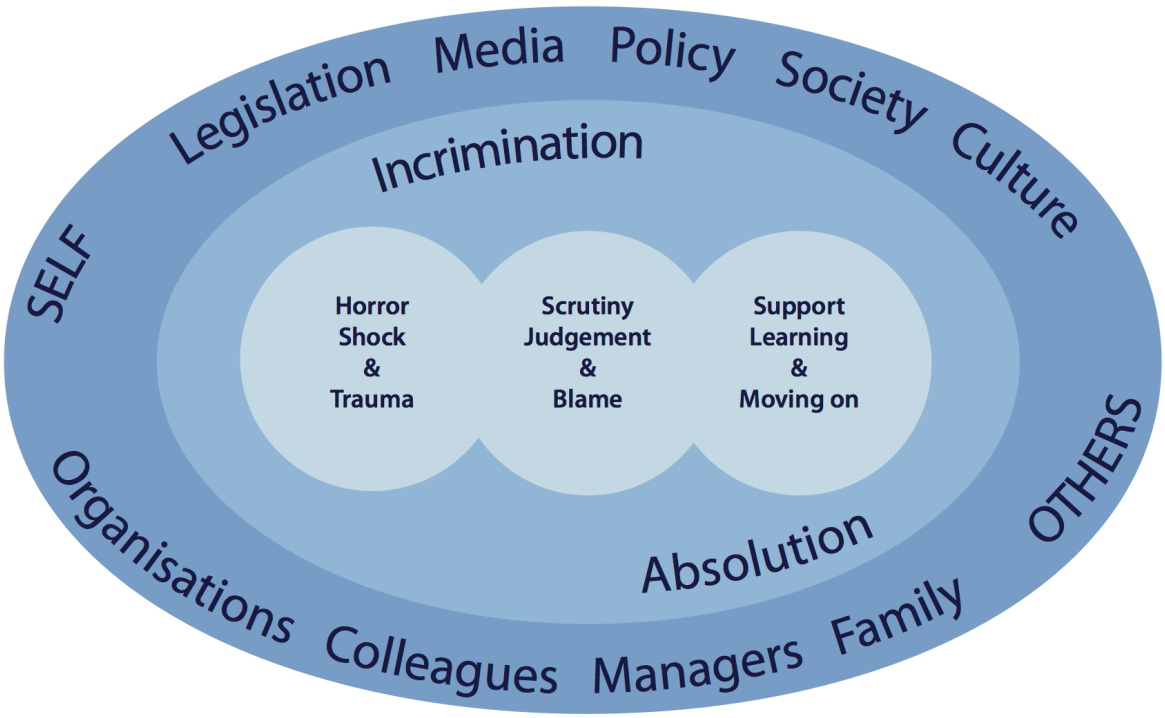

Figure 4: An overarching framework of the context surrounding practitioner experiences (Causer et al., 2019).

My findings from this review demonstrate that practitioners experience a range of adverse emotional and distress responses to a client death by suicide. As might be expected, this aligns with the findings of other studies reporting the experiences of mental health professionals and front-line staff (Castelli-Dransart et al., 2017; Gaffney et al., 2009). Indeed, following a client death by suicide, some practitioners experienced trauma responses such as intrusive thoughts, nightmares, sleeplessness, sickness, dissociation, and heightened aversion to risk in their contact with clients. This aligns with previous research, which found that post-traumatic symptoms may be a response to suicide, in wider circles beyond family members, including therapists and mental health professionals (Castelli Dransart et al., 2014; Mitchell & Terhorst, 2017). Some of the most tangible of these trauma experiences were reported by those practitioners who were either present at the time of the death, who interacted with the body of the deceased, or who imagined what the death may have looked like. Previous research has found that train drivers who witness a death find the visual experience to be the

most distressing aspect (Malt et al., 1993) and law enforcement officers exposed to suicide scenes experience increased post-traumatic symptoms (Cerel et al., 2018). This suggests that visual experience may heighten trauma responses. In a HEI setting, it might be that staff members are the first to arrive at the scene of a death by suicide, and as such, they will experience visual exposure, and possibly physical contact with the body of the deceased or dying student.

Practitioners in this review demonstrated that they experience moral and ethical dilemmas following a client suicide. A sense of moral- or value-led anguish was evident for practitioners as they struggled to reconcile clients' suicidal actions with their professional drive to preserve life; this was palpable in their self-scrutiny as they asked 'what did I miss?', 'what did I get wrong?' This self-incriminating behaviour was apparent across professions and appeared to deepen the sense of responsibility and blame that practitioners perceived. The dominant psycho-pathological model of suicide positions suicidal individuals as patients, and therefore places mental health practitioners in a position of responsibility to prevent suicide (Bantjes & Swartz, 2017). In omitting consideration of the socio-economic, political, or cultural contexts of suicide, the dominant model of suicidality may feed into practitioners' perceptions of responsibility, that give rise to the kinds of self-scrutiny and -blame evidenced in this review. Sometimes the possibility of a repeat experience, should a subsequent client die by suicide led practitioners to seek to routes toward self-protection. This might include the adoption of practice habits that identify subsequent clients as risky, or engaging in choices and behaviours that affect clients' experience of the service, even affecting their treatment through early hospitalisation (Tillman, 2006). Indeed, previous findings suggest the impact of client suicide on professional practice may affect clinical assessment and treatment decisions including changes in assessing suicide risk, the frequency of referrals to other colleagues and choices of treatment including increased hospitalisation (Séguin et al., 2014). HEI staff, in contrast to the practitioners in this review will be exposed to a student suicide, in a range of job-roles many of

which have no therapeutic responsibility toward the student. As such, the sense of self-scrutiny and -blame might take a different form, or be absent from their experience. For staff in student wellbeing roles, the experiences of these practitioners might be replicated, however it is to be expected that due to a wider range of job-roles and relationships and responsibilities toward the student that responses and perceived impact may be more diverse. Indeed, as was revealed in my literature review in chapter two, experiences of first responders are different to those of practitioners who have a pre-existing connection with the deceased. Therefore, it may also be, that those HEI staff with a pre-existing relationship with the student who died are also impacted in different ways to those who did not know the student.

The review also demonstrates that the experiences of practitioners are socially and culturally situated, both within and beyond their place of work. The studies included in the review did not seek to situate practitioner experiences in broader socio-cultural contexts, focusing rather on individual experiences within a specific professional setting. It was in the process of bringing the studies together and synthesising their findings that this aspect of practitioners' experiences came to light. The behaviours and responses of multiple others, from the family of the deceased to legislative processes, shaped practitioners' sense of responsibility through mechanisms of perceived absolution or incrimination. For some practitioners, a sense of being incriminated by others further intensified the processes of self-scrutiny and -blame that they were already experiencing. Once again, the diverse relationships and job-roles of HEI staff might mean experiences are different, when compared to the kinds of relationships of either health practitioners or first responders, who have been previously researched. However, a HEI, whilst being a different, previously un-researched setting, does operate within wider social contexts, and is subject to scrutiny from external others, and so, this kind of experience might be replicated according to setting.

It is clear from the findings of this review that postvention support is needed for health, social care and education practitioners. Indeed, practitioners themselves have previously acknowledged that they have support needs in relation to the suicide of a patient or school student (Murphy et al., 2019; Kõlves et al., 2017). It is clear however, that within the postvention literature practitioners are identified as the providers of postvention and support (Maple, et al., 2018) rather than as potential recipients (Talseth & Gilje, 2017). Those who have been impacted by a suicide death are often identified in the role of 'client', that is, the person who will be supported by a practitioner. The practitioner who has been impacted and who needs to be supported appears to be largely absent in the research literature that explores postvention need and provision. Indeed, on reviewing the guidance that is currently available to HEI settings (Chapter 2; section 2.4.5) it became clear that HEI staff members are most often positioned as the potential providers of postvention support rather than as being in need of it (Samaritans, 2020a) and where it is acknowledged that staff may need support in addition to members of the student body, it is not acknowledged that staff needs may be different to student needs (UUK, 2018). As I have previously established, the current guidance available to UK HEIs has been developed either for community wide interpretation, or for HE settings, but is currently not underpinned by site-specific research findings. Furthermore, it remains to be discovered whether HEI staff perceive themselves in need of any kind of support following a student death by suicide; and indeed, if they do express needs, what those needs may be and how they might be met.

3.5 Strengths and Limitations

I have undertaken the first published review to bring together and synthesise the qualitative literature that reports the experiences of health, social care and education practitioners following the death by suicide of a client, patient, student or service user. As such, the review contributes new knowledge regarding the experiences and postvention needs of this group of

practitioners after a suicide. In bringing together the findings of eleven studies it was possible for me to situate the individual experiences of practitioners socially and culturally. A strength of this review lies in the rigorous methodology applied to searches, quality appraisal, analysis and synthesis, guided by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement (Tong et al., 2012). However, my findings must be considered in the context of the limitations of the study. I set out in this review to synthesise qualitative literature with a focus on experiences and perceptions, and as such I have not included studies that considered causal relationships. Whilst the studies I did include in the review are situated globally, it is worth noting that four of the eleven studies were undertaken in the US; and that two of the papers came from a single study in Canada. I only searched for and included studies published in the English language and the review is therefore limited by the exclusion of research published in other languages. Due to the inclusion of 'English Language' in the search criteria, I do not know whether there are additional studies addressing this topic that have been published in other languages. I do not know therefore, how much literature has been excluded due to these criteria. The diversity of professions, organisational settings and cultural contexts may also be seen as a limitation in terms of enabling generalisations to be made in the analysis; however, they identified a number of unifying experiences and together contributed to my synthesis highlighting how social and cultural contexts shape individual experience.

In the context of informing further research in the thesis, the findings of my synthesis highlight that practitioner experiences are distinct from those who are in closer networks around the person who died and are more likely to include trauma and work-related symptoms and responses. My findings are based on the experiences of diverse practitioners who are all professionally qualified health, social care or education workers who had a previous professional relationship or connection with the person who died. HEI staff members include a more diverse range of workers, not all of whom are professionally qualified; and not all of

whom are likely to know or have an existing relationship with the student who died. Therefore, it is my next task to discover whether the experiences of this different and more diverse group of HEI workers are distinct or not. My review did not return any studies that explore the experiences of HEI staff members, affirming that there is a gap in current knowledge which remains to be filled. As such, the lack of literature exploring the experiences of HEI workers does strengthen my argument for such research to be undertaken, as the experiences and needs of this group are currently unreported and unknown.

Chapter 4

Exploring the experiences of HEI staff following a student death by suicide:

Methodology & Methods

4.1 Chapter Overview

In chapter one I outlined the social constructivist philosophical paradigm that underpins my thesis. In addition, I presented the research questions, aims and objectives in relation to both studies undertaken. In the current chapter I explore the methodological and ethical considerations that are specific to the second of my two studies. For this study I designed a two-phase, mixed-methods approach. I will outline the study design, discuss the use of a constructivist grounded theory, and explore relevant ethical considerations including researcher role, positionality and power, and the question of voice in qualitative research. The methods that I have used in participant recruitment and consent, data collection and storage, and data analysis are outlined.

4.2 Study Design

Johnson et al. (2007) define mixed-methods research as the combining of qualitative and quantitative elements; that is, viewpoints, methods of collection and analysis, and inference techniques, to generate a breadth and depth of understanding and corroboration. Taking this inclusive approach (Rogers & Apel, 2010) to study design embraces the strengths of both qualitative and quantitative approaches. In the case of this study, I have used methods that will enhance my understanding what is happening, and explain why it might be happening. Mixed-methods have been suggested as a revitalising approach for suicidology, which has in recent decades been dominated by quantitative study (Rogers & Apel, 2010). Of particular relevance to my research and to the topic of suicide, employing mixed-methods promotes engagement with sociological factors such as the role of cultural contexts in shaping

experiences (Kral et al., 2012). In addition, a mixed-method study design enabled me to gather different types of data from the same participants, thus expanding and strengthening the conclusions that I was able to draw from the data making the study more valuable in terms of contribution to knowledge and application to policy and process (Schoonenboom & Johnson, 2017), through enhancing theory development (Kral et al., 2012).

I therefore adopted a mixed-methods design utilising two distinct methods of data collection. Data in the first instance was collected using a purposively designed survey that utilised closed and open questions. I outline the survey in detail in section 4.5.3.1 and table 6 in the current chapter. Following the survey, I gave participants the option to take part in a semi-structured interview, the topic guide being informed by findings of the survey. Interviews are outlined in section 4.5.3.2 of the current chapter. I also utilised mixed methods in my data analysis; I analysed quantitative data to give descriptive results, and I brought together interview and open text survey data to develop a constructivist grounded theory (Charmaz, 2014).

Mixed-methods proved particularly suited to the study topic and population. The topic is un-researched and therefore it was unknown who amongst HEI staff would perceive themselves to be impacted by a student death by suicide. The survey was a tool that helped me to identify those staff members; to understand who they are and to gain an insight into their perceptions of how they were impacted by the event. The interview phase of the study then gave me the opportunity for deeper exploration of experiences and the meanings that participants attached to their experiences. The mixed-methods design opened up a range of options to me in terms of analysing and presenting the data, which proved particularly helpful, as the findings will be disseminated to diverse interested groups such as academic researchers, HEI leadership teams, and postvention support services.

Schoonenboom and Johnson (2017) provide a helpful framework of dimensions to consider, I called upon this framework when designing this mixed-method study. The framework draws

on dimensions of study design such as purpose; theoretical drive; timing (simultaneity and dependency); point of integration; planned versus emergent design and design complexity as outlined below.

4.2.1 Purpose

Mixed-methods were used in this study as a developmental tool, that is, I intended that the results from the survey would help to develop the questions used in the interviews. Furthermore, I intended to draw a purposive sample of interview participants from the survey participants. I designed the study to also provide complementary sets of findings, that is, findings from the survey might enhance those from the interviews and likewise the findings from the interviews may elaborate on and enhance the findings from the survey. In generating descriptive and qualitative findings I might be able to answer the research questions more comprehensively.

4.2.2 Theoretical Drive

My aim, through this study, was to explore participant perceptions and experiences; an explorative study is by nature inductive and qualitative, thus giving this study a core qualitative component with a supplemental quantitative component. Where quantitative methods do very well at offering explanations for what is happening; qualitative research has an important role to play in suicidology in seeking to grow our understanding of why or how such things are happening as well as acknowledging the contexts within which things happen and in which they are experienced (Hjelmeland & Knizek, 2010). This mixed-method design therefore enables me to explore both 'what' is happening and 'why' it is happening. Indeed, in the survey design, I included a number of open text questions adding to the qualitative components of the study design. As Johnson (2007) states, a mixed methods study that has dominant qualitative elements is congruent with a constructivist view of the research process.

4.2.3 Timing

I paid attention to the timing of the components of the mixed-methods. For instance, in considering the simultaneity of the design, components might be used concurrently or sequentially; in the case of this study, I adopted a sequential design, in using the survey component before the interviews, this was necessary in order for the developmental aspects of the study to be met, survey findings informing interview questions and the recruitment of participants for the interview phase of the study. So, there was also an element of dependence in the design; the sampling and the design of the topic guide were informed by responses to the survey.

4.2.4 Point of integration

The point of integration occurs where the two components are bought together, it is posited that this usually happens at the results stage (Schoonenboom & Johnson, 2017); however, as the survey in my design collected both quantitative and qualitative data, there was an opportunity for me to integrate data at the stage of analysis. By utilising a grounded theory analysis I opened up potential for comparisons to be made across data sets (Charmaz, 2014); in addition, I integrated data from both the survey and the interviews to inform an analysis of tasks undertaken by HEI staff following a student suicide. Teddlie and Tashakkori (2009) suggest that integration is present at both conceptual and physical levels, identifying that integration can take place at the point of study conception; during data collection; at point of analysis and at the inferential stage. Indeed, I have taken an integrative approach from the point of study design; the conceptualisation of one study with two phases informed my thinking about subsequent stages such as data collection; participant sampling; data analysis and dissemination. In my study design, integration has occurred conceptually throughout, and physically at the point of analysis and presentation of the findings.

4.2.5 Design Process

In terms of design typology, (Schoonenboom & Johnson, 2017) I describe the design of this study as a qualitatively driven sequential design (Johnson & Christensen, 2017). The process of shaping this study design has been ongoing. At each stage of the study, new information, learning and experience have triggered my reflection, response and adaptation of the study design, resulting in a process of ongoing interaction (Maxwell, 2013). During that process, I have paid attention to ensuring that adaptations remain aligned with the key aims and conceptions of the overall study. Maxwell's (2013) description of an interactive process is presented as a guide for qualitative research rather than for a mixed-methods study design, however the suggestion that an ongoing process of close attention and monitoring of five crucial components (goals, conceptual framework, research question, methods and validity, [Maxwell & Loomis, 2003]) has provided appropriate guidance for me within this qualitatively driven sequential mixed-methods design.

4.3 A Constructivist Grounded Theory

I sought a qualitative method to drive the sequential design of my mixed-method study. As such, I made four considerations in selecting grounded theory as the most suitable method. Firstly, I needed a method that would align with the social constructivist paradigm that underpins my research. Grounded theory is a method rooted in sociology, it is a tool that enables the exploration of social processes and contextualises those processes in the environment in which they are experienced (Starks and Trinidad, 2007). I have already established the social contexts of suicide loss and postvention in Chapter 1, in this particular study I explore experiences within a workplace in the form of an academic institution and community. For this reason, grounded theory may be particularly suitable.

Secondly the selected method should meet the needs of the topic and population. The topics of student suicide and the postvention needs of wider populations are both sparsely explored in the literature to date. Grounded theory analyses develop explanatory understandings that prove helpful in under-researched areas (Urquhart, 2013). Grounded theory is also suitable for examining experiences of the same phenomenon under different conditions, which is congruent with the experiences of the participants in this study (Starks and Trinidad, 2007). For instance, in the contexts of different job-roles and kinds of involvement following a student suicide.

Thirdly, the method should align within a mixed-method study design. In using grounded theory I gain a flexibility in that different kinds of data collection may provide different vantage points from which to understand the participants experiences (Palmquist et al., 2017).

Finally, the method ought to generate findings that meet my desired outcomes in terms of contribution to knowledge. As I highlighted in the findings of the literature review in Chapter 2, there is an evidenced need for research findings to inform sector specific policy and practice development. In addition, participants in my study have, on occasion, expressed specific desires that data and findings might inform future practice and guidance. Grounded theory is a good method to use for seeking explanatory models upon which to design interventions, that is, in utilising theory generated from participants' experience (Starks & Trinidad, 2007). In meeting the needs of the four criteria, I believed that grounded theory be a suitable method for the collection of interview data and the analysis of interview and open text survey data.

The founding aim of grounded theory was to adopt a systematic approach to working with empirical data to develop theories of human behaviour (Urquhart, 2013). In their book, 'The Discovery of Grounded Theory' (Glaser and Strauss, 1967) Glaser and Strauss challenged the idea that the role of data be to 'test' existing theory; instead proposing that data be used to generate or 'discover' new theory. They recognised that existing sociological theories, often

rooted in moments of inspiration or developed through processes of hypotheses, did not provide adequate explanations for evolving aspects of social life (Urquhart, 2013). Rather, they proposed that theory discovered from the data of social research would 'fit' the situation being researched and would 'work' when applied in practice (Glaser and Stauss, 1967, pp3). Thus, the theory is grounded in the data (Urquhart, 2013), a factor to which Glaser and Strauss (1967) attribute its credibility; they additionally state that such theory would have longevity in application, whilst being suitable for modification and reformulation over time (Glaser and Strauss, 1967).

Key to their work and to the development of research processes, Glaser and Strauss also asserted that both quantitative and qualitative data were useful sources for research (Urquhart, 2013). By developing a systematic approach to working with qualitative data they challenged the existing quantitative methodological consensus and lay the groundwork for the rising popularity of qualitative methods over the subsequent decades (Charmaz, 2014). Glaser and Strauss each brought their own strengths to the development of grounded theory; Glaser contributed robust codified methods and specific guidelines for working with qualitative data; Strauss brought a pragmatic philosophical tradition that informed a symbolic interactionism perspective (Charmaz, 2014).

In considering which branch of grounded theory would be best suited to this study, I paid attention to my philosophical paradigm, and to the role and relationship of myself as the researcher with the study participants. Constructivism 'denies the existence of an objective reality'; seeing reality as an individualistic social construct (Mills et al., 2006); this idea sits comfortably within my social constructivist paradigm. In terms of impacting on the way I will conduct this study, the idea of 'construction' as opposed to 'discovery' acknowledges the traits and contribution of myself as the researcher and of the participant(s) in the co-creation of data. That is, the findings of this study are the result of the coming together and working

together of the study participants with me. Mills et al., (2006) suggest the choice of which grounded theory method to follow might be informed by the kind of relationship that exists between the researcher and their participants. In constructivist grounded theory the researcher 'reconstructs' participants experiences and meanings. Charmaz (2014) states that the researcher's privilege, perspectives, and position are considered and acknowledged as present in the research relationship. In utilising constructivism it is the subjective interrelationship between myself and the participant(s) that nurtures the co-construction of meaning. Researchers are acknowledged as human and present in the research process (Mills et al., 2006); likewise, participants stories are seen and understood by relating them to the wider contexts in which the participants live and operate (Mills et al., 2006). The idea, therefore, of the neutral observer and value free expert are dismissed (Charmaz, 2014). As will be described later, a number of the tools used for analysis in this study call on my processes of reflection on and consideration of the data. In acknowledging these processes, and the presence of myself in all stages of the study, it is possible for me to give a congruent account of what happened, how, and why it happened, and what the resulting outcomes, or findings, are. Therefore, I decided that a constructivist grounded theory (Charmaz, 2014) be used in this study.

4.4 Ethical Dilemmas

4.4.1 Researching suicide

I have given thought to the ethical challenges of undertaking a study that asks participants to recall details of their experience following a suicide. Such a process might be perceived to present risks of psychological harm to participants that would understandably give rise to caution on the part of ethics committees. In weighing up such risks I have also paid attention to the benefits that the study may have, for the individual participants, for the population that they are drawn from, and in furthering knowledge within the field.

Using knowledge gained from human experience to inform and shape human response seems an obvious process. To grow our understanding of how we might respond to and support individuals who are in pain, or who have experienced challenges, or who are impacted by the events in their lives, we might be better placed if first we listen to those who are affected by the experiences that we seek to understand. In understanding experiences, we can then move toward meeting needs. Qualitative research interviews provide a structure within which researchers can hear, explore and learn about the experiences of diverse individuals, groups, and populations (Matthews & Ross, 2010). However, when research interviews seek to explore sensitive topics or include vulnerable groups, caution and hesitation on the part of ethics committees might be understandable responses. The purpose of research ethics committees is to ensure maximum benefit with minimum risk or harm to potential participants (British Educational Research Association, 2018; ESRC, 2020). Other concerns for ethics committees regarding participants include issues of consent, the right to withdraw, respect for rights and dignity, informed and voluntary participation, privacy and data protection, and that research be conducted with transparency and integrity throughout (British Educational Research Association, 2018; ESRC, 2020).

Internationally, suicide researchers report a shared experience of concerns being raised in response to applications for ethical approval for suicide related studies (Andriessen et al., 2019c). The concerns of ethics committee members centre around means of accessing the population; potential harm to participants and researchers; researcher competence; maintaining confidentiality; providing appropriate support to participants and researcher ability to respond sensitively to family needs (Lakeman & Fitzgerald, 2009). Additional concerns may include the ability of suicide-affected participants to give informed consent as well as the potential for participants to experience the interview as distressing or bringing on a low mood (Buckle et al., 2010). Caution amongst ethical board members may be understandable, but may also lead to reluctance in approving research in vulnerable

populations (Dyregrov et al., 2011). As such a judgement is required that might consider whether the benefits of suicide research outweigh the risks (Omerov et al., 2013). To resolve such a dilemma, attention ought to be given to the means by which any potential risks are mitigated and to any potential benefits that may arise for suicide-affected participants from taking part in research studies (Omerov et al., 2013).

One means by which we may mitigate risk of potential harm to suicide research participants is to pay attention to the relationship between the researcher and the participant. Hewitt (2007) provides a guiding framework that suggests consideration be given to aspects of the researcher/participant relationship when conducting research interviews. For instance, by paying attention to and acknowledging bias; rigor; rapport; respect for autonomy; avoidance of exploitation; and confidentiality the researcher may create an environment and experience that feels safe, valuing, and purposeful to the participant. A research interview can take the form or give the experience of an empathic, compassionate, non-judgemental environment that is conducive to a positive sharing of their experiences for participants (Buckle et al., 2010). Seeking to establish an equal partnership between researcher and participant might nurture a sense of neutrality that participants appreciate; acknowledging and adhering to clear boundaries that promote the researcher's role as listener, learner, and observer can ensure clarity for participants that may prove helpful (Rossetto, 2014).

The experiences of past participants also prove helpful in informing ethical decision making. The experience of participating in qualitative research for 97 individuals bereaved by suicide was described as overall positive (62%); unproblematic (10%); and positive and painful (28%) (Dyregrov et al., 2011). Suicide-bereaved parents (n=666) who took part in a survey study aiming to improve the professional care they receive were also asked about their experience of participating in the research. Whilst 10% perceived that they might experience a negative effect following participation, 95% of the parents felt that the study was valuable (Omerov et

al., 2013). A recent systematic review echoed these findings and added that the experience of distress during an interview did not prevent the participant from seeing participation as a helpful experience and vice versa (Andriessen et al., 2018). Littlewood et al (2019) undertook the first longitudinal study of suicide research participants' experiences and found that perceived benefits remained for some participants through the following months, and whilst some participants can experience short-term dips in mood in the hours or days following the interview, that any negative responses were confined to the days immediately following the interview. The kinds of benefits experienced by participants in suicide research have been reported to include meaning-making and sense-making experiences (Owens et al., 2008; Dyregrov et al., 2011); feeling heard (Rossetto, 2014); increased self-awareness or new insights (Rossetto, 2014; Dyregrov et al., 2011; Littlewood et al., 2019; Andriessen et al., 2018); and a sense of altruism or satisfaction from helping others through their contribution (Dyregrov et al., 2011; Littlewood et al., 2019; Andriessen et al., 2018). This kind of knowledge can help inform the suicide researcher who in turn can use it to prepare participants of the kinds of affects they might expect and offer signposting on how they might manage any difficult experiences. Indeed, it is important to remember that potential participants are not a homogenous group, and they may or may not perceive themselves as vulnerable. There is an important balance to be struck between taking a paternalistic approach of making decisions on behalf of vulnerable populations, or a more liberal view of recognising that people, when given informed consent, are able to make autonomous decisions regarding their choice to participate or not (Ross & Athanassoulis, 2014).

So, whilst evidence demonstrates that ethics committees may feel caution around suicide research. There is also evidence that the experience of taking part in suicide research can feel less problematic for the participant, with fewer negative or long-lasting impacts than might be anticipated. Indeed, participants have evidenced that the experience can return some positive or helpful outcomes for them. Therefore, if thorough ethical consideration is paid to the

methods adopted in undertaking this study, it might be that participants experience limited negative effects and unanticipated positive effects. In addition, the value of the study in giving voice to an unheard population and exploring a previously unexplored problem may generate for participants a sense of doing something for the greater good. If the findings then inform policy and practice changes, their contribution has benefit for themselves, their colleagues and the HEI sector.

4.4.2 Researcher role, positionality, and power

> ***My personal reflection:***
>
> *"In undertaking this study, I am curious to hear and learn about the realities of my participants; to work alongside them to develop or construct an understanding of the meanings they attach to their experiences; and to ensure that this inquiry be rooted in the natural settings in which the study participants operate. In doing so, I aspire to create new knowledge from their experiences so that real world outputs can be created from that knowledge to inform or improve the experiences of future others. Thus, completing the research and practice cycle."*

This journal extract, from early in my PhD journey reflects the hopes that I held at that stage with regard to my role as researcher. In this reflective section, I hope to present a critical account of my role, my positionality, and the potential impact of the power that is embedded in both.

Developing awareness as a researcher of these dynamics both within the tasks of research, and alongside those I am researching is important and necessary if I am to present an honest account of how the research happened and the strengths and limitations of the study findings (Chandler, 2020b; Polanco et al., 2017; Fitzpatrick, 2011). I intend this account to demonstrate the thought and attention that I have applied to this topic, as such I hope it will offer some

form of 'internal validity' (Ranahan & White, 2017, p56) to the work I present in this thesis. Bantjes and Swartz (2017) call on us as qualitative researchers who critique the methods of more dominant approaches in suicidology, to also critique our own methods, and to be explicit about the limitations of our own work. I aim to do that in this section by reflecting on these issues. These reflections are illustrated with extracts from my personal reflective research journal, and are informed by debates in current critical suicidology literature and feminist literature. Chandler (2020b) notes that whilst reflexivity is an integral part of qualitative research, it is rarely a reported aspect of the process. I aim to report my process here.

My personal reflection:

"Reflexivity has informed and shaped my learning and my research processes throughout the PhD. Taking the time to think, to reflect, to analyse, question and probe my own thoughts, responses, experiences and ideas, whilst engaging with the thoughts, responses, experiences and ideas of others, including those of the study participants, has added dimension and depth to my work. It has also aided my progression through data collection, and analysis toward findings; and then, beyond findings, to understanding more deeply what they might mean, or be telling me, and how I can present them to tell other people what I think I may have learned. Reflexivity has shaped the way I have been able to work with other people's stories, to form and structure and shape a brand-new story. The story contained within this thesis."

I have given thought to my role within the processes of research. The researcher might be seen as the interpreter of data (Polanco et al., 2017) or as holding two roles, that of story analyst and that of storyteller (Fitzpatrick, 2011). The role of storyteller, for me, highlights that my work continues beyond data analysis, to data reporting, and so there continues to be a need for reflection on how I choose to report, or to tell the story. I acknowledge the power that I hold as a researcher to make these decisions. I wonder if that act of acknowledgment

facilitates movement toward using my power as a positive aid in the research process. Oakley (1981) talks about the researcher as an instrument or a tool through which accounts might be articulated and recorded. She draws a distinction between the former role of the researcher as a 'data-collecting instrument' for researchers and the current potential for researchers to be 'data-collecting instruments' for the researched (Oakley, 1981). Indeed, researcher power might be used to create platforms from which our participants might be heard and seen (Polanco et al., 2017). I aspire that my role be platform creator or even mouthpiece – the storyteller (Fitzpatrick, 2011) - through which accounts may be heard more clearly and more widely. I experienced the interview as a process of exchange between two people who are each playing a different role – the interviewer and the interviewee - each of whom enter with their own set of hopes, fears, expectations and ideas about how the interview might pan out and serve their and each other's needs. My hope was to do my best to meet the needs of both of us. As Oakley states, there is 'no intimacy without reciprocity' (1981, p 49). I expressed curiosity about what had bought my participants to take part in the research and the interview and what they hoped to get out of it. I listened as they expressed how they had experienced the interview. And for those participants who chose, at any stage, not to participate, or to opt out of participating, I respected their choices and was mindful that I shouldn't continue to pursue them unduly. I acknowledge that in the interview dynamic there are of course power imbalances and I address these later in this account.

My personal reflection:

"It has been an important, and very personal aspect of this project to reflect on my own thoughts and ideas around suicide. To test those ideas, to stretch them and to try to articulate them in meaningful ways. If I, the researcher, am unable to put words to my own experiences and ideas, how can I congruently ask my participants to do so? But it is more than that. It is about knowing my topic, and knowing my personal position with

regards to the topic, so that I can then be mindful of whose story I am telling. This project is not about giving myself a platform, it is about bringing a platform to my participants, allowing them to tell their stories, without any sense that I am dictating behind them. If I know my own story, I can strive to spot it, to contain it, to keep it aside. I am, however, present in the research, in my interactions with the participants and with the data; in my searches of the literature; in my shaping of the thesis. And that is ok, because in exploring my own ideas and views and experiences, I can know, with confidence, that I have worked hard to ensure that it is not they that shape this project, but those of my participants, shared in my presence, and given meaning – theorised - through my analytic processes."

In paying attention to my position in the research dynamic, my experiences with suicide to some degree situate me alongside those of my participants. I am not a bereaved family member or a very close friend. I am a colleague, a professional, a member of the wider, often unseen, network of people that surrounds the person who has died. I am exposed to, affected by, but not necessarily bereaved by the deaths by suicide of six human beings, one was my boss when he died; two were ex-colleagues; and one was a service user at my place of work. I bring this experience with me into my research in the form of empathy, compassion, and curiosity to discover more about the experiences of others whose job role has bought them into contact with a death by suicide. The participants of this study are all employees in HEI settings, and I am a research student in a HEI setting, so we share familiarity, albeit through different eyes, of the HEI context. As such, it felt to me, that we had some common ground. In addition, I have a practice background in social care and counselling, thus introducing a further similarity between myself and those of my participants engaged in student wellbeing and counselling roles. Indeed, whilst similarities with participants might feel advantageous it may also be the case that similar attributes could raise issues around assumed knowledge (Merriam et al., 2001). I experienced this in particular with three participants of this study who all

acknowledged our similarities in terms of being either a practitioner or an academic or an expert in HEI postvention, in all cases these participants used phrases such as 'as you will know', whilst sharing their accounts in the interview, alluding to their sense that we have shared knowledge or experiences. From my perspective, I can only be clear that in finding empathy with participants, or on hearing shared experiences, I strived to remember that I am not walking in their shoes, but, at best, walking alongside them (Rogers, 1980). As I reflected in my personal account above, my aim was to retain clarity around the boundaries between my own story and that of my participants. To aid this process I engaged in reflective writing following each interview, which gave me an opportunity to comment on and acknowledge my personal responses to participant accounts, and through that process to become aware of them before engaging in an analytic process. In these efforts, I can only be sure that I did the best I was able.

Alcoff (2009) critiques the practice of including an author or researcher autobiography, calling for such inclusions to be subject to critical interrogation regarding the purpose and the effect. The purpose here is firstly, transparency and honesty, secondly, to self-interrogate my own motivations and position within the research. The effect, I hope is a demonstration of my awareness and reflective process. However, I do have to acknowledge that there may be additional affects which are not visible from my standpoint.

It is relevant here to acknowledge my reasons for undertaking this research. One of the driving reasons is to meet the requirements of my PhD programme. That fact should not be assumed to be known, nor be ignored. It is the case that I sought to engage participants with the process of recalling and recounting difficult, uncomfortable, or distressing accounts and memories of a very challenging experience, in part, to meet the aims of an educational award. Of course, there were additional reasons, but I was never shy about the helpfulness of their participation in my opportunity to gain an academic qualification. Whilst I shared this fact in

the interests of transparency, it may in cases have made participants either less or more inclined to engage in the research, especially as my participants are themselves employees in Higher Education. Indeed, one participant did share in their interview that they had felt they should participate in the interests of supporting research. In addition, in connection with my practice background I also hoped that findings from the study might eventually be reported in both academic and professional platforms with the hope of informing, in some small way, future practice. Further, I could see a gap in knowledge, and I believed it was important to fill that gap, because, I understood that within that gap there were individual people who were facing challenging experiences without the recognition or support that they needed.

Whilst I had shared with participants my status as a research student undertaking a PhD in the introductory email sent to all participants, I chose not to share my personal and professional experiences of suicide loss. I chose to withhold this information as the purpose of the research interviews and the survey was not to compare our stories and experiences but to hear the accounts of others. Burman (1994) suggests that if an interviewer is seen by the interviewee as unknowledgeable that more detailed information may be offered. My choice to withhold information, however, whilst asking participants to share information does create an imbalance of power.

4.4.3 'Voice' in qualitative research

> ***From my reflective journal: 25 July 2017:***
>
> *'Reading Rossetto (2014), and feeling my passion for undertaking qualitative interviews with participants being piqued. Wanting to do a good job in translating the experiences and stories of people into meaningful findings from which understanding, knowledge and theory might arise. Wanting to do a good job of it. I see it as collecting stories – giving people a space in which to share, to feel heard and valued and creating*

> *an environment through my presence within which the cathartic process of story-telling, of sharing, may play out safely and that the experience may be of benefit for my participants.*

The above excerpt is from early in my PhD journey, and once again reflects the hopes that I carried into my work at that stage.

In practice, I found the process of conducting the interviews to be one of the least stressful experiences of the PhD. I am comfortable in sitting with people, hearing their stories, giving them the space to talk, to pause and to reflect on their experiences. I am well practiced at leaving my own narrative outside the interview room, and on being present with the story and experience of the participant. I am grateful for the privilege that this kind of connection with another human being presents. I observe the way in which the study participants respond to having that space, to being invited to share, in their own way, in their own time, without interruption or comment, or judgement. I hope that I let them see that I am interested, that I value their accounts and stories, and that I welcome as much or as little information as they feel comfortable in sharing. What I don't know, of course, is how it felt for the participants of this study. I recall the participant who was visibly very nervous; the participant who checked with me that their colleagues wouldn't know what they had told me; the participant who talked non-stop and often departed from the topic at wide and varied tangents. I do not know what their internal dialogue or worries were; whether they perceived a power imbalance; whether they worried about my integrity as the researcher; whether they were trying to avoid talking about the topic or were worried about my reactions if they shared their experiences. I worked hard to respond in the moment to all of these participants, to offer compassion, assurance, kindness and direction. And they all stayed with me and completed their interviews. However, I cannot claim to know what that experience was like for them.

Whilst I wanted to 'give a platform' to, and 'hear the voices' of, my participants it is important that I also examine the idealistic nature of that desire. There are a number of ways in which such a desire is problematic (Mazzei & Jackson, 2009). When we as researchers present participant accounts as transparent truths, we fail to acknowledge the role that we have played in extracting such accounts. As the researcher, I have made multiple choices around how I will recruit and select participants, which questions I am going to ask them (and which questions I won't ask), what prompts I will use to elicit further information, and when I will use those prompts, (and when I won't). Through the analytic process I select which participant quotes I believe best illustrate the points that I choose to emphasise. In all of these tasks, I am calling on the power that I have as the researcher to make such selections and choices, and so there are ethical questions attached to how I am 'hearing the voices' of my participants and 'creating a platform' from which they can be heard more widely (Mazzei & Jackson, 2009).

A further issue rests in the assumption that 'first-person' accounts are honest, reliable and valid sources of data from which we can claim to know 'truths' and generate knowledge (Bantjes & Swartz, 2019). It may be the case that people don't always mean what they say; misperceptions, misinterpretations and cognitive disorders may be present and shape accounts; memory is unreliable; narratives are constructed, culturally informed and dynamic; people may be partially ignorant to the 'truth'; people have unconscious internal processes; issues of subjectivity and intersubjectivity shape the stories that are told (Bantjes & Swartz, 2019). All of these factors may shape the quality and reliability of the accounts that participants shared with me. Therefore, it is important to acknowledge that accounts are at best, partial, and there is a limit to what truths can be inferred from first person accounts (Bantjes & Swartz, 2019). In light of such limits, it is necessary to consider the kinds contributions that qualitative research can make to knowledge (Fitzpatrick, 2011). I acknowledge that my own interactions with participants, with the data I have collected and with the reporting of the data are complex and that I have consciously and unconsciously

constructed the messages that are conveyed through my participants voices in my findings (Fitzpatrick, 2011).

If the voices of my participants are partial and situated, and my own interactions with their voices have further shaped how they are represented here, the idea of using voice as evidence also presents a dilemma (Mazzei & Jackson, 2009). By looking beyond the 'easy' voice, however, a route toward addressing such a dilemma may be found (Mazzei and Jackson, 2009). Engaging just with the obvious voice limits what I can learn; in this study I purposively sought participants from across all departments and job-roles in HEIs. As I was planning the study and seeking input from other academics I found that the assumption was often made by others that my participants would be academics, lecturers and personal tutors. Rather, I sought out diverse participants and engaged with the voices of cleaners, security officers, chaplains, wellbeing and counselling staff, managers and leaders, as well as those in academic roles. I am clear in my presentation of findings that they are generated by the voices of my participants, the people who chose to engage, and as such, I don't know what other voices would have bought to the project. I report the experiences of my participants, heard through my ears, without claiming those experiences to be universal or collective. Therefore, I don't make claims of causality; I acknowledge that accounts are constructed with a particular audience in mind; and that power dynamics are at play in the collection of qualitative data (Bantjes & Swartz, 2019). In employing a constructivist grounded theory (Charmaz, 2014) I took an interpretative and constructive approach to analysis, indeed, the method is explicit about the processes of researcher interaction with the data.

Within this thesis, the findings of this study are presented within the context of the findings of my other study (Chapter 3) that utilises a different form of data; both of these studies are situated within the context of the literature review (Chapter 2), and in the context of wider knowledge within the subsequent discussion sections (Chapters 3 & 6). As such, a kind of

triangulation process is in operation, whereby the first-person accounts in this study are supplemented with other information sources (Bantjes & Swartz, 2019). All of these additional sources of data serve not only to contextualise the participant data, but also to sit alongside it, as additional sources of information from which, as a whole, the thesis conclusions and recommendations are drawn.

I acknowledge the partiality of voice and I also value the role that it can play in the wider context of research and knowledge. Subjective accounts of challenging or troubling experiences provide important insights into specific human encounters (White, 2016). Even as the limitations of voice are noted, there remains value in a knowledge base that is drawn from first-person accounts. Those with experience have important and relevant contributions to make to the current evidence base. Additionally, qualitative evidence supports and informs better responses to human troubles across health and social care settings. Qualitative evidence is also well-placed to address historical, political and cultural contexts within which experiences of oppression, marginalisation, stigma and suffering may impact on human experience (White, 2016). A broader social and political viewpoint informed by qualitative research gives greater insight into the sources of human suffering and also considers the local and particular context (White, 2016).

Because, as the researcher, I am speaking for others when I present my findings and conclusions, I do so whilst considering and acknowledging that my social location is likely different to that of my participants; and affects the way and by whom, my message is heard (Alcoff, 2009). Therefore, once again when I do speak I do so whilst scrutinising the power relations that are at play. For instance, I might ask myself what drives my impetus to speak, to share my conclusions? To whom am I speaking what do I intend my speech to do? (Alcoff, 2009).

As well as scrutinising my role in speaking for others, I also reflected on my role in listening to those others.

Personal reflection:

"What I have learned in my process of working with the data is the value of re-hearing the participant during transcription processes, hearing again, maybe hearing differently, more deeply, hearing the participants voice this time in the context of other participant's voices. And again, in coding transcribed data, the power of re-reading those same words. Each stage of the process is so much more than a task, it is an opportunity to learn more from the data."

15 January 2019:

"As I am coding this transcript I become aware of a heavy feeling in my chest – it is as if I am feeling the participant's anxiety, sadness, feeling their struggle to process and reconcile and make sense of their experience – just as I am also trying to make sense of it through my process of coding and analysis. This isn't just academic work, this isn't just science, it is feelings work; it is an internal presence; it is a weight. It is emotional work. And it comes with a sense of responsibility, to do justice, to reflect and respect and value my participants' words, experiences and feelings and to value their process by taking the greatest of care with my process."

17 July 2019:

"Currently transcribing interview 8. Hearing differently that the participant is more deeply affected than I perceived during the interview – it is present in her tone of voice, in her pauses and sighs, in the quieting and hesitating, the slowing down of words as they are picked with what sounds to be great consideration and thought in response to my questions."

For me, transcribing is research. It is slow, mindful, meaningful research. Transcribing and coding also gave me ample opportunity to reflect on my own presence and role in the research interviews. Whilst transcribing, whilst listening again, I found myself engaged in a process of re-listening, or even listening to myself listening (MacLure, 2009). In one sense critiquing my own process, in another, noticing all of the cues and clues that I may have missed in the moment of the interview. In transcribing I hear all of the pauses, nervous laughs, false starts, silences, stutters, tears, and awkward jokes that fall in between the words that might be labelled data. It might here that, in these often-overlooked nuances that I might find myself getting closer to the authentic voice of my participant (MacLure, 2009).

Given the ethical problems, dilemmas and questions discussed here, I called on Hewitt's (2007) ethics of care approach to guide my presence within the researcher – researched relationship with the study participants. I considered the safety, wellbeing, rights and choices of participants during the research process, this included acknowledgment of bias; attention to rigor and rapport; respect for autonomy; avoidance of exploitation and confidentiality. The steps that I took to engage in these ethical considerations are reported elsewhere in this chapter, for instance, in the use of Participant Information Sheets, risk assessments and consent forms (Appendices 4.4 – 4.7).

Voice is partial (Bantjes & Swartz, 2019), it may not be a transparent truth, but in this study, it is my source of data, and so I have strived to work with that source, as if in partnership with my participants, each of us with our own roles and areas of expertise. I have done my best through my analytic process to ensure that there is clarity and transparency and that the findings and conclusions presented later in this thesis are done so with honest and congruent reflection on both their strengths and limitations.

4.4.4 Ethics

Ethical approval for this study was given by the University of Worcester Health and Science Research Ethics Committee (HSREC) on November 6th 2017, HSREC Code: SH17180008-R (Appendix 4.1). The application for ethical approval for this study together with a record of queries made in regard of the application by the ethics committee and the subsequent responses are included in Appendices 4.2 & 4.3.

I undertook a risk assessment and management pro-forma (Appendix 4.4) for this study. In it I detail identified risks and associated management and mitigating factors that pertain to the HEI sites from which data were collected; the individual participants; myself as the researcher undertaking data collection for the study. I included further protective factors for participants in the Participant Information Sheets (Appendices 4.5 & 4.6).

A further issue that I considered was that of anonymity for individual participants and their HEIs. As such, I gave great consideration to the potential identification of participants from use of participant verbatim quotes. I was vigilant in ensuring that the use of verbatim quotes did not reveal details pertaining to the participant's identity or any other identifying details. I also took care at every step of the research process to protect identification of HEIs. I have done this in the transcription, coding, and reporting stages by ensuring that specific details pertaining to a student death by suicide are not included or are anonymised. Such details include the location or geographic region within which the HEI is situated; specific job titles of participants or of participant colleagues; the time of year of the student's death; the gender and age of the student; any further potentially identifying details of the student such as the student's course of study, details about the student's family, and details of the means of death.

My professional experience and skill set provided additional protective factors for both the participants and myself that pertained to ethical considerations in undertaking this study. For instance, I brought comprehensive workplace experience in conducting assessment interviews and support sessions with vulnerable adults and children. I also hold a skills-based qualification in counselling skills. This, together with Continuing Professional Development and experience in listening to others and in working with individuals in face-to-face, one-to-one settings, ensured my confidence in providing as relaxed, open and supportive environment as possible for participants during the research interviews. My previous experience of undertaking semi-structured research interviews with counselling clients further added to my skill set. I used a process of ongoing observational 'risk assessment' throughout all contact with participants; whereby, if I felt concerned about the safety or wellbeing of a participant I would address my concern with the participant and if necessary pause, postpone, or cancel the interview so as to safeguard participants from undue stress or anxiety. I have a total of 16 years of professional and academic experience of using supervision to promote consideration and reflection in decision making, and as a tool for promoting reflexive practice. Indeed, I utilised supervision as a significant protective factor in terms of safeguarding myself and my participants throughout all stages of the research process. The British Psychological Society's (2014) code of human research ethics informed me in all aspects of the research.

4.5 Methods

4.5.1 Recruitment of Participants

My aim of recruitment into this study was to capture stories across a range of staff members relating to their experiences of a specific student death by suicide. My hopes being to gain a collective account of staff experiences within the socio-cultural context of the institution, and to compare experiences across job roles and between institutions. To meet this aim, I focused on recruiting staff members across diverse job-roles who had experience of a student death by

suicide at three UK HEIs, to participate, initially in a survey with an opt-in to express an interest in participating in a subsequent interview phase of data collection. I hoped to engage three HEIs at which I could adopt a site-based approach to the recruitment of participants into the survey and interview phase of the study. This approach was adapted from the method used by Arcury & Quandt (1999) and is detailed below in sections 4.5.1.1; 4.5.1.2; and 4.5.1.3. I aimed to recruit a purposive sample in the region of 50 participants to the survey and in the region of 20 participants to the interview phase. The survey was designed to collect categorical and open text data that related to participants demographics, and to their perceptions and experiences. A purposive sample of 50 people would provide data suitable to meet the analytic aims of my survey design (Matthews & Ross, 2010) and I felt this to be achievable given that the population size was unknown due to being previously un-researched. My aim to recruit in the region of 20 participants into the interview phase of data collection was informed by the grounded theory literature and theoretical sampling method (Charmaz, 2014).

I undertook recruitment of participants in three stages:

1. the invitation to potential HEIs to become a site for the recruitment of participants

2. the recruitment of individual staff members within consenting HEIs to participate in the survey.

3. an opt-in for survey respondents to express an interest in participating in the interview phase of the study.

4.5.1.1 Stage 1: Invitation to HEIs to become sites for the recruitment of participants

Inclusion criteria for HEIs was as follows. A full-time student at the HEI had died by suicide no longer than two years and no more recently than 9 months prior to the commencement of data collection. My rationale for this time-scale was dictated by three things. Firstly, cause of death is clarified by the coroner's court, this process can take between six and nine months

following death, so this dictated that the death should be no more recent than nine months prior to the start of data collection. Secondly, the death should be no longer than two years before the commencement of data collection; the death needed to be recent enough to allow recall by the participants. Finally, it was important that enough time should have passed following the student death, that the tasks of dealing with the aftermath were completed; and that potential participants had enough time prior to the study to overcome initial responses of shock or grief. Theories of grief and bereavement refer to 'stages' (Kubler-Ross, 1975), or phases or tasks (Worden, 2003). Most theorists agree that the process of passing through such stages is an individual one influenced by a range of personalised factors, and as such it is difficult to suggest a 'normal' time frame for the process. However, it is likely that after a period of nine months that the initial stages of denial/shock and anger (Kubler-Ross, 1975), or the phases of numbness and yearning (Worden, 2003) will have been completed by those impacted by the death.

I have detailed the process of inviting HEIs to act as sites for the recruitment of participants in figure 5 and I followed the steps detailed below:

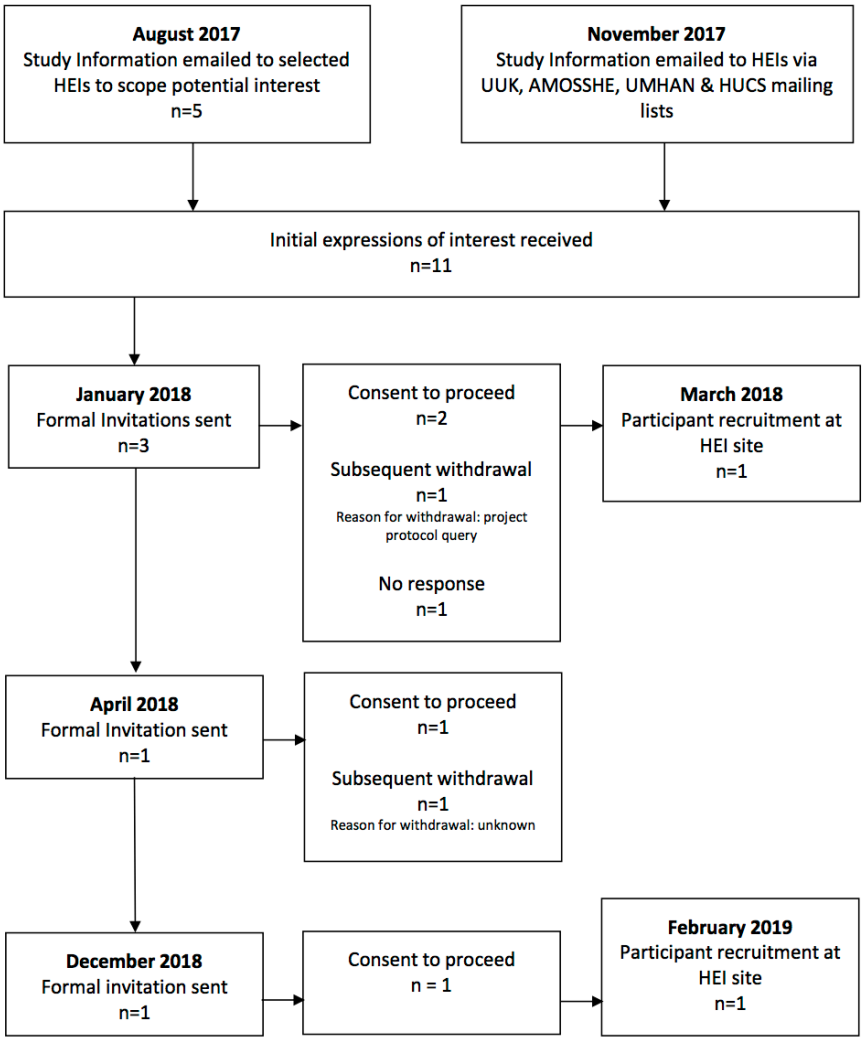

Figure 5: Flow chart of recruitment of HEIs to act as sites for the recruitment of participants.

- A preliminary email (Appendix 4.8) was sent to a small selection of HEIs to scope potential interest in the study. Five HEIs were contacted that were known to meet the inclusion criteria; this selection of potential sites was informed by the expert knowledge of a member of the supervisory team regarding student suicide within the HE sector. The email set out the purpose and nature of the study and invited initial expressions of interest from HEIs to act as sites for participant recruitment for data collection. All five HEIs expressed an initial interest.

- To recruit into the study from across the UK HE sector the same email (Appendix 4.8) was sent to four HE Organisations: Univerisities UK (UUK); AMOSSHE – The Student

Services Organisation; University Mental Health Advisers Network (UMHAN); and Heads of University Counselling Services (HUCS). Each of these organisations disseminated the email via their mailing lists. Due to GDPR restrictions, it is not known how many HEIs received this mailout. Six HEIs expressed an initial interest in the study as a result of these mail-outs.

- A formal invitation was made by letter (Appendix 4.9) to three HEIs. These HEIs were selected through a process of consideration and comparison by myself in discussion with my supervisory team. My aim being to engage three diverse HEI sites so that a wide range of experiences might be reported in the data. The letter (Appendix 4.9) was sent by email from me to the respondent at each HEI (in all cases a senior leader or Vice Chancellor or Pro Vice Chancellor). The respondent self-identified as the person who would act as the key point of contact throughout liaison with the HEI and through the processes of dissemination of the survey and organisation of subsequent participant interviews.

- The Assistant Director of Policy at Universities UK, and the Pro Vice Chancellor for Students at University of Worcester both gave their support to the recruitment process and this was highlighted in the letter.

- The letter outlined the study details and rationale and invited the HEI to act as a site for participant recruitment for data collection.

- The letter included an overview of the research proposal and proof of University of Worcester ethical approval.

- Consent was given by two HEIs and no response was received from the third; subsequently one HEI withdrew from the study. The process of inviting further HEIs to engage with the study is outlined in Figure 5 above.

- Confirmation of interest in becoming a recruitment site for participants and signed consent was received from respondents at two HEIs. I made telephone contact with the respondents to discuss the participant selection framework (Appendix 4.10); to identify potential staff groups from which participants would be recruited; and to discuss and agree site-specific strategies for recruitment and safeguarding of participants.

- I provided each respondent with a proposed site-specific timeline for the study.

4.5.1.2 Stage 2: Survey participants

The criteria for inclusion for individual participants within the HEIs were that they were a member of staff employed directly, or via a contracted provider, to work at the HEI. That they had experience of a student death by suicide either because they knew of and/or had worked with the student who died; or because they took on roles or tasks associated with a student death by suicide after the death had occurred at their HEI. My process of participant recruitment is detailed below. I used participant information packs and consent forms in the recruitment process (Appendices 4.5, 4.6 & 4.7).

- The respondent at each HEI identified departments within which staff members either knew or had worked with the student who died, or where staff members had taken on tasks following the student death. At each HEI this included staff in facilities teams; student wellbeing teams; academic departments; chaplaincy staff and senior leadership staff. An email was disseminated (Appendix 4.11) to identified heads of department who in turn disseminated to their staff members. Due to the multi-layered nature of dissemination, it is not known how many staff members received the invitation to participate. The email contained an introduction to the study and to myself as the researcher, and a link to the electronic survey.

- The study survey included participant information sheet and consent form (Appendix 4.5). The survey and associated information were offered in both electronic and paper formats so as to meet the differing needs of individual job roles or employees. Neither HEI requested paper versions of the survey and associated information.

4.5.1.3 Stage 3: Interview participants

- An opt-in question at the end of the survey gave participants the opportunity to request information about the subsequent interview study. If interested, participants were asked to share their name and contact details so that I could contact them directly.

- I made contact with 13 interested participants via an email to their workplace email account (appendix 4.12). The email contained an attached participant information sheet and consent form that gave further information about participating in the interview. Participants were given 14 days to read the information sheet, sign, and return the consent form.

- Electronic copies of consent forms were stored on a password protected hard-drive; paper copies were stored in a locked filing cabinet in a locked office on University of Worcester premises.

- At the end of 14 days a brief reminder email was sent to participants who had not returned consent forms (Appendix 4.13). This email stated that if the participant chose not to respond that no further contact would be made.

- I contacted the ten participants who returned a signed consent form within the 14-day time-frame by email or phone to arrange a mutually convenient time to meet for the interview.

4.5.2 Consent

I obtained consent from a senior staff member at each of the HEI sites (Appendix 4.9) for participants to be recruited at the HEI site. I also obtained consent from the individual staff members within the HEI firstly before they participated in the survey phase of the data collection process, and again before they participated in the interview phase of the study. Consent forms are included in Appendices 4.5, 4.7 & 4.9. These documents were offered in either electronic or paper format so as meet the needs of different staff job roles and participants.

4.5.3 Data management

I ensured that all data collected in the course of this study were protected in line with current UK GDPR legislation and University of Worcester policy and procedure. It was of utmost importance that participants and the HEIs within which data collection took place were assured anonymity and as such secure storage of all data collected was according to the data management plan in Table 4.

Data collected	Personal experiential responses and accounts of individual participants
How was data collected	Online survey. Utilising Bristol Online Surveys which subsequently became JISC Online Survey. Semi structured one-to-one interviews, digitally audio recorded.
How was data stored	In line with the University of Worcester Data Protection Policy and GDPR guidance, digital data is stored securely on the researcher's password protected computer drive. JISC Online Survey is also GDPR compliant. Storage spaces are accessible only by the researcher, but will be available for auditing by the supervisory team and relevant ethics committees.
How data will be retained and disposed of	In line with recommendations of the University's Policy for the Effective Management for Research Data, digital audio recordings will be retained on the researcher's password protected computer drive until the audio has been

	transcribed by the researcher and will then be destroyed. Anonymised surveys, data processed from surveys and anonymised interview transcripts will be retained for up to 10 years, after which point data will be destroyed. Participants were informed of this process in their participant information pack prior to data collection.
How retained data will be accessed	Retained data can be accessed by contacting University of Worcester Research School or the researcher directly. Freedom of Information requests will be referred to the University of Worcester's Head of Information Assurance. Data that is part of an ongoing research project is not able to be subject to a Freedom of Information request. Data that pertains to individual participants is protected by UK Data Protection legislation. Data that pertains to Institutions will be protected by use of a coding system that will be destroyed by the researcher at the end of the research project.

Table 4: Data Management Plan

4.5.4 Participant Details

In total I recruited 21 participants from two sites. Two participants, from site two, who completed the survey and opted to be included in the interview phase, had to be excluded from the study, and I removed their data from the survey results. This was because their experience related to a student who had made a suicide attempt, rather than to a student who had died by suicide. The participant information sheet was explicit that the survey was for staff members who had experienced a student death by suicide. I sent an email explaining the reasons for this to each of these participants. Subsequently, this left a total of 19 participants in the study; all 19 completed the survey phase; 13 expressed an initial interest in participating in the interview phase of the study, all of whom I invited. Ten of the 13 responded with consent and participated in the interview phase. I report the participant details in Table 5.

		Site 1		Site 2	
		Survey	**Interview**	**Survey**	**Interview**
Gender of participants	Male	6	2	2	1
	Female	6	5	5	2
	Total	**12**	**7**	**7**	**3**
Job-role of participants	Executive Staff	1	1		
	Student Facing Staff	5	3	1	1
	Facilities Staff	3	3	2	
	Academic Staff	3		4	2
	Total	**12**	**7**	**7**	**3**

Table 5: Study participants by gender, job-role and site of recruitment.

Job-role descriptors that I have used in table 5 match those used in the survey. I provided participants with the following guidance to aid their identification with an appropriate descriptor. Student Facing Staff: (eg. Student support services; student counselling & wellbeing; student union). Facilities Staff: (eg. Accommodation; maintenance; domestic; security staff). Administrative staff: (eg. Registry). Academic staff. Executive staff. A further category of 'other' was provided. One participant identified as 'other'. Their job role was university chaplain, which is a student facing role, and so I included their data in the group of student-facing staff throughout.

Recruitment of participants resulted in considerably fewer participants than I had anticipated. In exploring a previously unresearched population, this was both disappointing and interesting. As I have detailed in figure 4.1 engagement of HEI sites from which to recruit participants was a drawn-out process that resulted in two sites rather than the three sites I had hoped for. In addition, recruitment of individual participants from site two in particular was a slow and challenging process. The design of the recruitment process resulted in a disconnect between myself and potential participants. Gaining information and updates

regarding the dissemination process proved challenging. I pay further consideration to the limitations of my recruitment methods in section 6.8.4**.** I discuss the implications of a smaller sample in terms of theoretical saturation in section 4.5.5.3; and in terms of survey data analysis in section 4.5.7.

4.5.5 Data Collection

4.5.5.1 Survey

The first phase of data collection took the form of an electronic survey hosted by JISC Online Surveys. I designed the survey to gather data that responded to my research questions, aim and objectives. The survey was split into three parts; the first sought to gather demographic data about the nature of staff members' job-roles, their age and gender (Questions 1-5). The second part of the survey sought to gather data about the staff members' experiences after a student death by suicide; it sought to scope the kinds of impacts that were perceived by staff members; the kinds of needs that staff members perceived themselves as having; and the kinds of support that they sought or received to help with any identified needs (Questions 6-9). The third part of the survey explored the kinds of roles or tasks that staff members may have undertaken following a student death by suicide; how they came to undertake the tasks; any needs that they may have had in connection with delivering those tasks or roles; and any support that they sought or received in connection with those needs (Questions 10 – 14). A final open text question asked participants if there was anything further that they wished to share (Question 15). To identify if participants would like to participate in the second phase of data collection, a semi-structured interview, the last question of the survey invited interested participants to share their name and contact details in the form of either a phone number or an email address. Participants were informed that I would contact them in due course to share further information about the interview phase of the study, after which they could decide whether to participate or not. The full survey is included in Appendix 4.14.

I designed the survey to be disseminated in both paper and electronic formats to optimise accessibility to staff members across all university departments. At the point of dissemination, no requests were made for paper versions. I made a check by email, with the key contact at each HEI and it was confirmed that no paper versions were required.

Table 4.3 sets out the survey questions and question designs in relation to the research questions, aims & objectives that underpin them, together with the kinds of information that was gathered by the questions. The questions were specifically designed to collect data that would respond to the research questions and study aims. That is, to collect data that will seek to understand what is happening, and to explain why it might be happening. It is this aim that underpins my design of survey questions, utilising both closed and open text questions to gather categorical and open text data.

As no previous research has been undertaken in this area, I firstly wished to discover whether HEI staff members perceive themselves as being impacted. Question 6 utilised a yes/no/unsure format to ascertain this information. Secondly, if staff do perceive a level of impact, I wanted to understand more about that. Question 7 was designed to inform understanding of the kind of perceptions that staff members held regarding how they felt impacted. I did this using an adaptation of Cerel et al., (2014) Continuum of Suicide Survivorship. The continuum suggests that people impacted following a suicide death may perceive themselves to be 'exposed to' a suicide; 'affected by' a suicide; or 'bereaved by' a suicide, where bereavement may be a short term or long-term experience (Cerel et al., 2014). Respondents were given the following descriptors to inform their understanding of the different terms used and to aid their self-assessment (descriptors adapted from Cerel et al. 2014). 'Exposed to' describes an impact that involves knowing about the event but does not include a significant emotional effect following the event. 'Affected by' describes an impact that involves feeling significantly upset or distressed by the event and during the period

following the event. 'Bereaved by' describes an impact where the loss carries a deep personal meaning and a process of grieving takes place either in the short or longer term following the event. I will be able to compare participant responses to question 7 according to their job role, and according to the open text data they provide in questions 8a, 9, 11, 12a, 13a, 14 & 15. I chose this model as it has been recently developed in light of growing understanding that there are wider networks of individuals who do perceive an impact following a death by suicide, including those who encounter a death because of their job-role. The continuum of suicide survivorship has also informed national postvention guidance in the UK (Public Health England, 2016a). Therefore, the findings of my survey question will be translatable alongside public policy and current research.

I also asked participants about the kinds of needs that they had following the student suicide (Questions 8 & 8a) and in relation to undertaking tasks following the suicide (Questions 13 & 13a). Needs were explored as a means of identifying the kinds of support that may be required for this population. For the purpose of these questions I gave participants the following definition of the term 'needs': 'the word 'needs' refers to the things that you require in order to be able to come to terms with the event of the student suicide and to feel able to continue doing your job and leading your life to a satisfactory level on a day to day basis'. I formulated this definition specifically for this survey for two reasons. Firstly, to make sure that the data I gathered in response met my research aims; secondly, to ensure that participants were providing responses within a similar frame of reference as each other. Each question was presented in two parts; firstly, participants were asked to select any needs experienced from a given list. With this question I aimed to generate an understanding of what kind of needs participants experienced, if any. The second part of the question invited open text responses should the participant wish to share more information about the needs that they experienced. The purpose of inviting open text responses was so that I could gather data that would meet the qualitative aims of my study in further understanding people's experiences. The remaining

questions gathered open text data to explore the experiences of participants in relation to the study aims, as described in table 6 below.

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
N/A Demographic Data Collection			1. Please write your participant ID number here:	Open text	Coded ID
			2. Would you describe your job-role as being (please select one): a) Student-facing staff (eg. Student support services; student counselling & wellbeing; Student Union) b) Facilities staff (eg. Accommodation; maintenance; domestic; security staff) c) Administrative staff (eg. Registry) d) Academic staff e) Executive staff Other. Please state your job-role here	Multiple choice – single option.	Job roles of participants
			3. How long have you been in your job-role?	Open text	Length of time in job-role
			4. What is your age?	Open text	Age of participants

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
			5. What is your gender?	Open text	Gender of participants
How is a student suicide experienced by staff members within a UK HEI and what are the features of that experience?	Identify how a student suicide is experienced by staff members within a UK HEI and highlight the features of that experience	To ascertain the range of staff within UK HEIs who identify themselves as having been impacted by a student suicide, and to explore the range of impacts and needs as identified by these staff.	6. Following the event of a student death by suicide at [insert name of University], would you describe yourself as impacted by the event? (please circle the one that best describes your experience) a) Yes b) No c) Unsure	Multiple choice – single option.	Perceptions of impact following a student death by suicide
			7. Would you describe the way you have been impacted as being: (please circle the one that best describes your experience) a) Exposed to a student suicide death b) Affected by a student suicide death c) Bereaved by a student suicide death	Multiple choice – single option	Perceptions of impact following a student death by suicide

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
			8. If you had any needs following a student death by suicide, would you describe them as: (please circle any that describe your experience) a) emotional needs (This describes needs that relate to an emotional response eg. Sadness, tearfulness, anger, confusion, fear etc.) b) psychological needs (This describes needs that relate to a psychological response such as anxiety, sleeplessness, depression etc.) c) practical needs (This describes needs that arise in connection with your practical ability to do the things that you need to do.) d) personal needs (This describes needs that arise in your life away from your job-role) e) work-related needs (This describes needs that arise in connection with your job-role)	Multiple choice – multiple options	Perceptions of need following a student death by suicide

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
			f) none of the above (please describe your experience below).		
			8a. Please use the space below if you would like to tell us more about the different kinds of needs that you may have had following a student death by suicide.	Open text	Perceptions of need following a student death by suicide
			9. Please use the space below to describe any support that you sought or received to meet the needs that you identified in question 6.	Open text	Experiences of seeking or receiving support following a student death by suicide
Do staff members undertake specific postvention roles following a student suicide, if so, what kinds of role, and are there any staff needs attached to delivering them?	Explore whether staff members undertake specific postvention roles following a student suicide, if so what kinds of roles, and are there any staff needs attached to delivering them?	To ascertain the formal roles which are undertaken by staff members following a student suicide. To understand who undertakes these roles, and whether there are any specific needs	10. Following a student death by suicide did you take on any specific role/s, task/s or job/s that arose in connection with the event of the student's suicide? Yes No	Multiple choice – single option	What kinds of task were undertaken by staff in connection with a student death by suicide
			11. Using the space below, can you name or describe the role/s, task/s or job/s that you undertook?	Open text	What kinds of task were undertaken by staff in connection with a

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
		attached to delivering them.			student death by suicide
			12. Thinking about the role/s, task/s or job/s that you undertook, was the role/s, task/s or job/s: (please circle the answer that best describes your experience). a) Given to you by a line/department manager or other colleague? b) Something that you knew you needed to do because it is part of your job description? c) Something that you recognised needed to be done? d) Other 12a. If you selected other can you explain how you came to undertake the role in the space below.	Multiple choice – single option Open text	How did staff members come to do tasks in connection with a student death by suicide.?
			13. If you did undertake any specific role/s, task/s or job/s following the student death by suicide can you tell us about the different kinds of needs that you may have experienced in the	Multiple choice – multiple answers	Perceptions of needs in relation to undertaking tasks following a student death by suicide.

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
			process of doing it? (please circle as many as describe your experience) a) emotional needs (This describes needs that relate to your emotional wellbeing eg. Sadness, tearfulness, anger, confusion, fear etc.) b) psychological needs (This describes needs that relate to your psychological wellbeing such as anxiety, sleeplessness, depression etc.) c) practical needs (This describes needs that arise in connection with your practical ability to do the things that you need to do.) d) personal needs (This describes needs that arise in your life away from your job-role) e) work-related needs (This describes needs that arise in connection with your job-role) None of the above (Please describe your experience below).		

Research Question	Research aim	Research objective	Survey Question	Question design	Information gathered
			13a. Please use the space below if you would like to tell us more about the different kinds of needs that you may have had in connection with the role/s, task/s or job/s that you undertook following a student death by suicide	Open text	Perceptions of needs in relation to undertaking tasks following a student death by suicide.
			14. Please use the space below to describe any support that you sought and/or received to meet the needs that you identified in question 11. Please tell us about the kind of support you received and where it came from and about any other things that you would have found helpful.	Open text	Experiences of seeking or receiving support to meet needs in connection with undertaking roles following a student death by suicide.
All questions, aims and objectives listed above.			15. If there is anything else that you wish to say about any aspect of your experience following the student death by suicide at [name of HEI]; or if there is something that you thought we might ask you about but we haven't, please use the space below	Open text	Other aspects of the experience that staff perceive to be relevant to this survey.

Table 6: Survey questions and question design in relation to research questions, aims and objectives

I employed an iterative process in designing the survey through constant checking to ensure that the survey questions made sense, responded to my research questions, aims and objectives and would gather the kinds of data I hoped for. I utilised discussions in supervision, and pilots with academic staff and PhD students to support my checking process. I piloted the survey both in the paper and electronic formats to check for readability, usability and functionality. Four PhD students and one Dr of Psychology took part in the piloting process. Some minor typographical errors were corrected; the spacing on some questions was increased to enhance readability; and the wording of the participant information sheet was amended in two places to improve clarity. The collection of data from the electronic survey was accurate, readable and usable by myself. I found that the paper and electronic surveys were usable, and made sense to my pilot participants.

4.5.5.2 Interviews

The second phase of my data collection utilised semi-structured interviews. I created a topic guide (Appendix 4.15) to respond to my study questions, aim and objectives. My topic guide was designed to utilise open-ended, non-judgemental questions, to be followed, if necessary by further exploratory prompts (Charmaz, 2014). I used the open-text data gathered in survey questions 8a, 9, 11, 12a, 13a, 14 & 15 as a tool for checking whether any additional topics should be addressed. That is, if additional topics had been raised in the survey data then I could construct a prompt to further explore the topic during the interview. After this checking process I found that there were no further topic prompts needed. Topics that I included in the guide were the participants' experiences and perceptions of the events following the student death by suicide (including their thoughts and feelings, perceived affects, perceived needs, experiences with support); their experience and perceptions of undertaking roles or tasks following a student death by suicide (including details of roles/tasks undertaken, experiences of undertaking roles/tasks, what helped and what difficulties were encountered in connection

with the roles/tasks); participants' experiences of helpfulness following the student death by suicide (who helped, how, what did they do). I employed an ongoing process of checking the relevance of the topic guide as the interviews progressed. I updated the topic guide in response to new topics shared by participants during the interviews. As such, I was able to 'test' the experiences reported by one participant against the experiences of subsequent participants according to the method of a grounded theory study (Charmaz, 2014). The final version of the topic guide is included in table 7. I kept a record of all versions of the topic guide with a commentary of the changes made throughout the interview data collection (Appendix 4.15).

Topic	**Potential Question**
Opening questions	I would like to start our interview by asking you if you can tell me what your job is and what kinds of things you do
	How long have you worked here? Have you always done the same job here?
	What would a typical day look like?
Participant's experiences and perceptions of events following the student death by suicide	So, we are here to talk about your experiences following a student death by suicide here at the University, is it ok if I ask you some questions about that now?
	How did you hear about the student's death?
	What were the events that followed the student's death by suicide?
	Could you tell me about your thoughts and feelings following the suicide?
	Tell me about any ways in which it affected you?
	What kinds of things did you need to help you at that time?
	What kinds of support were you offered?
	Can you tell me about something that was particularly helpful at that time?
	What other things might have been helpful to you?
	Tell me about any ways in which it continues to affect you.

	Can you share with me any particular moment or image that has stayed with you?
Participant's experience and perception of taking on any role/s following the student death by suicide	Tell me about any particular tasks or jobs that you took on following the suicide? How did you know what to do? What was it like for you to undertake that role/task/job? What helped you to manage that role/task/job? What were the difficulties that you encountered in doing that role/task/job? Tell me about any ways in which the experience has changed the way you work now.
Participant's experience of helpfulness following the student death by suicide	Is there any person or organisation that has been particularly helpful or supportive of you since the student's death? What kind of things have they done?
Additional experiences and perceptions not covered within the interview so far	How do you feel about it all, when you look back now? Is there something that you might not have thought about before that has occurred to you during this interview? Is there something else that you think I should know about to understand your experiences better?

Table 7: Interview topic guide, final version.

I scheduled Interviews at a mutually convenient time and in a private location on the participant's campus. If it was not possible for me and the participant to find a mutually convenient time to undertake the interview in person, we scheduled a telephone interview instead. I conducted two of the ten interviews by telephone.

All of the face-to-face interviews were undertaken in a quiet, private room on the participant's campus. I had assistance with locating and booking a suitable room from a key contact at the HEI site. Telephone interviews were conducted as a booked appointment with the participant. I checked that the participant was in a private office or room and believed them-self unlikely to be disturbed before beginning the telephone interview.

Due to the distance of recruitment sites from my place of work, I undertook interviews in batches at the participating sites. Table 8 illustrates the process and time-frame of interviews undertaken. Interviews lasted between 38 minutes and 1 hour 15 minutes.

Interview Location	Date	Number & Format
Site 1	June 2018	4 Face-to-face Interviews
Site 1	September 2018	2 Face-to-face Interviews; 1 Telephone Interview
Site 2	May 2019	2 Face-to-face Interviews 1 Telephone Interview

Table 8: Participant Interviews: Location, date and format.

4.5.5.3 The question of saturation

The question of sample size in grounded theory studies, and indeed throughout qualitative research is much debated, and always conceptualised quantitatively, with suggestions ranging from an optimum of up to 50 interviews down to 'at least six' as being enough (Low, 2019). Sample size is taken in grounded theory to be an indicator of the potential to reach theoretical saturation in the analytic process. Glaser and Strauss (1967) defined theoretical saturation as being the point at which *'no additional data are being found whereby the sociologist can develop properties of the category'* (pp61). This definition is echoed in many variations throughout the qualitative literature, nearly always with the focus on the idea of 'no new information' (Low, 2019) as being the indicator that saturation has been achieved. Low (2019) acknowledges that the researcher may never know if there would be further new information in subsequent interviews or data; and therefore, may never be able to claim with full certainty that theoretical saturation has been achieved. A more pragmatic definition of theoretical saturation that lets go of the practice of quantifying interviews, and engages fully with the process of 'conceptual rigor', a process that is emphasised in the writings of Glaser, Strauss,

Corbin and Charmaz, may be more helpful in grounded theory studies (Low, 2019). Charmaz (2014) points out that many researchers are aiming to saturate data, whereas grounded theorists are aiming to saturate categories and concepts; she argues that the saturation of categories requires a deeper engagement with the data and highlights that using *'mixed qualitative methods can strengthen a study with a small number of interviews'* (pp107).

I conducted ten interviews in this study. As detailed in figure 4 it was hoped that a third HEI would engage with the study to act as an additional site for the recruitment of participants, however, just two HEIs engaged, which limited the pool of potential participants. In addition to data gathered in interviews, I already had qualitative data that had been gathered from 19 participants in the form of open text survey responses. Taken together, the qualitative data from the survey and from the interviews provided me with a rich source of accounts detailing multiple aspects of experience from a diverse range of HEI staff members. For this study, I decided that the concept of theoretical saturation be informed by the quality of the data collected, and depth and rigor of the analytic process. As such, I felt that the analysis of data to be complete when there was nothing further that the data could add to the categories that I had developed.

4.5.6 Transcription of data

4.5.6.1 Open text survey data

I copied and pasted open text survey data from the online survey platform into a word document. I removed or anonymised all identifying data from the transcript. This included details of individual's names, specific job-roles, location details, identifying details of the HEI, specific details of the means by which the student died, and any identifying details of the student who died including reference to their gender, the course they were studying, their year of study, their age, and the time of year that they died. I organised the data by survey

question with individual participant responses identified by participant number. This organisation felt logical as I was going to use the data at a later more conceptual stage of the analytic process.

4.5.6.2 Interview data

I digitally recorded data collected in interviews onto a password protected memory card for later transcription by myself. The audio recorded files were transferred immediately after the interview was completed, whilst I was still in the interview room, from the memory card onto an encrypted and password protected hard drive where they were stored for the duration of the project. I immediately deleted the recording from the memory card. I stored a back up of the audio files on the University of Worcester OneDrive cloud storage facility that is password protected to the individual user and ensures encryption of all data. I numbered audio files according to the sequence in which the interviews took place; participants were identified sequentially by a letter of the alphabet, eg. the first interview was Transcript 1; Participant A. I transcribed data verbatim into word documents, an example extract of one transcript is included in Appendix 4.16. During transcription I removed any identifying data. This included details of individual's names, specific job-roles, location details, identifying details of the HEI, specific details of the means by which the student died, and any identifying details of the student who died including reference to their gender, the course they were studying, their year of study, their age, and the time of year that they died. I transcribed interviews in batches; interviews 1 – 5 were transcribed prior to initial coding; interviews 5 – 10 were transcribed prior to second stage coding. The process of transcription allowed me to hear again the words of the participants; and in listening to their words, slowly, phrase by phrase as they were transcribed, the experience of hearing them was different to the hearing that happened during the interview. The second hearing of participant words, experiences and stories allowed me to hear more deeply the participants' choice of words, the meanings of

their words, their voice tone, and the relevance and meanings of the spaces in between the words. I experienced, at some points during transcription, a visceral emotional response to the participants' experience and their sharing of that experience. As such the transcribing process allowed me a second and different hearing of the interviews during which I gained new insights that generated a useful process of reflection.

4.5.7 Analysis of survey data

Data from nineteen participants was eligible for analysis; data from a further two participants was ineligible as explained in section 4.5.4. I used all data entered by eligible participants including incomplete data sets. Three of nineteen participants responded to every question in the survey. All of the incomplete data sets omitted only open text questions. Two participants answered 'no' to question 10 which asked whether they had taken on any tasks, jobs, or roles following a student death by suicide; a 'no' response automatically sent the participant to question 15, missing out questions 11 – 14 which all pertained to the undertaking of tasks. The following questions were omitted by some participants: question 8a, (asks participants to share more about the needs they had) by 5 participants; question 11 (asks participants to describe the task/s that they undertook) by 2; question 12 (asks participants to specify how they came to undertake task/s) by 2; question 12a (asks participants to share more about undertaking tasks) by 13; question 13 (asks participants to identify the kinds of needs they experienced in relation to undertaking tasks) by 2; question 13a (asks participants to elaborate about their needs in relation to tasks) by 13; question 14 (asks participants to describe experiences of support in relation to their needs) by 5; and question 15 (asks participants if there is anything further they wish to say about their experiences) by 3.

I designed the survey firstly, to ascertain the range of staff within UK HEIs who identify themselves as having been impacted by a student suicide; to explore the range of impacts and needs as identified by staff members. Secondly, to ascertain the formal roles which were

undertaken by staff members following a student suicide; and to understand who undertakes these roles and whether there are any specific needs attached to delivering them. My aim for the study was not to collect generalizable data as an inferential statistical analysis would not prove useful in answering the study questions. The quantitative data from the survey provides useful context and insight into the sites examined in the study that meet my aims for the survey. I gave consideration to the value of analysing data according to participant groups, for instance, by site, by job-role or by gender. These analyses might have been possible with a larger sample size. However, given the relatively small number of participants (n=19), the difference in total number of participants per site and the differences in job-roles of participants by site I decided that such comparisons of data would be very difficult and would not result in useful findings or conclusions. Therefore, I analysed the data as a complete set of all participants regardless of site of recruitment, job-role, or gender.

I used descriptive statistics to summarise categorical data from questions 2 to 5, to describe traits of the study participants regarding their age, their job-role and the length of time that they had been in their job-role in order to situate the sample. I also used descriptive statistics for categorical data from questions 6 and 7 to describe participants perceptions of impact; and again, in questions 8 and 13 to describe the kinds of needs that participants had.

I conducted an initial thematic coding (Braun & Clarke, 2013), of the open text data from questions 8a, 9, 11, 12a, 13a, 14 & 15, to give an overview of the kinds of experiences and perceptions reported by participants. These questions asked participants to describe their needs in relation to a student death by suicide and in relation to undertaking tasks following the suicide; to describe their experiences of support in relation to the student suicide and in relation to undertaking tasks; to describe the task/s that they undertook; and to share any else about their experience. These findings informed my development of the interview tool. Subsequently, I synthesised the data from questions 8a, 9, 13a, 14 & 15, regarding participants

experiences of support and perceptions of need, with the interview data during the grounded theory analysis.

I coded the open text data from question 11, describing the tasks that participants undertook, according to task descriptors in order to identify initially the number of tasks undertaken across all participants; and subsequently, the nature of those tasks. I found further data that described specific tasks undertaken by staff members was present in the interview transcripts. I synthesised the interview data that reported additional tasks with the survey data. In total, I identified sixty-three tasks in the survey data; and a further twenty-nine tasks in the interview data.

4.5.8 Analysis of Interview and Open Text Survey Data

I used a constructivist grounded theory analysis following the protocol described by Charmaz (2014). I used a number of analytic tools throughout the process. In this section I will firstly describe the analytic tools that I employed; secondly, I will present an overview of the stages of analysis; and, finally, I will present the details of the analytic process from initial coding to the construction of a grounded theory.

4.5.8.1 Analytic tools

4.5.8.1.1 Constant Comparison

Throughout each stage of the analysis of data I employed the method of constant comparison. Developed by Glaser and Strauss (1967) as a robust and systematic analytic procedure for qualitative data, the method combines the tasks of coding with that of theory development. The method ensures that in the process of theory development, or construction (Charmaz, 2014), I am able to remain close to the data, so that the theory is plausible, integrated and consistent (Glaser and Strauss, 1967). I utilised the method throughout the process of coding, code development, category development, theory construction and writing up the findings. I

engaged the process of constant comparison in this study as a core element of a constructivist grounded theory approach (Charmaz, 2014) so that I constantly revisited, reviewed and checked data against data. I did this within and between transcripts; within and between codes; within and between categories; also, codes with transcripts, categories with codes, and categories with transcripts. Through this process I was able to engage in an ongoing reviewing of the data in the light of new constructions and ideas as they were developed through the analytic process. My aim being to ensure that as analysis becomes more conceptual and theoretical that it remains close to, and therefore, generated from the data.

4.5.8.1.2 Memos

Writing memos is an integral method for aiding analysis in constructivist grounded theory (Charmaz, 2014). Memo-writing produces analytic notes that in turn support the process and become a part of the constant comparison technique (Charmaz, 2014). Throughout the data collection, transcription and analysis processes I used memo-writing as a tool for analysing field notes, examining codes and categories, and developing theory. Memo-writing, in this study, often took the form of free-writing in response to the ongoing process of collecting and working with data. I used a research journal (Charmaz, 2014) to capture memos which were hand-written, in-the-moment, reflections and responses. I subsequently typed memos into a word document, a process which allowed me to re-visit those responses and reflections which in turn, on occasion, prompted further insights and ideas. An example of some of the memos I created in this study is included in Appendix 4.17. I used memos as a tool for furthering the analysis of data, the development of codes and the construction of categories and theory. Memos that I created in the construction of focused codes and categories also served as prompts in the process of writing up the study findings.

4.5.8.1.3 Clustering

Clustering provides a means of exploring how codes and categories fit together (Charmaz, 2014). It is a creative method that when used quickly and spontaneously allows rapid, visual, exploration and discovery of connections and pathways within and across data. In this study, clustering took the form of quickly drawn, free-hand, maps and diagrams that I created with the aim of seeing what the data looked like. I used clustering in the later stages of analysis when working to construct categories and then to understand the relationships that existed between and across categories. It was the method of clustering that contributed to my construction of the core category in this study.

4.5.8.2 Overview of analytic stages

I transcribed and coded interviews in the order they were undertaken. For instance, I transcribed and coded interview one before I transcribed and coded interview two. I followed this sequence for the first five interviews. After I completed initial coding and code development, I then transcribed and coded interviews six to ten using the same sequential process. I developed and constructed initial codes, then focused codes and then categories through a series of stages described in Table 9.

Stage of Analysis	Data source	Process	Outputs
Stage 1	Interviews 1 - 5	Line by line coding using gerunds Collapsing codes into each other to develop focused codes	569 Initial Codes 32 groups of Codes
Stage 2	Interviews 6 - 10	Coding using code group headings New codes developed where data did not 'fit'	158 Codes That sit within 23 groups of codes

Stage of Analysis	Data source	Process	Outputs
		Groups of codes from interviews 1-5 and new codes collapsed into each other to generate focused codes	
Stage 3	Interviews 1 - 10	Ongoing comparison of transcripts, codes and groups of codes. Memo-writing and clustering to develop focused codes and categories	63 Focused Codes 11 Categories
Stage 4			
Stage 5	Open text data from survey incorporated	Data coded using focused codes. Data comparison to confirm categories. Memo-writing and clustering used to check and broaden categories	11 Categories
Stage 6	All data	RE-naming of some categories. Development of a final set of categories and sub-categories and the construction of a core category from an existing category;	One core Category Six categories Four sub-categories
Stage 7		Construction of a grounded theory	Diagramatic representation of the theory.

Table 9: Stages of code and category construction in grounded theory anaylsis

4.5.8.3 Analytic Process

4.5.8.3.1 Initial coding

I used gerunds for initial line-by-line coding which I undertook by hand on paper copies of the transcripts. Gerunds are words that end in 'ing', they are doing words. I used them as a tool for coding to ensure that the codes closely reflected what was happening for the participant in the data. Gerunds keep the codes very close to the participant account. I recorded initial codes from the transcripts on a word document together with illustrative verbatim quotes (Appendix 4.18). During the stage of initial coding, I employed a process of checking and comparing within interview transcripts and between them, to seek out similarities and differences to test, confirm or refute the codes. After this process was completed for the first five interviews, I loosely ordered initial codes into topic groups.

4.5.8.3.2 Focused Coding

I continued to engage comparison techniques together with memo-writing and clustering during the next stage of analysis, to construct focused codes. I did this by comparing, exploring and synthesising the meanings of the most frequent and significant initial codes. The construction of focused codes marked the beginning of my thinking more conceptually about the data as the focused codes were employed to describe larger portions of the data, whilst retaining the detail contained in the data (Charmaz, 2014). The resultant set of focused codes provided me with a starting point for the subsequent coding of interviews 6 - 10. I introduced further codes where the data did not sit comfortably within the existing codes. I worked iteratively from the data to the codes using the verbatim words of the participants as the generator of the codes. I repeated this process with codes tested against the data and data compared across transcripts to ensure that codes were generated from the data and reflected the meanings and experiences within the participants' words.

4.5.8.3.3 Construction of Categories

Glaser and Strauss define a category as a 'conceptual element in a theory' (1967, p.37). Categories may be constructed from existing focused codes, if they are felt to have significance or greater conceptual qualities. In this study, I found memo-writing and clustering helpful in the construction of categories by utilising processes of reflection, questioning, checking and testing to explore the relationships, similarities and differences between and across the focused codes and within the data. Once I had developed a tentative set of categories, I introduced the qualitative data from the survey to the analysis and I used this data to test the categories that I had developed from the interview data. By introducing 'slices of data' (Glaser & Strauss, 1967; Urquhart, 2013), that is, data from a different source I found different views, or ways of knowing, through which to interrogate, test, and explore the developing categories by using the process of constant comparison. An example of the process of developing categories from focused codes is in Appendix 4.19.

4.5.8.3.4 Construction of a Core Category

My construction of the core category came to being through the elevation of an existing category through the processes of clustering and memo-writing. It felt that there was something different, or more universal about this particular category. Clustering provided a means for me to visually check this out and through memo-writing I was able to test, check and articulate this idea.

4.5.8.3.5 Constructing a Grounded Theory

I used transcripts, memos, and tables of codes and categories as tools in the construction of theory. An iterative process of checking, re-visiting, comparing, and further memo-writing meant I could ensure that, as codes, categories, and theory were constructed, they remained close and true to the data. Throughout this process, and indeed at all stages of analysis, my

observations, ideas and prior perspectives contributed to the co-construction of theory as typified in constructivist grounded theory (Charmaz, 2014). The participants' stories which were embedded in the data, were developed through my processes of applying research questions, ideas, and perspectives, to construct a theoretical explanation of their experiences, needs and perceptions. The result was the grounded theory that I present in Chapter 5.

Chapter 5

Exploring the experiences of HEI staff following a student death by suicide: Study Findings

5.1 Chapter Overview

In this chapter I present the findings from the mixed-method study in three sections. In the first section I report the descriptive findings from the survey to describe who amongst university staff members perceive themselves to be impacted by a student death by suicide. In the second section I report the results of the synthesis of open text survey and interview data to give an overview of the tasks undertaken by staff members following a student death by suicide; as such I describe what staff members did following the event. Finally, in the third section I present the grounded theory that I have constructed from interview and open text survey data to explain what it was like for those staff members who were impacted following a student death by suicide.

5.2 Descriptive Findings from Survey Data

In this section I report demographic survey data pertaining to the study participants. I also report participants' perceptions of impact following a student death by suicide and their perceived needs attached to their experiences.

5.2.1 Demographics

Participants of the survey were nineteen staff members from two HEIs; twelve participants were recruited from site one; seven from site two. They consisted of one member of a senior team; six student facing staff; five facilities staff; and seven academic staff. Eleven were female, eight were male. Participants had been in their job roles for between one and a half and twenty-four years. They ranged in age from 30 to 68 years.

5.2.2 Perceptions of Impact

Eighteen staff members said that they did perceive themselves to be impacted by a student death by suicide. One staff member stated that they were unsure of an impact. However, when asked to describe the kind of impact that they perceived, all staff members were able to select a descriptor from the continuum of suicide survivorship. The continuum describes levels of perceived impact following a death by suicide as being 'exposed to', 'affected by' or 'bereaved by' a death by suicide (Cerel et al., 2014). Seven of the staff members stated that they felt exposed to a death by suicide; 11 stated that they felt affected by the death; and one stated that they felt bereaved. These responses revealed that staff members perceived an impact whether or not they knew the student prior to their death.

5.2.3 Perceived needs following a student death by suicide

Participants were asked about the kinds of needs that they had following a student death by suicide; the findings are reported in table 10.

Job-role	Emotional needs	Psychological needs	Practical needs	Personal needs	Work related needs	None of the above	I had no needs
Student facing staff	Y						
	Y		Y				
	Y						
							Y
			Y		Y		
	Y		Y		Y		
Facilities staff	Y	Y			Y		
	Y	Y	Y				
	Y						
	Y	Y			Y		
	Y	Y					
Leadership	Y				Y		
Academic staff						Y	
							Y
	Y	Y	Y	Y	Y		
	Y			Y			
	Y						
	Y	Y			Y		
	Y				Y		
Totals	**15**	**6**	**5**	**2**	**8**	**1**	**2**

Table 10: Participants' perceptions of need following a student death by suicide by job-role.

The responses recorded in table 10 illustrate that staff members identified a range of needs, with twelve out of nineteen staff members perceiving more than one need. Emotional needs were the most reported, followed by work related needs; personal needs were the least reported. One academic staff member reported that they had none of the needs listed, and two staff members, one student facing and one academic, reported no needs at all. Six staff reported psychological needs, they included four out of the five staff that were in facilities job-roles, this being the staff group most likely to report psychological needs. The other two were amongst the seven participants who were academic staff. This is an interesting finding, as it might be that these psychological needs arose from different experiences. Facilities staff were most likely to be involved in crisis response activities; whilst academic staff were most likely to know the student before they died. Practical needs were most likely to be experienced by student facing staff, these were the group of staff who appeared most busy following the student death by suicide. These findings illustrate a diverse experience across staff members, and suggest that, for these staff members, provision of support ought not to focus solely on responding to the emotional impact of a student death by suicide; and ought to be broad enough to meet a range of needs.

5.3 Staff experiences of Undertaking Tasks following student death by suicide

5.3.1 Tasks undertaken following a student death by suicide

Seventeen of the 19 survey participants stated that they did undertake specific jobs, roles or tasks following a student death by suicide. I synthesised open text data from the survey question, *'can you name or describe the role/s, task/s or job/s that you undertook?'* with data from the interviews in which participants described and talked about the tasks that they undertook. I organised the findings according to the kind of task undertaken. I developed four Categories of Tasks from the open text survey data and interview data. They are listed below with details of the kinds of tasks that sit in each category:

1. Crisis response
    - Lifesaving
    - Incident response
    - Incident management/liaison
2. Strategic Tasks
    - Information sharing/gathering/liaison
    - Response Planning
    - Expert Adviser
3. Support Tasks
    - Supporting students
    - Supporting staff
    - Liaison/support of student's family
    - Remembrance
4. Practical & Administrative Tasks
    - Practical tasks
    - Administrative tasks
    - Media/Legal Process Tasks

Staff across a range of job roles described a wide range of tasks undertaken after a student death by suicide. Staff accounts illustrate that the tasks vary in complexity and sensitivity; that some tasks were completed very quickly after a student death whilst others were undertaken later, or were ongoing months after the event. The tasks, diverse in nature and function, are described here within four distinct categories; crisis response tasks; strategic tasks; support tasks; and practical and administrative tasks in tables 11, 12, 13 & 14. In each table, an overview of the tasks undertaken by job role of staff member is presented. This is supported by qualitative data in the form of verbatim quotes from those staff members who responded to a student death by suicide, telling, in their own words, exactly what they did after a student death by suicide had been discovered on their HEI campus.

5.3.1.1 Crisis response tasks

	Crisis Response Task	Student Facing Staff						Facilities Staff				Senior Team	Academic Staff						Total No. of Staff per Task
1	Inform other staff of suicide	Y																	**1**
2	Attend site of the suicide	Y				Y		Y								Y			**4**
3	Support Housemates	Y	Y			Y	Y					Y				Y			**6**
4	Liaison with student community	Y																	**1**
5	Liaison / strategy planning with academic colleagues	Y																	**1**
6	Contact the family	Y																	**1**
7	Informing other staff teams	Y																	**1**
8	Undertaking a safe and well check							Y											**1**
9	Informing major incident team							Y											**1**
10	Calling emergency services							Y											**1**
11	Liaise with staff from Major Incident Team							Y											**1**
12	Securing the property							Y											**1**
13	Move housemates out of the property							Y											**1**
14	Liaise with emergency services							Y											**1**
15	Secure area for removal of body							Y											**1**
16	Performing CPR										Y								**1**
17	Breaking into the room							Y											**1**
18	Sending staff to the site											Y							**1**
19	Staying until the body was removed					Y						Y							**2**
	Total No. of Tasks per Person	**7**	**1**	**0**	**0**	**3**	**1**	**1**	**9**	**0**	**1**	**3**	**0**	**0**	**0**	**2**	**0**	**0**	
	Total No. of Tasks per Team	**12**						**11**				**3**	**2**						

Table 11: Crisis response tasks undertaken by HEI staff following a student death by suicide

Staff reported nineteen distinct crisis response tasks. Nine staff across all job-roles undertook at least one crisis response task. Staff in facilities job-roles undertook the greatest number of tasks per person, with 11 tasks across four staff members, followed by staff in student facing job-roles with 12 tasks across six staff members. Only one member of academic staff reported undertaking tasks in this group, it is worth noting that the member of staff who undertook those tasks is a member of the postvention team at their institution.

Crisis response tasks included life-saving and incident response, management and liaison. Staff members may be first on the scene, and life-saving might be the first task performed. A staff member in a facilities role undertook the most crisis response tasks, this being a security officer who was first to the scene when called to undertake a safe and well check. Another security officer reported undertaking just one task, that of performing CPR, it is likely, in that instance that they were also one of the first to attend the scene, and may have undertaken additional tasks, such as responding to a safe and well check or liaising with emergency services, however these were unreported.:

> *'I was the security officer that found the student during a welfare check.'* Facilities staff.
>
> *'I performed CPR.'* Facilities staff.

In responding to a call-out, the reality of discovering a student death can be clumsy and awkward as practicalities get in the way of the desire to respond efficiently:

> *'we physically couldn't open the door, the paramedics and the police had to break in really'* Facilities staff.

Incident response tasks and liaison with other emergency service workers were also carried out by members of facilities teams:

'I had to take control of the area and move the remaining students of the property out to a safe place so they did not have to see anything.' Facilities staff.

'I was also tasked with blocking the area while the coroner removed the body.' Facilities staff.

'[I] also had to relay all information to the police and ambulance services' Facilities staff.

For other staff members, the immediate response to a crisis was more strategic:

'once we discovered that they'd found the student obviously they were, they immediately rang emergency services, and … we then called together the major incident team' Senior Manager

The tasks that engaged the highest numbers of staff, including staff across diverse job-roles were those of attending the site and providing immediate support to housemates of the student who had died:

'I went to the accommodation to immediately support the housemates of the deceased.' Student facing staff.

Management of the site was necessary:

'We knocked on doors to explain why the police and ambulance were on site (student death) and provided support information and advice not to talk to journalists … or speculate on social media.' Student facing staff.

It is likely that participants' accounts of tasks performed may be incomplete, suggesting that some tasks are not identified here, and that other identified tasks may have been undertaken by more staff members than those recorded.

5.3.1.2 Strategic Tasks

	Strategic Task	Student Facing Staff						Facilities Staff				Senior Team	Academic Staff						Total No. of Staff per Task
1	Initiate Response strategy	Y																	**1**
2	Gather & Collate Info	Y																	**1**
3	Liaise with Student Services	Y																	**1**
4	Informing the student body	Y				Y													**2**
5	Liaise with Comms	Y																	**1**
6	Liaise with local media	Y																	**1**
7	Sit on major incident team	Y																	**1**
8	Info sharing to course-mates												Y		Y			Y	**3**
9	Member of the Major Inc Team											Y							**1**
10	Briefing & Liaison with Vice Chancellor & Board											Y							**1**
11	Member of postvention group															Y			**1**
12	Providing expert advice to postvention group															Y			**1**
13	Informing my boss of the death								Y										**1**
14	Planning the response					Y						Y				Y			**3**
15	Managing the response											Y				Y			**2**
16	Ensuring security personnel remain at the property							Y											**1**
17	Liaising with colleagues					Y			Y										**2**
18	Backfilling staff roles							Y											**1**
19	Containing campus gossip							Y		Y						Y			**3**
20	Liaising with other HE & FE providers in the community	Y																	**1**
	Total No. of Tasks per Person	**8**	**0**	**0**	**0**	**3**	**0**	**3**	**2**	**1**	**0**	**4**	**1**	**0**	**1**	**5**	**0**	**0**	
	Total No. of Tasks per Team	**11**						**6**				**4**	**7**						

Table 12: Strategic tasks undertaken by HEI staff following a student death by suicide

These are tasks that include information gathering and sharing; liaison with others; response planning and advising. Nine staff members, across all job-role groups, reported twenty distinct strategic tasks. The individual staff members who took on the highest number of strategic tasks were in senior or team management roles or were part of their HEIs postvention response team. Tasks that engaged the most staff members were response planning, undertaken by managers, senior staff or postvention response team members; sharing information with course mates, undertaken by academic staff; and containing campus gossip, which was undertaken by one member or academic staff who sat on the postvention team, and by two members of facilities teams, a cleaner and a team manager. This may highlight the diverse roles that facilities workers engage with in terms of their contact with students in accommodation and other informal campus settings.

Some strategic tasks need to be done immediately the event comes to light:

> *'so we quickly met and decided who was going to do what and what the follow up action was and what we needed to do straight away'* Student Facing staff.

> *'… doing that quickly just made sure we all understand what's happening, and we're all on, you know we all know where we're at and what's, what's occurring … it was agreed that [our head of student services] would be the main liaison point really in terms of those emergency services working with security'* Senior Leader.

Others tasks happened over the following hours and days:

> *'Met with academics and agreed shared way of informing course-mates.'* Student facing staff.

> *'Briefing and keeping updated the Vice Chancellor and Executive Board colleagues'* Senior leader.

Some of these tasks, whilst strategic, are also very sensitive in nature. In addition to planning the response, it was necessary to learn, very quickly, about the student who had died:

> *'it was really trying to work out who knew this student, who needs, who is it more appropriate that we can inform in person, verbally, rather than sending out an all student email, which happened later on, so we were trying to identify which students, were they a member of a society, were they in a sports team, you know, who were the people that we actually needed to ring and say are you ok.*' Student facing staff.

In some cases, the same staff members that were carrying out crisis response tasks and front-line delivery, were also taking a lead role in response planning or expert advice:

> *'Throughout all this I was on the Major Incident Team convened to manage the situation.'* Student facing staff.

> *'my role there was to give expert advice to the group on how best to manage the needs of staff and students affected by the deaths'* Student facing staff.

5.3.1.3 Support Tasks

	Support Task	Student Facing Staff							Facilities Staff	Senior Team	Academic Staff						Total No. of Staff per Task
1	Inform housemates of available support	Y															**1**
2	Support and liaison with the family	Y															**1**
3	Informal support of colleagues	Y	Y														**2**
4	Attend funeral	Y															**1**
5	Writing to parents		Y														**1**
6	Supporting wider student body		Y														**1**
7	Conducting memorial service		Y														**1**
8	Providing one to one support to housemates			Y													**1**
9	Considering the needs of course-mates										Y						**1**
10	Instigate a monitoring system for coursemates										Y						**1**
11	Signposting support for students					Y				Y		Y					**3**
12	Line management of support staff									Y							**1**
13	Briefing HR staff to support colleagues									Y							**1**
14	Supporting student friends & peers				Y			Y						Y	Y		**4**
15	Support housemates to make police statements					Y		Y									**2**
16	Identifying potentially affected students and staff					Y											**1**
17	Making contact with peers/friends/networks					Y								Y			**2**
18	Providing ongoing support to friends/peers					Y											**1**

	Support Task	Student Facing Staff						Facilities Staff				Senior Team	Academic Staff						Total No. of Staff per Task
19	Managing the needs of student peers														Y				**1**
20	Counselling students					Y	Y									Y			**3**
21	Providing support to security staff															Y			**1**
22	Supporting practice placement staff																Y		**1**
23	Supporting parents of housemates						Y												**1**
24	Being point of contact for the housemates					Y													**1**
25	Fielding housemates questions								Y										**1**
26	Liaising with housemates networks						Y												**1**
27	Taking housemates to say goodbye															Y			**1**
28	Putting a picture in the chapel		Y																**1**
29	Attending remembrance service									Y									**1**
30	Accessing external support for housemates						Y												**1**
31	Passing on care						Y												**1**
32	Facilitating conversations						Y												**1**
33	Managing student needs	Y																	**1**
34	Supporting students on the anniversary of the death					Y										Y			**2**
35	Facilitating a drop-in for students															Y			**1**
36	Engaging external agency to support staff	Y				Y										Y			**2**
37	Signposting staff to support											Y							**1**
38	Providing support to other staff															Y			**1**
	Total No. of Tasks per Person	**6**	**5**	**1**	**1**	**9**	**8**	**0**	**1**	**1**	**0**	**4**	**2**	**0**	**2**	**9**	**2**	**0**	
	Total No. of Tasks per Team	**30**						**2**				**4**	**15**						

Table 13: Support tasks undertaken by HEI staff following a student death by suicide

Support of others started in the immediate aftermath of the death and continued in various forms for months or even years afterwards. Tasks included supporting students; other members of staff; liaison and support for the family of the student who died; and facilitating opportunities for remembrance. Thirty-eight distinct support tasks were reported by thirteen members of staff across all job-role groups, making this group of tasks the largest, involving the most staff members. Staff in student facing roles undertook the most tasks, followed by academic staff. However, it is worth noting that one member of academic staff (who was also a member of HEI postvention response team) undertook nine support tasks, whilst three other academic staff undertook just two tasks each, and two others undertook no support tasks. Members of facilities teams only undertook two support tasks, and one of those was attending a remembrance event, the other being responding to housemates' questions in the earliest moments following discovery of the student who had died. The tasks that engaged the most staff members were supporting student friends and peers, which engaged four members of staff; and counselling students which engaged three members of staff.

In supporting students, staff provided immediate comprehensive support to the housemates of the student who died:

> *'Myself and the Chaplain stayed with [the housemates] whilst the Police were taking statements. We stayed with them until they were transported home.'* Student facing staff.

> *'just being there, being, being kind, some students in this particular case didn't have parents that came down … some [students], didn't have parents, so really just, kind of a helpful slightly parental role I think just to emotionally support the students'* Student facing staff.

For some staff members the experience of being in a supportive role within the context of a death by suicide proved challenging:

> *'we were sort of put together in um a room where we had all the cur- all the blinds were down, that was quite, a bit odd really, sort of dark, you know, couldn't see, they couldn't see out, you know, what was happening, and one by one they all went off and made their statements'* Student facing staff.

Staff also offered wider support to the student's course-mates, the student body and in particular to students identified as being vulnerable in the context of suicide.

> *'Meeting with two of the deceased student's housemates who came to access support'* Student facing staff.

> *'We also put in place a monitoring system afterwards to assess … how well the other students were coping.'* Academic staff.

> *'Continued to stay in contact with the most closely affected (by phone and email/in person) in the months following the death. Signposted those affected to appropriate external support options and options in their home areas as well.'* Student facing staff.

Reaching out to impacted students wasn't necessarily a straightforward task:

> *'I had a plan of like I'm going to ring them once a week and if they don't respond I'll leave a message and whatever, a couple of [the housemates] I had conversations with, but two of them I never did, so I haven't spoken to them since, but I rang … and … I emailed …'* Student facing staff.

Support of staff affected by the event was in some instances targeted to particular staff groups, sometimes it was part of the 'supporters' line management responsibilities, and other

times it took the form of generic 'open door' support. In some instances, the task was delivered even though it wouldn't usually form part of the supporter's job role:

> *'Line manager support for those colleagues dealing directly with the incident'* Senior Leader.

> *'[I] offered informal support to faculty staff'* Student facing staff.

> *'I also, with a colleague, supported security staff affected by the deaths through running peer support / debrief sessions.'* Student facing staff.

Support of the student's family may be a formal response, but was also offered through individual initiative:

> *'Once we knew police had informed family I contacted them to offer condolences, any assistance and stated that I was the contact for the university for them to liaise with.'* Student facing staff.

> *'I gathered some electronic copies of work that the student had done … to give to [their] parents.'* Academic staff.

Support was also offered at a community level in the form of ritual and remembrance:

> *'Conducting the [memorial] service'* Student facing staff.

5.3.1.4 Practical & Administrative Tasks

	Practical & Administrative Task	Student Facing Staff						Facilities Staff				Senior Team	Academic Staff						Total No. of Staff per Task
1	Arrange transport home for housemates	Y																	**1**
2	Overseeing administrative tasks	Y																	**1**
3	Contacting coroner's office	Y																	**1**
4	Arranged transport to the funeral	Y																	**1**
5	Clearing student's room							Y											**1**
6	Packing student's belongings							Y		Y									**2**
7	Arranging transport of belongings							Y											**1**
8	Re-housing housemates						Y	Y	Y			Y				Y			**5**
9	Delivering students belongings to parent's house									Y									**1**
10	Emailing students work to parents													Y					**1**
11	Helping students move to new accommodation						Y									Y			**2**
12	Attending coroner's court						Y												**1**
13	Managing the future of the property							Y											**1**
14	Writing a serious incident report								Y										**1**
15	Keeping a log of actions taken					Y													**1**
	Total No. of Tasks per Person	**4**	**0**	**0**	**0**	**1**	**3**	**5**	**2**	**2**	**0**	**1**	**0**	**1**	**0**	**2**	**0**	**0**	
	Total No. of Tasks per Team	**8**						**9**				**1**	**3**						

Table 14: Practical and administrative tasks undertaken by HEI staff following a student death by suicide

Practical tasks were encountered in supporting the housemates, dealing with the aftermath, supporting the student's family, and in supporting the wider university community. Fifteen distinct practical and administrative tasks were undertaken by nine staff members across all job-role groups. Members of facilities teams undertook the most tasks, such as those pertaining to student accommodation, followed by student facing staff. The task that involved the highest number of staff was that of re-housing the housemates of the student who died.

Some tasks were unseen and unexpected, but in their being done by staff, provided essential practical support to other students:

> *'moving the, the other [students] out of the house into somewhere safe for them, and we couldn't tell them anything either, I grabbed the keys, I got my colleague to guide them out away from the room, so it was just kind of get them out the way and make sure they don't see anything'* Facilities staff.

> *'this involved helping [the housemates] relocate (we helped arrange the move and physically helped them move their possessions on the day of the death)'* Student facing staff.

Other tasks arose in connection with the student who had died:

> *'Involved in clearing the students' room and packing [their] belongings. Arranged for belongings to be transported to [the student's] home address.'* Facilities staff.

> *'I also went with a driver and delivered the belongings to the student's parent's house.'* Facilities staff.

And others were focused on offering practical support to the wider student community:

> *'Arranged transport for the funeral.'* Student facing staff.

Administrative tasks may appear straightforward, but ensuring that they are performed avoids the potential for upset at a later time:

> *'asked Registry to update records, Library to not inadvertently send out any library fine messages'* Student facing staff.

Media/Legal process tasks were also necessary:

> *'Worked with our comms team to pressure the local paper to withdraw their story as it described the method of death.'* Student facing staff.

5.3.1.5 Holistic analysis of all tasks reported.

I undertook additional analyses of tasks by combining all four task groups to identify any patterns evident across all tasks. In table 15 I report results for tasks by seniority of job-role and, in table 16 for tasks by departmental job-role.

Seniority of Job-role	No. of tasks	No. of Respondents	Tasks per person
Senior Manager	55	3	18.3
Team Manager	15	2	7.5
Front-line Professional	29	9	3.2
Front-line Service	14	3	4.6

Table 15: Tasks undertaken by seniority of job-role.

This analysis shows that for the participants in this study, the most senior staff undertook the highest number of tasks following a student death by suicide. This was followed by those staff in second-tier seniority roles, such as team managers. However, front line service staff such as facilities staff performed more tasks per person than front line professional staff such as lecturers and student counsellors. The highest number of tasks per person being almost six times as many as the lowest average.

Team by Job-role	No. of tasks	No. of respondents	Tasks per person
Student facing staff	61	6	10
Facilities staff	23	4	5.75
Leadership staff	12	1	12
Academic staff	27	6	4.5

Table 16: Tasks undertaken by departmental job-role.

When analysed by departmental job-role, it was found that the member of the leadership team undertook more tasks than the average of other staff members across all job-roles. This was followed by staff in student facing roles, such as student wellbeing and chaplaincy staff; then by facilities staff

and finally academic staff. The highest number of tasks per person being almost three times that of the lowest average.

In combination these figures suggest that it is seniority of job role that is the factor with the greatest influence on the number of tasks undertaken, followed by having a student-facing job-role. Those who undertake the fewest tasks are academic members of staff.

5.3.2 Perceived needs attached to undertaking tasks

To understand whether the experience of undertaking tasks following a student death by suicide gave rise to any needs, participants were asked to identify the kinds of needs that they had experienced:

Job role	Emotional needs	Psychological needs	Practical needs	Personal needs	Work related needs	None of the above	I had no needs
Student facing staff	Y						
	Y		Y				
					Y		
							Y
			Y	Y	Y		
	Y		Y		Y		
Facilities staff	Y	Y			Y		
					Y		
	Y						
		Y					
	Y	Y					
Leadership			Y		Y		
Academic staff						Y	
							Y
	Y	Y	Y				
	Y			Y			
				Did not respond to question			
				Did not respond to question			
	Y						
Totals	9	4	5	2	6	1	2

Table 17: Participants' perceived needs in connection with undertaking tasks following a student death by suicide.

The responses recorded in table 17 illustrate that staff members identified a range of needs arising from the experience of undertaking tasks following a student death by suicide. Two staff members did not respond to this question. They stated that they did not undertake any tasks following the

student suicide. Two staff members, one student facing, and one academic, stated that they had no needs, and one academic staff member that they did not have any of the needs listed. This means that 14 of the 17 members of staff who undertook tasks following the student death by suicide identified needs in connection with those tasks. Two members of staff identified just one need – in both cases this was emotional needs; 12 staff members identified more than one need. The most reported need was emotional needs and the least reported was personal needs. Once again it is only staff members in facilities or academic job-roles who report psychological needs attached to the tasks that they undertook. The staff group who reported the most needs attached to delivering tasks were student facing staff. These findings suggest that for these staff members there was a diverse experiencing of needs in connection with undertaking tasks. It is important therefore that recognition is given to the fact that needs do arise in connection with delivering tasks as well as in connection with a student death by suicide and that any support offered ought to meet diverse needs across staff job-roles and teams.

5.4 A Grounded Theory of the experiences of UK HEI staff who are exposed to a student death by suicide

5.4.1 Constructing a grounded theory

In this section I present the focused codes, categories and sub-categories that I developed from the data and that subsequently contributed to the construction of the core category and a grounded theory. Table 18 shows the focused codes and categories and illustrates their relationships to each other. As this is the first study to explore the experiences of this particular group of people in connection with this particular experience, I wish to present, as fully as space allows, the participants' words pertaining to their experiences. As such, I will present verbatim quotes under the headings of the focused codes to which they apply. Readers will note that the focused codes nearly all employ gerunds, this was a conscious choice to demonstrate the multiple layers of 'doing' that participant accounts demonstrated, in terms, not only of responding via tasks, but also in making

choices, adopting behaviours, and containing and managing their personal responses and reactions to the event of a student death by suicide. The decision to use gerunds in this context reflects the active (pro-active and reactive) participant. Whilst participants shared their experiences with me in a sedentary, quiet, and reflective setting, it is their 'doing', their actions, even in the emotional aspects of their experiencing, that filled their accounts. To show how participant accounts via my interpretative analysis led to the construction of a grounded theory the focused codes will be grouped within the category or sub-category to which they contribute. I will strive to guide the reader as to how the data contributed to the construction of the categories and ultimately the construction of a core category and a grounded theory by sharing my interpretations alongside the verbatim quotes. In addition, my interpretations of the data seek to understand any connections between participants' reported experiences and the social, cultural and political contexts within which their experiences were situated. Finally, I will represent the grounded theory diagrammatically (Figure 6) together with a detailed explanation. By presenting the study findings in this way I hope to show the reader how my analytic process developed and deepened at each stage of construction from focused codes, through categories to the core category. I am showing my workings if you like, by sharing my process.

Chandler (2020b) states:

> *"'listening to' and 'describing' accounts of self-harm and suicide is not sufficient … For qualitative approaches to suicide and self-harm to contribute meaningfully to social justice, it is vital that accounts are analysed and presented critically, theorised and tied to broader issues of justice, inequality and oppression. Further the position of the researcher and their 'informant' should be directly reflected on, carefully and with sensitivity to power" (p.39).*

I have engaged in a comprehensive reflection on my role, position and associated power as a researcher, alongside the roles and motivations of the study participants in sections 4.4.2 and 4.4.3. In the following section I present the accounts that I listened to, and have applied analytic and

interpretative processes to as described in sections 4.5.6 and 4.5.8. In Chapter 6, I will further contextualise these accounts by situating them in relation to the wider literature and theory, I will draw out and discuss connections with broader issues and social, cultural and political contexts.

Core Category	Category	Sub-Category	Focused Codes
Bearing witness	Responding to a student death by suicide	Being the responder	Finding the body
			Seeing the body
			Hearing the news
			Crisis response tasks
			Strategy, Comms & Management tasks
			Support tasks
			Practical & Administrative tasks
			Managing student needs
			Supporting other students
			Containing the narrative
			Offering support to staff
			Strategies for support
		Ways of responding	Doing the job
			Challenges of responding
			Being directed
			Being a leader
			Process & Procedure
			Working with other agencies
			Information sharing
			Roles & Expectations
			Team working
			Working together
	Experiencing a student death by suicide	Body & Mind	Physical responses
			Initial responses
			Emotions on hold
			Emotional responses
			Visual echoes
			Managing the emotions
			After the event
			‘an impactful event’
			Recalling

Core Category	Category	Sub-Category	Focused Codes
		Reflections and Perceptions	Wondering why
			Searching for meaning
			Ongoing thoughts
			Finding personal connection
			Leaving a note
			The unknown student
			Knowing the student
	Needs & Fears		Impacting on other students
			Reputation & Blame
			Unmet needs
			Dealing with needs
			Training needs
			Needing acknowledgment & recognition
	Experiences of Support		Accessing support
			Engaging with support
			Experiencing support
			Not being supported
			Building relationships with students
			Experiences of supporting
			Supporting each other
	Personal stories	Being Pro-Active	Calling on experience
			Supporting self
			Using strategies
			Using networks
		Being Human	Human connections
			Not/the first time
			Reflecting on the experience
			Emotional responses & reflections during interview
	Cultural Stories		Organisational provision
			Cultures of support
			Creating culture

Table 18: Summary of Core Category, Categories, Sub-Categories and Focused Codes

5.4.2 Categories, Sub-Categories, and Focused Codes

5.4.2.1 Responding to a student Death by Suicide

5.4.2.1.1 Being the Responder

Participants shared with me the multiple ways in which they responded to a student suicide by doing tasks immediately and in the subsequent days, weeks, months, sometimes years after the death. I heard accounts of different kinds of tasks that staff may take on due to their job role or because they happen to be available at the time. These accounts led me to understand that staff respond to the event and to the other students in the immediate vicinity; they also respond to the wider student body; to the family of the student who died; and to each other, informally and formally offering support to colleagues, and to staff in other teams within the HEI. I noticed that participant accounts were full of the doing of things that happens in the aftermath. This doing sometimes happens at the point at which adrenalin is flowing. Panic, nervousness and fear might be present, I suggest that these actions appear driven by a need to respond quickly, professionally, and completely, to manage and contain the event as smoothly and cleanly as possible. It seemed to me, in listening to these accounts, that staff attention appears focused on the tasks, on the needs of others, on the busy-ness and the necessity to respond efficiently, to get it right, to be thorough, to notice need and to meet it.

Finding the body

Members of facilities teams were most likely to be the first member of staff to have any contact with a student who has died by suicide. One facilities worker recalled the experience of physical interaction with the body of the student:

> *'[the student] was cold and obviously checking for a pulse and there was nothing there, yeah [pause] [nervous laugh] bit of a bad thing to find'* Facilities staff.

Seeing the body

Other members of staff recalled how the act of responding brought them into close vicinity with the student's body, this account refers to visual contact as being the moment that created a sense of deeper connection or understanding of what has actually happened:

> *'it's that moment when you see it and you just think … I certainly know for me that lasting image was of the body bag coming out and being put in the ambulance, I think that was just an absolute moment where everyone had their [pause] hearts in their mouths really [crying] it's quite emotional … it was really just very shocking, very shocking'* Senior Leader.

Hearing the news

Staff shared with me varying accounts of how they came to hear the news. Some staff were informed in person, others by telephone:

> *'I could tell by her face it was bad news, erm, she said there'd been a death eh in halls and instinctively I knew it was going to be a suicide'* Student facing staff.

> *'and this is where I cry [nervous laugh] um, it was really upsetting, this one actually … if my colleague emails me saying could you ring me, then I know that there's a student dead. So, I immediately knew, that was really quite traumatic … yeah, I rang my colleague fairly immediately from that, I found a quiet area, and she's very good, you know, she said these are the details you know …'* Academic staff.

As I listened to these stories, I noticed the instances of nervous laughter, of tearfulness or brief crying, I heard pauses that appeared to serve as a preparatory space in which the participant searched for or found the necessary courage to continue talking. These instances suggest to me that the 'doing' does not exist separately from the 'feeling', and that the 'feeling' continues to be present for the participant, in the 'recalling' of the experience.

Containing the narrative

Staff spoke of the challenges that they faced, in the era of social media and instant communication, of ensuring that the narrative around the student death was appropriate, timely and respectful:

> *'lots of students in that same block could see what was happening, maybe they didn't know what had happened, so we had to say there's been a death and we can't tell you anything about it but we don't want you , you, you don't need to be concerned about yourself, you're trying to reassure them, you can't really tell them anything, you can't tell them who it is even though they probably know who it is'* Student facing staff.

I sensed a palpable fear, for some staff, that their inability to contain or control the spread of information might lead to further risk for other vulnerable students. This staff member appeared torn by their wish to be able to contain the narrative, and their understanding that this was an impossible task:

> *' and the ambulance turned up someone, another student videoed it, it was on social media within about twenty minutes … and I think it's really hard then to contain that in some way in terms of if that, if suicide's kind of a dangerous idea, if people identify with those kind of events and stories it's really, it becomes a known kind of, it's kind of a, almost like a cultural script within a kind of a community.'* Academic staff.

One student counsellor expressed how the legacy of student suicide in a HEI embeds within a community-wide narrative that is passed from one generation of students to the next:

> *'it doesn't go away, it sits, it erm [pause] you feel like you're in [pause] in a, oh, I don't know how to explain it, like, the community impact, and suicides that have happened before students even arrive, the stories stay, and the new students in year one, you know hear the stories of the students that died, it just seems to have a swelling, escalating, I don't know quite how to articulate it.'* Student facing staff.

These accounts helped me to understand the challenges that staff faced whilst they urgently wished to keep students safe, they also knew that it was impossible to prevent the spread of information through students' use of and engagement with social media technology. I suggest that this struggle is one of the most explicit illustrations in these accounts of the collision between staff responses and the sociocultural context within which students live and operate.

5.4.2.1.2 Ways of Responding

Hearing staff accounts highlighted to me the different ways in which staff deliver the response. I heard over and over accounts that led me to understand how staff adopt a mindset of 'doing the job', as well as strategies for working with others, for working with procedure, for taking on roles and responsibilities. Some of these 'ways' seemed rooted in policy or experiences of practice, or in hierarchy of job-role and responsibility within the HEI; others appeared rooted in external frameworks such as emergency services and coroners' responses, procedures and roles.

Doing the job

Multiple members of staff used phrases such as 'doing the job', 'getting on with the job', 'it's my job'. It appeared to me that this mindset helped staff to retain focus on tasks rather than on the tragedy of a student death; as such, I suggest that this mindset enabled them to better meet the expectations of what might be considered an appropriate response:

> *'well I think for the first few days, it's just er get on with the job'* Student facing staff.

For other staff members, the quality of the work that they had done was important in the sense of knowing that they had done all they could:

> *'making sure that we'd obviously done the best that we could do for the student and with the police and everything, and obviously helping the university out, it was just sort of, right, that's it done now, we've done our job, we did it to the best of our abilities, that's fine, there's no*

come back from it, there's nothing, we've done exactly what we could have done' Facilities staff.

Once again, these quotes illustrated to me a relationship between the necessary 'doing' and the inevitable 'feeling'; as I listened to staff accounts I heard a dominant narrative of professionalism, or of 'needing' to 'do' that over-rode or buried emotional responses during the earliest moments or days following the event.

Challenges of responding

Whilst the desire for professionalism appeared dominant, staff accounts of the challenges that arose for them in responding to a student suicide led me to hear underlying stories of fear or overwhelm. These stories spoke of complex feelings and emotions in response to doing tasks that were outside staff members usual job-role and beyond their comfort zone. In some of these accounts I heard a sense of feeling at a loss, or out of their depth:

'I didn't. I didn't [know what to do] [laughs] and it was, yeah, it was so difficult.' Academic staff.

Other accounts let me to notice a sense of discomfort at being in close proximity to the place the student died:

'although I didn't know that student personally, but, actually being at the kind of coalface of going in and in to that room, um that's not something those other colleagues have to experience' Facilities staff.

'we went in there and it's like, you're just [unclear], you're just looking at [the place the student died] because you know that's where, you know, the [student] had taken [their] life, and you know, you kind of focus on that [place] all the time'. Facilities staff.

As staff spoke of other tasks that were undertaken in the weeks or months following the death I noticed feelings of overwhelm & challenge for staff members. Even when these were tasks that were familiar to staff members, it seemed to me to be the connection to a student death by suicide that created a sense of the task being somewhat harder:

> *'it was daunting, the memorial service was daunting because the of the lack of information … how was I going to do something that was appropriate for somebody I didn't know ... but I think of any service that I've done here, probably the most daunting'* Student facing staff.

> *'Well the coroner's court was awful. I'd been to coroner's court in my job and personal life and they're just awful, awful to be there and to, to meet the [student] who died parents who were sitting there devastated'* Student facing staff.

This leads me to suggest that emotional responses were felt in connection with the doing of the tasks and with the expectations that staff perceived were placed upon them. In some instance staff pushed these emotional responses away, in other instances they appeared to feel overwhelmed by them. What I see here is a tension and entanglement between 'doing' and 'feeling'.

Being a leader

I noticed in their accounts that some staff in leadership roles appeared to carry a greater sense of responsibility, sometimes about very practical tasks such as daily processes, but also connected to the staff members' fear of missing a detail or of getting it wrong. For instance, this excerpt led me to understand that the weight of responsibility is about more than getting the task right, there is also a sense of needing to ensure that everyone is ok:

> *'a little bit worried about how the, it's funny things, you know, will the coach turn up, you know all the things, I'm responsible for getting all these people to a funeral … and will they all be ok'.* Student facing staff.

Those in leadership roles may hold more power within an institution; what I see illustrated here is that they also hold a sense of responsibility. In seeking to understand experiences, it was these ideas of power and responsibility that formulated my understanding that staff members' job role not only affected the kinds of task that they may have been involved in undertaking in response; but also, their broader interpretation of their own role, and subsequently, their experience of being a responder and the weight attached to delivering that role well.

Process & Procedure

For those who were in leadership positions the presence or absence of policy and procedural guidelines appeared paramount to their sense of being able to lead effectively. Senior or leadership staff who had access to guidance repeatedly referred to its helpfulness, in terms of providing structure and reassurance at all stages of response, throughout their accounts. Likewise, those who had no such guidance or policy to follow, the absence of such was repeatedly regretted as they spoke. These excerpts suggested to me that the presence or absence of such guidelines shaped the staff members experience of being a responder:

> *'having a, something tangible to hold, like our checklist, what to do when a student dies … is really helpful, because it allows you to focus rather than just have things going on in your head, whose job is it to do that and all those different things as well'* Student facing staff.

> *' I think what would have probably been helpful was, was more written guidance around suicide particularly about what to do … we had the major incident planning around a student death, and what we did, I think suicide is particular and we didn't really have that, so I didn't have anything I could just quickly pick up and say ok, let me just think about this and, and um that would have been useful for me I think at the time.'* Senior Leader.

For others, I heard how the event of the student suicide highlighted gaps in process which needed immediate resolution:

'we've got a new accommodation system, and we haven't actually got an option to put on there that that student is deceased and we needed to do something to stop emails being generated to a student account, or, and heaven forbid, family get something, but one of those things that nobody had ever thought about' Facilities staff.

These participant quotes lead me to suggest that policy, by its presence or its absence, affected staff members sense of being in control; of having confidence in their decision making and of feeling reassured that nothing was overlooked or missed.

Working with other agencies

Some staff members shared with me that they sought sources of support and expertise beyond the HEI, thus introducing a community level element to the experiences of responding for some staff:

'I was able to talk to two people who had been through this process lots of times, erm, er, and so it was really a case of this is what I'm doing, erm, thinking of doing this, and it was that, it was that professional sort of, you know, do you think this is right, you know' Student facing staff.

'we work closely with the Mental Health trust and er suicide prevention leads and things, public health, so I was able to try and draw on support if we needed it' Academic staff.

Information Sharing

The experience of sharing the news of a student death by suicide proved challenging for those whose responsibility it was:

'I think that the, it's always difficult isn't it, telling somebody that somebody's died, that is never a nice thing to have to do at all … but I think at those moments in time you kind of go to a little bit of auto-pilot, so I'd say that part of going to tell a senior colleague that we've got a student who's died is probably the hardest bit I think' Senior Leader.

I noticed in these accounts how this responsibility was further complicated by multiple considerations such as what information ought to be shared, how and with whom. In addition, the wishes of family members might also inform what information is to be shared, how and when it can be shared:

> *'certainly that information sharing is initially important, because if people don't know and then find out it is quite hard for them … they are, oh, I didn't know anything about it, but also, sometimes families don't want it known, particularly families that it was suicide, and so that information sharing is quite complicated'* Academic staff.

> *'we do have discussions about who needs to know, who we might tell and what information we are giving'* Academic staff.

Once again, I noticed how staff were carrying the weight of needing to get it right in these accounts.

Roles & expectations

For some members of staff, I noticed that the experience led to reflections on expertise and who amongst staff teams were best placed to provide that expertise; for instance, the account below illustrates that for one senior leader this involved stepping beyond the usual ordering of hierarchy and authority:

> *'I suppose as any … as a [senior lead] rather than someone who is operational … I think sometimes you can feel a little bit useless, because actually your very highly skilled professionals, they, they, kick in, and they're the ones that say we need to do this, we need to do that, actually I was at that point I thought that I had to be there for my team, um, I have to be there for the students, I have to make sure I'm aware of what's happening, but essentially I felt the best thing to do in that situation was to be led by my head of student services about what was appropriate'* Senior leader.

For others, who held expertise, I heard accounts that suggested a weight of responsibility. For one staff member this was expressed somewhat ambiguously; on one hand they attempted to rationalise the responsibility as being understandable in the light of the crisis; however, they then go on to express their sense of being abandoned to 'get on with it':

> *'One of the things I reflected on later, cos it was fraught and it was challenging, one of the more challenging periods I've been through with work was that the amount of holding and containing and responsibility that a small number of people had … which is fine and it fitted with our roles and what our skills were, but it did feel from an institutional level that they would let us get on with it'* Academic staff.

In listening to other members of staff, I noticed that they felt seen only by the stereotypes and expectations attached to their job-role. This participant's account suggests to me that they perceived there to be no room for an emotional or personal response beyond that expected within their job-role:

> *'you know, so they will expect you to be calm, they will expect you to be wise, they will expect you to say things that are comforting, there is a lot of expectation projected on to [people in this job], and, to be honest with you, that's fair enough, because that's the role of [job role]'* Student facing staff.

It seemed then that their sense of person was rendered invisible by their job-role; and that this left them feeling that they had no place in which to express a personal response to the death. Once again, I notice that it is not just the nature of the task that shapes the individual's experiences, but that there are additional inequalities of experience attached to their job role.

Team working

Across staff accounts, it seemed to me that the event served to highlight the strengths and advantages of team working and team cultures for some staff. This was expressed through a sense of belonging or of having a shared experience with colleagues:

> *'I think it has really emphasised for me that the importance of um, team, in those situations, and um, how when anything happens, um, different people bring different things and, you know, I think, which has re-emphasised the fact that you need to draw on those people around you and you need to work as a team'* Senior leader.

> *'cos it is, it's much, it's much easier to bear if you are sharing the same experience I think'* Student facing staff.

However, this was not the case in all accounts, I noticed how other staff members expressed a sense of being left alone with responsibilities that they felt were out of their area of expertise:

> *'all we can do is pass them to the wellbeing team … but obviously at three o clock in the morning, there's nobody to call apart from us'* Facilities staff.

In comparing the accounts in this section, I am aware, yet again, of the different job-roles that staff members hold, and how they align with the different experiences that are reported here. This leads me to wonder whether there are any connections between these 'individual' experiences, and differing team cultures within HEI departments.

Working Together

When staff members recalled experiences of working together I noticed that, in using the language of togetherness, their sense of being able to cope and of feeling that they were doing a good job appeared strengthened:

> *'The student union president sat on the major incident response team … so that means we get the support of the student union, it also means we have to support them because they are*

generally less well equipped to deal with you know, this sort of information … but it feels like you're all together' Student facing staff.

'everyone has a different role, so we don't, it's not like it's just you having to deal with this terrible thing that has happened, so I think that is helpful.' Student facing staff.

'the closeness probably, it's just about working with the people that I was working with and a sense of working together in something that mattered' Academic staff.

The category reported above, 'Being the responder', is about the things that people did. In a number of the focused codes in these categories I have highlighted how the job-role of the individual appears to shape their experiencing of responding after the event. This happens through levels of responsibility or holding power to influence change, or because of the assumptions that others might hold about the kind of person who might undertake that role, or it might be due to the differentiations in team cultures across departments within a HEI. For all staff members, however, I suggest that the participant accounts across both sub-categories in this section speak of an entanglement and tension between the 'doing', and a seemingly inevitable process of 'feeling' as they were 'doing', or a process of trying not to 'feel', or to wait until later before it felt safe to 'feel'. These accounts lead me to consider whether the emotional and psychological responses may be connected both to the fact that a student had died by suicide, and to the nature and experiencing of the tasks that were taken on following the suicide. It seems to me that staff energy is engaged in their attempts to navigate this complicated entanglement, and the stories of how they attempt that navigation are reported in subsequent categories. The 'feeling' of the event continues to be present more comprehensively in the second category, which I report below.

5.4.2.2 Experiencing a Student Death by Suicide

After the early, crisis response stage of the event, there were stories in staff accounts that mark the beginning of 'Body & Mind' responses and processes of 'Reflections and Perceptions'. The beginnings

of the processing seem to be experienced in diverse ways, which will be highlighted in this category as staff recall the thinking and the feeling; or the waiting to feel, as they put 'on hold' their emotional engagement with the event as the tasks are still ongoing. In staff members accounts I heard experiences of physical, psychological and emotional responses that differed as time progressed. I noted that the processes of reflection and developing personal perceptions of the experience, and developing an understanding of what happened or a rationale for why it might have happened appeared to be a prominent process for most of the participants. Their accounts suggest this to be a complex process that involves much thinking, reasoning, processing, searching and sense making. In listening to staff members, I heard about processes of noticing and highlighting perceived connections with the student – who they may never have met before – these connections may take the form of similarities in age, gender, or circumstance with close family members – or processes of identifying with the pain of the student's family & parents, for instance. These accounts lead me to suggest that staff members are engaging in the construction of 'perceptions of closeness' with the student who died. The stories that I heard illustrate that this process may be triggered by seeing a photo of the student who died, or through hearing some personal details about the student; for some it started on seeing the student's body after their death. I suggest that as the student is humanized, so a process of identification starts through which the staff member perceives connections or commonalities with the student and this in turn develops into a need to more fully understand the reasons and meaning behind the student's death. I noted in staff accounts that as these perceptions develop, so also does the likelihood that the staff member will feel an increased sense of being impacted in some way by the death.

5.4.2.2.1 Body & Mind

Physical Responses

The majority of participants shared with me their experiences of physical manifestations of adrenalin on hearing the news and knowing that they needed to respond:

'you know there is very much the heart starts beating fast, your hands start shaking … but then you move into well what do I need to do mode' Student facing staff.

It wasn't unusual in their accounts for staff to report that physical responses were also experienced later, after the event:

'I had quite a few sleepless nights [pause] um, and, you know, physically just felt, um [pause] drained, I think would be the best description.' Facilities staff.

One account, in particular, helped me to understand that, for some participants, a physical response was closely aligned with the ongoing emotional impact. This was evident even when recalling the event during the interview. It was the honesty and congruence in this short exchange with one participant that really bought to my attention that staff may continue to bear the experience even years after the event:

Interviewer: *'Is it ok if I ask you, how do you feel about it all when you look back now?'* ***Participant:*** *[long pause] 'I just feel like my chest is heavy –'* ***Interviewer:*** *Mmm* ***Participant:*** *'erm [pause] very sad [pause]'* ***Interviewer:*** *'So, there's a physical response?'* ***Participant:*** *Yeah, yeah, yeah'* ***Interviewer:*** *'- alongside the emotional one?'* ***Participant:*** *'Yes.' [long pause]'.* Student facing staff.

Initial responses

Staff shared with me their sense of panic as thoughts and words flew around their heads:

'that initial sort of five minutes where you are like, I don't know what I am meant to be doing, … because you can't think straight when something really unexpected and terrible happens, you're just like in shock … oh my god, I know I need to do something, but I'm not quite sure exactly what it is' Student facing staff.

Emotions on hold

In many accounts though, I was aware that the requirement to engage fully with responding, meant that the thinking and feeling couldn't happen until later:

> *'you go into um, kind of automatic mode don't you, and you kind of go right this is a job we have to do'* Senior leader.

For some staff, the necessity of having to perform their job over the following days meant that they experienced an ongoing process of quashing their emotional responses. This was particularly evident to me when I listened to this member of staff recall their process of fighting against feelings that seemed to be bubbling just under the surface, whilst having to continue to work in the environment where the suicide had occurred:

> *'Yeah, no, I [hesitantly] literally, sort of, dealt with that and then I came back to do the nightshift the following night, it had just, I just had to push on and keep myself busy to stop myself thinking about it … obviously being in the same environment it was kind of a bit difficult to forget it at the same time'* Facilities staff.

I noticed how, for some, this was done through intense efforts of self-control as recalled by this student counsellor, who experienced an entanglement of responding within the boundaries of their job-role, whilst fighting the urge to respond as an emotional human being:

> *'while you are doing your job you're feeling it, but you can't because your responsibility is to the other people, you can't break down, it's incredibly difficult, especially if … there's people crying in front of you, it's incredibly difficult not to break down, but you do it, you keep it together'* Student facing staff.

These participant quotes showed me that the 'doing' of the job took priority over the 'feeling' work that was set aside. However, the very act of 'setting aside' created further work in engaging in the fight or battle to control and quash instinctive emotional responses, that staff perceived would get in the way of being able to continue to do their jobs.

Managing the Emotions

I noted that when staff members did experience the emotional impact, it appeared to feel like a juggling challenge to find space for the emotions of others whilst dealing with their own. Again, this lead me to understand the extent of the emotional labour that staff engaged in following the suicide:

> *'there's a whole mix of eh, emotions, th-the thing about it is, it's tiring [pause] it's um [pause] Well, dealing with er, other peoples' emotions – especially difficult emotions is tiring – dealing with that whilst you've also got all of yours going round is even more tiring'* Student facing staff.

Some staff members shared with me that they found personal strategies for managing the emotional impact:

> *'I would take those feelings to God and say, well whatever I did I hope it was helpful, but you know wherever [the student] is, look after [them], that's the way I would process it in a faith-based way'* Student facing staff.

Visual echoes

For the staff members who were present during the aftermath of the event, it seemed clear to me from their accounts, that the scenes that they witnessed continued to play on their minds for some time afterwards. I noticed that in these lasting echoes, the emotional impact resurfaces in both physical and psychological forms. It felt palpable to me, in the struggle that it took for some staff members to share these experiences, that this was a very challenging aspect of the experience:

> *'every time I shut my eyes all I could see was [the student], so, er, yeah, it did affect us quite badly … the main image is as I've pushed the door open that has always stuck with me has that one [describes the physical appearance of the student's body]'* Facilities staff.

'I thought you might ask me, I don't know why I would think this, but I thought you might ask me about traumatic images or traumatic moments or, or, I thought you might use the word trauma, but you haven't, um [pause] because that's what sticks in my mind, is a visual image of police vans, and [the housemates] going out to make their statements and the coff-, not the coffin, the stretcher, that, that, that's the traumatic image that stays in my mind' Student facing staff.

I purposely didn't mention the word trauma during interviews with participants as it wasn't my role to make this assumption; however, it was statements like these that let me know that participants had and were experiencing trauma symptoms following the suicide.

For others, I noticed that it was in hearing details of the student's death that triggered disturbing visions or imagery:

'I mean you really deeply, psychologically, I, I heard that [the student] [describes means of death] that's sort of, that's, that's, it's there, not as an image, it's, yeah, sort of an image, yeah, that piece of information.' Academic staff.

This suggests to me that staff members do not need to witness or be present at the site of the death, for them to experience trauma like symptoms later on.

5.4.2.2.2 Reflections & Perceptions

After the Event

In many of the staff accounts that I heard, it was in the processes of stopping, or of hearing further information that triggered the response of reflection:

'I suppose it is when you stop that you later finally go oh god, you know, that's awful, or later on you kind of hear more things about either what happened, or the family, and, and, you

know, motivation, or a note that they'd left, and you kind of get more of the human details about it' Student facing staff.

'An impactful event'

When staff reflected on the kinds of impact experienced, there were a range of responses, but in all cases, I noticed that it was the depth or the breadth of impact that was emphasised. For instance, some staff shared that it was the trauma attached to witnessing the death of a student:

'[the student was] kind of known to security around accommodation … so not only did they have the trauma of seeing a dead body, but it was also someone they knew … and the impact on two of our security who have been involved has been significant … actually quite traumatised' Academic staff.

Other staff shared accounts that let me know that it was in the increased workload:

'it kind of wipes my diary for weeks really Yeah, as, as it should probably, but there is an impact on um, because, this, the way we manage it, there's a lot of work to do' Student facing staff.

Further impact was apparent to me in the accounts of staff who reflected on how they felt in their job-roles. In these accounts, I sensed that it introduced a heightened experience of anxiety, which was apparent when staff spoke of undertaking certain tasks, or of encountering certain times of the year:

'it comes through like if the welfare team come across to us and like you gotta do a welfare check, you're kinda, [release of breath] oh, not another one, please say it's not another one and you go and deal with it and luckily most of the time it's been fine … just obviously plays on your mind if there is going to be another' Facilities staff.

'[the same week this year] made me a bit nervous because you know [that time of year] can be tricky and… it's always been a tricky time and I've spoken to students who, you know, it will get better, but yeah, most definitely' Academic staff.

One student counsellor shared with me how they continued to provide regular support to the best friend of the student who died. Their words illustrated an ongoing emotional response which I understood to be driven not just by the event, but by seeing the ongoing impact of the event on another student:

'it still breaks my heart, seeing the effect it had on [this student's] life you know, [their] degree, [their] um [pause], yes, [their] self and [their] er um, anxiety and depression and, and that's really sad' Student facing staff.

One staff member articulated a sense of community-wide impact, which they explained to me as feeling different to the kinds of impact that they had experienced in other work settings. This account helped me to reflect upon the culture of the HEI as informing the kind of response and in elevating the perceived impact throughout the institution; and, due to these factors, as affecting staff experiences:

'it kind of blew my mind a little bit the, the impact on the close community is so different to dealing with that in [my previous workplace] where there'll be an investigation, it's sad and we move on. It doesn't happen that way at university, does that make sense? Erm, it feels like we're in a massive family, and you know the effect of suicide on family and community – I suppose in [other workplaces] you're a little bit detached from it, to some extent as a care provider. I think at the university we, particularly the people who get involved, chaplains, [wellbeing staff], it doesn't go away, it sits.' Student facing staff.

I heard participants use the term 'community' when talking about impact both within and beyond their institution. This suggested to me that staff were situating the event beyond that of the death of

an individual human being. I believe that the experiencing of the death was heightened by the fact that the deceased was a student in their university community; and that the university is embedded within the wider local and regional community.

In other staff accounts, it was clear to me that the impact led to reflection on the experience of being part of the HEI community, and what that meant for them following a student suicide:

> *'I think it affected me more in terms of thinking oh that was really hard, do I want to be around this, you know, in a selfish way … I think I've done a good job but do I actually want to be doing that job?'* Student facing staff.

Recalling

In many staff accounts I witnessed moments where the act of recalling appeared difficult, leading me to suggest that this further illustrates the ongoing bearing of the experience:

> *'I think there was, in the beginning, I, sorry, it's just sort of coming back, I haven't thought about it, obviously pushed that away'* Academic staff.

Wondering why

Most participants expressed to me processes of reflecting on what had been happening in the student's life to prompt such an action or decision to be made. In these staff accounts, I heard an ongoing struggle articulated between the need to understand, and the knowledge that they would never know the full story. I suggest that this ongoing process of seeking understanding is another layer of the continued 'bearing' of the weight of the event that staff appeared to be engaged with:

> *'I think we'll never understand really what happened, or why, like I say, why did you do that, you were enjoying a night out, being out with [your friends], you know, why would you do something like that? You know, obviously, you're never going to know that.'* Facilities staff.

> *'I don't know, I didn't know [the student], so, and I don't know what went on in [their] family and what might have triggered it, and you know, it's not a blame game, really, you know, it's, it's er, it's mental illness and you don't know what triggers it, and you don't know if it could have been prevented, and er, no, it's not really, you can't get answers, but you still have questions in your head even if you can't find answers'* Academic staff.

I heard other participants talk about this kind of 'wondering', which suggested to me that whether or not the student had been known to them, they engaged in a process of 'story building' or of 'constructing' ideas about who the deceased student may have been in life.

Searching for meaning

One process that I noticed in nearly all staff accounts was their search for meaning and their efforts to make sense of the event. In most cases I noticed how staff struggled to clearly articulate their thoughts and experiences of processing the meaning of the event:

> *'I think that's the thing that some, if anything about the impact of suicide, it's, it's the exposure to it, but also the meaning of it, and the closeness and stuff'* Academic staff.

> *'I think it was, it was more, afterwards, when you suddenly realise that's a – an 18-year-old, 19-year-old who, who has just got to such a state that they can take their own life'* Facilities staff.

This struggle to articulate seemed to me to reflect their struggle to find clarity in their processing of the event.

Some staff accounts, in seeking to offer explanations, or in speculating on the potential of a different outcome, led me to better understand the cognitive wrangling that they experienced in attempting to reconcile what had happened:

'… and I've been doing this job long enough to know that it's, it's not, people can make mistakes, but it's all very complicated in terms of how people make decisions' Student facing staff.

'I just think if, [one of the students] if [they] had talked to someone, I think [they'd] have been alright, and if the [other student], if [something different had happened] and [they had] not done it I think [they'd] still be here, I don't, I don't, you know it was, it was a, I don't know if it was impulsive, do you know what I mean, I don't see anything in their lives that suggested that they were going to end it, there was, there was, I don't think it was inevitable that they would end up dead' Academic staff.

The most frequently expressed regret that I heard from staff, on behalf of the student, was that of 'waste':

'there was this feeling of waste, you know, waste of a young life' Academic staff.

These quotes suggested to me an intensity of need on the part of these staff members to find sense and understanding in the event of a student suicide. For instance, I noticed that where there were no answers, or no information, staff engaged in processes of hypothesising, ruminating and, again, 'constructing' answers to fill those gaps. It seemed to me that staff were not comfortable in accepting that there are aspects of a suicide death that will remain unknown. The stories that they shared with me, told me that they worked very hard to fill those gaps in their knowledge.

Ongoing thoughts

For some staff the processes of recalling and re-experiencing the feelings continued over time:

'but you think about it for weeks, even months after, even if I still go up there now, even though I don't work down there, that is always still there in my head, that, you know, that is the house, you know, so … yeah, it was very hard' Facilities staff.

For other staff it was clear to me in their accounts that the processes of sense-making or bargaining were ongoing:

> *'it's still horrible, still guilty, still thinking what could I have, I have done differently, um, to prevent [their] suicide, er, [pause] sad because I think this is [their] graduating year.'* Academic staff.

For this member of staff, I also noted the process of marking the passing of time by the milestones that the student would have achieved had they lived. These stories of experiencing a past event in the here and now showed me, once again, how staff continued to 'bear' the suicide of a student.

The unknown student

I also heard accounts that suggested to me that the anonymity of a student in death proved difficult for some staff members to accept, I suggest here that staff felt they had failed somehow in not knowing the student:

> *'it's just the fact that, er, you're just very, you're ever conscious, it's the challenge, you will know around student suicide is that er, very rarely actually, do we know of them actually, they're quite, you know, the students are not known'* Senior leader.

Knowing the student

Those staff who did know the student were keen to share with me their recollections of them, they seemed eager to demonstrate the connections they had with the student. I noticed that staff appeared particularly animated whilst sharing such recollections:

> *'I knew the [student] as well, cos I used to see [them] out and about, obviously we're working on there, I used to clean [their] house, so I used to talk to [them] in the kitchen, generally, like you do students, and you know, even if I saw [the student] coming out the house I'd always shout across, 'hiya, you alright?' you know we always spoke so …'* Facilities staff.

It felt that staff needed me to understand, through the urgency or passion of their accounts, how their prior relationship with the student had shaped their experiencing of the student's death.

Finding personal connection

Even for those staff who did not know the student before their death, I was aware, throughout their accounts, of processes of finding connection with the student after their death. Hearing staff share these processes leads me to suggest that staff were engaging in a process of constructing a perception of closeness with the student who had been unknown to them in life:

> *'[they're] an unknown [person] umm [pause] same age as my grandchild'* Student facing staff.

> *'I'll tell you what affected me most and what is heart-breaking, and it probably will make me cry again, is just to see pictures of people, and, and, usually if they are abstract students with a name and a course and things, and then you see a load of pictures … and that, that, I found that, I actually found that hard'* Academic staff.

The stories that staff shared with me during their interviews, illustrated in the above sections, speak to me of complex processes of construction. I suggest that in engaging with these processes staff seek to satisfy their need for information, for understanding, for meaning. It is these processes that lead me to recognise how the staff members develop or 'construct' a sense of closeness to the student who had previously not been known to them.

5.4.2.3 Needs & Fears

In listening to staff accounts, I noticed that as the impacts of the event settle in and the staff member experiences their personal process of reflecting on and processing the event; so, their needs and fears seemed to come to the fore. Some of these appeared to be connected with their job role. For instance, staff seemed, to me, incredibly mindful of the impact of a suicide death on other students,

particularly vulnerable students. Likewise, I noted a process of questioning the self and maybe their team's responsibility and role in what had happened. Within this I noticed fears around having missed something, or maybe being able to do more than they did. I heard stories of other needs and fears focusing on lack; on not being trained to deal with this kind of situation; or with the struggling student before their death. In some staff accounts, I heard an experience of feeling overlooked or forgotten about throughout the event, that seemed to leave them feeling in need of some kind of recognition or acknowledgement.

Impacting on other students

In their accounts it appeared clear to me that staff had a heightened awareness of the potential of the event to impact on other students; I sensed a palpable fear of potential harm, I also observed deep regret on witnessing the impact.

> *'thinking about the risk group, you know it's a young [student] and they're friends with a young [student] who has now taken [their] life, you just think, oh god, they might be at a lot more risk, well they will be at a high risk, because they know someone, so erm, I suppose there is that worry … so I think that is difficult*' Student facing staff.

> *'it's hard to see, how that event has just kind of, in many ways ruined [their] university experience umm, in an irreparable way really.'* Student facing staff.

The sense of fear, and in some cases panic, that was present in the sharing of these worries, suggested to me a feeling for staff of being unable to control further potentially tragic outcomes. These narratives highlighted for me that staff fears exist in the context of a wider societal narrative of students as being an 'at risk' population in terms of suicide, and student suicide as being currently 'prevalent'.

Reputation and Blame

From some staff members I heard accounts that suggested a very personal process of self-scrutiny, which seemed to me to be connected to their fear of professional failure:

> *'there is the feeling of guilt, obviously, because I did invite them … I remember that in that email, to all my tutees, not just to [the student], all tutees, I said, please make an appointment, I'm looking forward to seeing you … and then you think, I wrote this and you know [they] didn't come, and er, yeah, you feel like could I have said anything, could I have made it more urgent, to say well, you know, you need to come or, would [they] have shown up anyway [pause] yeah, so [big sigh] yeah, to be, you know, as a personal tutor whether there could have been anything else that I could have done differently'* Academic staff.

Such narratives of self-scrutiny highlight to me that there is an institution wide sense of responsibility toward supporting the wellbeing of students as well as providing them with an education. For some staff this was expressed as a fear that maybe something, a clue or sign, had been missed:

> *'I suppose it really, it really makes you think and really question about, oh, my goodness, did we miss something, should we have known, erm, you know, do we need to tighten up our systems, do we need to tighten up our processes'* Senior leader.

In some accounts this fear appeared to be escalated by knowledge of the media reporting experienced by other universities following student deaths by suicide. This leads me to suggest that staff experience is shaped by wider contextual narratives connected with student suicide and risk:

> *'then there is always the possibility of well what if we have made a mistake, or what if the press had picked up on it in a negative way, erm, th-the potential extra pressure that might happen'* Student facing staff.

In the reference to 'extra pressure' in the quote above I hear fears that exist in the context of HEIs shifting toward a competitive business model, whereby marketing and institutional reputation are key in attracting high student numbers and therefore adequate income. Whilst participants didn't explicitly talk about these shifts in HEI culture; this is the context within which their experiences are situated.

One member of staff shared with me their experience of a sense of absolution following a conversation with the student's father:

> *'I mean the Dad said, he came, you know, it's difficult, I went to see him to express my condolences at the funeral, he said, [big intake of breath], nothing you could have done, erm, don't blame yourself, it was a real shock to everybody.* ***Interviewer:*** *And what was it like for you to hear that from Dad?* ***Participant:*** *It was really nice actually, yeah…because ehm [pause] erm, because peo- people respond differently when they're grieving – and finding someone to blame is not an uncommon response – erm, for him to, to, I mean his – for him to say that – it touched me [spoken very quietly]'* Student facing staff.

In hearing these accounts, and in seeing them collected together here, I notice again the weight that is present in their words, I feel the presence of ongoing impact that is shared in the pauses, the sighs, the deep intakes of breath. These were stories that staff members found difficult to share with me. As such, I am led to understand that the 'bearing' that staff experience following a student suicide isn't only in the context of trauma responses and ongoing emotional impacts. It is also attached to fears, self-scrutiny, self-blame, guilt, maybe even shame. For some staff members, their stories let me know that they continue to sit with those uncomfortable feelings which appear further agitated by the weight of responsibility toward ensuring students' emotional wellbeing. In the final account, however, I hear a sense of release, when the staff member's fears are undone on hearing absolution from the student's father. This leads me to wonder how these other staff members might be supported to find a similar experience of absolution, of release from their ongoing 'bearing'.

Unmet needs

In some staff accounts I heard stories of needs that remained unmet. One team manager identified that a lack of life experience among her team may have impacted their ability to cope with a situation like a student death by suicide:

> *'I've got a very young team … who possibly haven't even experienced somebody, you know, death in the family, let alone somebody very similar age to them'* Facilities staff.

The same manager went on to reflect on what might have been done differently after the event to meet the needs of her team:

> *'I think in hindsight we didn't even get the people who'd been affected to talk to each other … when I look back, I've got, sort of, you know cleaners involved, I've got security involved and actually I don't know that we ever got them to [talk to each other] and that might have been beneficial'* Facilities staff.

This account leads me to question where the responsibility of meeting such needs and of facilitating support lies. This team manager is reflecting on their own role, and expressing regret at missed opportunities. Some team managers within a HEI, due to their professional role and skill set, will be far better equipped than others to understand and meet the kinds of needs that arise for their team members after a student suicide. Thus, creating an inequality for individual staff in the kinds and quality of support that may be accessible to them.

Dealing with needs

I heard that staff took diverse approaches toward dealing with the needs they were experiencing. Some accounts suggested to me that external support or validation was the staff member's primary requirement. It seemed to me that they needed their needs to be acknowledged, to feel seen and to feel that somebody cared enough to ask after them:

> *'somebody just saying, 'are you ok, do you need to talk?' Erm, I mean yes, I'm fully aware that we've got you know online counselling and phone calls and things like that and I was making sure that my, you know, getting my team aware of that and they could talk to me, but just somebody to acknowledge that actually what you've just dealt with is fairly crap … I don't recall anybody ever checking that I was ok'* Facilities staff.

Other staff reflected in their accounts that maybe they could have been more pro-active in accessing additional support:

> *'I think maybe I could have talked about it in more depth maybe at a later time.'* Student facing staff.

Whilst other accounts suggested to me that some staff felt their needs were more visible to others than to themselves:

> *'I think it catches up with you and you become a bit exhausted and a bit tearful and need a bit of time and I think my manager probably noticed that and booked me a one to one time with a psychologist from [our partner institution] and I had an hour with someone from there just to talk about my feelings, and um, and that was useful.'* Student facing staff.

The range of experiences that I heard in accounts of how staff dealt with their needs leads me to conclude that provision of support was patchy and depended to some extent on individual staff member's networks or pro-active strategies. Once again, there are inequalities of access and opportunity between different staff members.

Training needs

In some staff accounts, I heard how the requirements of responding left them feeling unprepared and unskilled in a very challenging situation. These accounts showed me how the stretching of staff

roles at the point of crisis response left some staff members feeling beyond their comfort zone in terms of feeling skilled or able to deal with the situation they found themselves in:

> *'it's always really challenging when students are kind of, and obviously they were distraught, erm, and I think, it's not something I've ever had any training in, in all the years I've been here'* Facilities staff.

> *'If I'm really honest … for me personally there were moments when I felt inadequate because I just thought, I'm not, I've never dealt with this before, I'm not trained in this, I'm not particularly skilled in this … I didn't feel hugely confident in that situation'* Senior leader.

Needing acknowledgement and recognition

Some staff shared with me that they felt either un-noticed or un-acknowledged despite their contribution:

> *'it's like actually when I think back, it was, my frustration was the fact that people were just kind of almost making that, 'well it'll just happen, because they'll just do whatever needs to be done', you know, which we did … but, bit of acknowledgement for the team would have been … would have made a big difference'* Facilities staff.

For one member of staff I heard how this resulted in a sense of having made no difference at all:

> *'that sort of feeling of impotence and [long pause] yeah, ur, yeah, it is impotence, because I didn't feel that I did anything that really helped anybody - I mean, I did go through the motions, but, [pause] certainly had no feedback from anybody [laughs] that anything I did was helpful'* Student facing staff.

The accounts in this section speak to me of unmet needs and unequal access to support, be they support needs, training needs or needs for acknowledgement. Hearing the sense of abandonment and of invisibility in these stories suggests to me that staff experiences were affected, not only by the

suicide of a student, but also by the experiencing of assumptions, inequalities and oversight that staff perceived from their institution and due to the means of delivery of support.

5.4.2.4 Experiences of Support

Throughout their accounts, one of the most dominant stories that I heard spoke of staff experiences of support. Staff members describe the ways and choices that they made in terms of accessing and experiencing support. The accounts shared in this section lead me to suggest that support needs are shaped by the participants' individual experience of the event; their role in responding to the event; the ways in which they have processed and developed a set of ideas about the event; and also, the cultures of support and supporting within their team and institution. In listening to their experiences of support as being helpful or complicating; their ideas around what might be helpful and what might meet their needs; their ability to ask and be pro-active; their sense of being seen and included within organisational ideas of who needs support and what kinds of support they might need, I am able to draw an understanding of how these factors also shaped their experiences.

Accessing Support

In listening to accounts of accessing support I noticed how they differed, with some staff expressing that just knowing what was available gave a sense of comfort:

> *'But it's knowing that you can go. And we do have a wellbeing team here as well so you can actually go if you wanted to talk, or we've got the Padre as well, [they're] really nice, which they've done a little peace garden out the back as well of the chapel, so I know that I could go and speak to [them] as well.'* Facilities staff.

Engaging with Support

Even so, I heard how some staff chose not to engage with the support that was available:

'I haven't contacted an organisation, no … that I didn't contact, sort of, University counselling service or anything like that' Facilities staff.

'I didn't feel I was needing anything else … I knew what, what was available, I could've, I could've asked for things' Student facing staff.

Whilst others shared with me that they took advantage of the opportunity available:

'there were drop-In sessions where the chaplaincy was there, and, um, some people centrally, I don't know, were called, and you know, you could just drop-in, and it was clearly for students and staff, so I dropped in and er, just talked a little bit about it' Academic staff.

These accounts showed me how staff made autonomous choices around accessing support, there were very few accounts by staff of being encouraged to access support, or of support being directly delivered to them. This leaves me wondering how easy it might have been for staff to become invisible, or to feel that they did not have a voice, in terms of support provision. The staff quotes above report that they 'could have asked' and that they 'didn't contact', and for these staff there is a sense that it was easy to avoid engaging, even when support might be needed. I suggest here, that the expectation that staff will be pro-active and voice their needs, is based on assumptions that staff know what their needs are, how they might best be met, and where to go to ask for the support they require. As illustrated above staff may feel disempowered or unheard if they are not able to, or do not know how to, confidently ask for the support they may need.

Experiencing Support

I heard how the experience of being supported was different for different staff members. For instance, some staff shared that they were in a position to access support from professional networks rather than from within the HEI:

> *'I think I may have talked to some of my [professional] friends about it, because some of them have dealt with suicides, I've never dealt with thi- death by suicide ever, so, um'* Student facing staff.

For one member of staff this support enabled them to overcome a specific challenge:

> *'so, I did meet with someone for an hour and a half, a couple of hours and just talk through, and she was really useful in helping me to reframe why I felt so responsible and actually quite practical about what I could do to make sure that responsibility was shared out'* Academic staff.

In other accounts, I heard that the experience of good support within their team meant that the perceived impact outside of work was minimal.

> *'it didn't unduly affect me outside of work. Possibly because I was well supported in work, and had the opportunity to talk about it in supervision, with my manager, and with my team as well'* Student facing staff.

What is unheard in these accounts are the voices of those staff who did not have additional professional networks, or supportive team cultures.

Not being supported

Other staff however, shared with me that they did not access support, in listening to their stories I suggest that this may have been due to feeling that what was on offer wasn't the right kind of support for them:

> *'there obviously wasn't a great deal of help come from them, literally, there was an email sent through, erm, there's a helpline number if you need it ring it. Who are these people? You know, I'm not gonna randomly talk to somebody over the phone that doesn't know me or anything like that'* Facilities staff.

Members of facilities teams are less likely to have professional networks and external agencies that they can call on for support, it is all the more pertinent then, that their needs are met by institutional provision. The account above however, illustrates to me that provision was perceived by this member of staff as narrow and not suitable to their needs. Without the privilege of additional networks and access that other colleagues benefitted from, this facilities worker was left unsupported.

Other staff members shared with me that support, even when offered, didn't happen:

> *'so, we were all going to get in a room and talk about [pause] support each other, but it didn't really happen'* Student facing staff.

In hearing the accounts in the above sections, I suggest that access to support was unequal, with some staff members having access to additional networks and services when compared to others, some being better able to pro-actively seek out support, and some being better equipped with the skills and language necessary to understand, articulate, and seek to meet their own needs.

Building Relationships with Students

In accessing support, I heard in some staff accounts how they prioritised the needs of others over their own needs. For instance, the support of students, for some staff appeared to be align closely with self-identity and a sense of connection with the students. In listening to this staff member's account of 'feeling like a mummy', I find myself wondering how much the perceived role of having to be there for the students met her needs as much as any provision of direct support might have:

> *'I think it's quite nice because I've got two children as well, that are, you know a certain age, and my grandchildren now, so I always see the students here as like 'the teenagers' and you know, it's nice, I do feel like a mummy'* Facilities staff.

For other staff, however, it was clear to me from their account, that being available to support others came from a strong sense of duty and responsibility:

> *'I'm very conscious of the need always just to really make sure that, you know, every student that comes in matters and that someone is keeping an eye on them'* Senior leader.

Experiences of supporting

In some accounts however, I noticed how the experience of supporting others created further exposure to distress:

> *'but I did go and see [the security officers] and um [pause] they were shocked and they did say to me [pause] we, you know, they were visibly shaken I mean, and I mean they were – actually sort of shaking, you know, they were not, not in a good way, the guys that [found the student]'* Student facing staff.

Supporting each other

I noticed that the focus for many staff, in terms of support, seemed to be on the wellbeing of their colleagues and team-members. For some this appeared to be due to their job-role, in being responsible for others:

> *'I spend a lot of time making sure others are ok … that's part of my job'* Student facing staff.

For other staff members, putting others first seemed very much driven by embedded values and behaviours:

> *'I went round all the people that had been involved, you know, the security guys for whom, you know the trauma was immense … And then I went to see the [students] tutors, if there's a death I tend to go round and see the people who knew the person'* Student facing staff.

In some accounts it seemed to me that staff members expressed a sense mutual support which I suggest was nurtured through being connected by the experience:

> *'but really, genuinely because you have to go back to work and into it the next day I think that knowing you've got those colleagues around you that you can talk to and you can share and everyone's kind of going through something similar, it's really important'* Senior leader.

The accounts above showed me that staff had diverse experiences with both receiving and delivering support. It was clear to me, in listening to their accounts, that experiences were shaped by inequalities, and by no means were all needs acknowledged or met. For some staff, it seemed that it was relatively easy to avoid being supported when it might in fact have been helpful, or to fall through gaps of narrow and inadequate provision. Whilst for others, the lack of direct and explicit offers left them feeling alone and abandoned. I suggest that both cultural and personal differences at individual, departmental, and institutional level shaped experiences and perceptions of support; and, in turn, the potential for a healthy process of reconciliation, professionally and personally, following the event.

5.4.2.5 Personal Stories

In listening to the staff experiences recounted in the above categories of responding and experiencing, I noticed that they seem to be further influenced or complicated by the personal stories of the staff member. Staff accounts were regularly punctuated by experiences in the participant's personal life and past history, such as previous exposure to suicide or sudden death, or a recent loss of a person very close to them. In hearing staff make these references and draw connections I came to understand their experience of 'being human' within the context of the event. This understanding leads me to suggest that it is these 'personal stories' that, in part, contribute to the differences in experiences that are evident in participant accounts in the previous categories. The stories that I heard in this category showed me how 'perceptions of closeness' may be fostered by

the staff member identifying connecting experiences and shared understandings with the student who died. I found that I was noticing connections between these 'personal stories' and staff accounts of the felt impact of the event. It was in these stories that I noticed personal traits coming to the fore. For instance, 'being pro-active' describes my observation that some staff members take a personal lead in seeking out support, whereas others seemed to wait to be supported.

5.4.2.5.1 Being Pro-Active

I noticed, as I listened to staff accounts, that many staff members described the steps and actions that they took to meet their own needs; to deal with the event; and in supporting their own processes of reconciling and coming to terms with the event. These pro-active behaviours and choices sometimes appeared to me to be integral to the individuals' way of being; at other times they appeared to arise from a sense of their needs not being met by their managers, departmental leads, or institutional provision. In these instances, I suggest that the staff member was driven to take individual, autonomous steps in order to meet their needs, where their institution failed to do so. Throughout these accounts, I noticed that experience, strategies, and networks shape individuals' ability and potential for effective pro-active choices.

Calling on Experience

Some staff shared with me that their professional experience informed their knowledge in approaching their job-role:

> *'it's mainly all learning from experience, erm, I've been in the security role for like 13 years now, erm, and I've worked in many different aspects of it'* Facilities staff.

Supporting Self

In other staff accounts I heard stories of a sense of personal responsibility in taking steps toward self-supporting behaviours and choices.

'But it's important, practice what you preach, there's no point saying this is what you should do and then I'm not showing that I can do that, er, yeah, if you don't look after yourself, you won't be able to look after other people' Student facing staff.

'I think it's really important that you are able to draw on your own resilience in those situations' Senior leader.

These statements appear to me to speak of personally held values, but I also found myself considering that these values may be nurtured by professional standards or codes of ethics attached to specific job-roles, for instance. As such, I suggest that a complex relationship between the personal and the professional is at play.

Using Strategies

One means of self-supporting that I noticed in staff accounts was by calling on established strategies, the things that staff members knew had worked in the past or that did them good:

'I mean in the end I resorted to - I've used – [a therapeutic technique] for other things, and that – that's what I used and that's what works for me in the end' Facilities staff.

'running's one of the things that I do, and I can't remember exactly if I ran a lot … so, erm, that's probably my helpful thing you know' Student facing staff.

'you always have to have a way of coping with what happens when you go home, so from me, that's walking the dog, sometimes that's meeting with friends, sometimes that's actually just being by myself and just digesting what's happened' Senior leader.

Using Networks

Another strategy for self-supporting that staff shared with me was using established support networks:

'I've got a really good family, so I've got the support from them as well' Facilities staff.

'ok, so there was a friend, the one that I spoke to, yeah' Facilities staff.

In drawing together the accounts shared in the above sections, I suggest that the pro-active self appears to be a product of cultural factors, such as professional cultures maybe, or of familial behaviours and individual traits and norms. As such, the accounts in this category tell the story of some of the individual differences that may impact staff members' experience. This does prompt me to wonder however, about the inequality of experience that this may have generated for staff members who are not as pro-active as others.

5.4.2.5.2 Being Human

Human connections

I heard over and over in staff accounts how they identified connections with the student who had died. These connections seemed to me to be perceived or constructed by participants in a number of different ways. I noticed however, that they were present whether or not the staff member had known the student prior to their death.

A number of staff members shared with me their personal experiences of loss by suicide. These acts of sharing appeared both painful and courageous for the participants. One participant, disclosed their perception of vulnerability, when they checked with me, before they shared their personal experience, that their colleagues would not find out their identity. I heard that attending to a student death by suicide triggered and exacerbated memories and feelings attached to personal experiences. I noted that for some staff members this was a private struggle that they chose not to share with their colleagues, which, I suggest, led to complex feelings of aloneness and invisibility:

'*I've got personal history of somebody committing suicide, it was somebody I was in a relationship with at the time, erm, and that kind of, that bought stuff back for me on a personal level*' Facilities staff.

'I'd also lost [a relation] as well, previously, not so long beforehand, and [they] actually [died by suicide] as well, so …' Facilities staff.

'I think part of what connects me quite emotionally to these things is that a friend of mine died very suddenly, so I've had some previous, um, and [my friend] ended [their] life but I guess when you've had that experience personally, as well, then it erm, it just makes it harder, you know, it triggers up some stuff from your past as well doesn't it, always when you've, when you have er [previous experience]' Student facing staff.

Other staff explained to me that their personal experience of parenting meant that they felt particularly connected or upset by the event of a student suicide:

'I suppose as a parent I just put myself in that situation' Student facing staff.

It seemed in some accounts that the experience of feeling a human connection presented some challenges in finding a way or a place to deal with the emotions that arose:

'I always have to, outside that container of my professional role but then I have to then go and take all my feelings, because of course are there, because I'm fully human' Student facing staff.

Not/the first time

Staff shared with me whether or not they had experienced a student suicide previously, it appeared to me to be an important detail for them, in terms of contextualising the personal and institutional aspect of the experiences that they were sharing during the interview. It also seemed to shape how they responded to the news of the suicide. For instance, for this member of staff, the significance of

this death being the institutions first student death by suicide appeared to bring into sharper focus their perspective of the potential risks attached in student wellbeing:

> *'I think what's [exhale] I suppose it's the first time that we'd ever had a suicide … and I think we talk about, as every university does, about student wellbeing, mental health etc etc and all of these issues, all of the time, but I suppose it affected me, because it actually became a reality'* Senior leader.

Whilst other staff members shared with me that this was not their first experience of a student suicide:

> *'we'd had [a number] [counting on fingers] [of] suicides in quite a short space of time [recalls dates]'* Academic staff.

For these staff members, in listening to their telling of these repeated occurrences, I had a sense of that there was an experience of compounding weight attached to 'another' student death by suicide for them to bear.

Reflecting on the experience

I noticed that the process of reflection was evident for all participants, their reflections revealed to me both their biggest regrets about what had happened, and also their biggest fears for the future. In listening to staff reflect throughout the interviews, I was aware that for them the processing of the event was an ongoing one:

> *'what really is so sad is that [students] didn't, didn't tell anyone how they were feeling'* Student facing staff.

> *'you sit and reflect don't you, because … you do really feel the level of responsibility, you know, students are, when their parents hand them over in September, they expect them to come home at Christmas …'* Senior leader.

'I think it is one of our biggest, well my biggest worry is that students will die and that that will be, you know, something that we've missed and could have prevented is something that I think about a lot' Student facing staff.

Emotional responses and reflections during the interview

I observed that most participants displayed some level of emotional response at some point during their interview. This heightened my awareness that the experience was still 'alive' for them; it seems to me that they continue to feel it; as they recall and re-tell they seem to also be re-feeling; or in some cases, finding new feelings attached to the event:

'I feel a bit emotional talking to you now, which is funny isn't it I don't think I really acknowledged how I was feeling, and then, I guess it just comes up [pause] and [long pause] and you feel, kind of, so sad that that, um, a young person's died [pause]' Student facing staff.

'and that made me cry, it's really, really sad' Academic staff.

Some participants displayed great courage in sharing difficult experiences when their preference might have been to not talk about it, to not re-live the experience, to leave the memories in the past. This staff member, shared with me that choosing to participate in the study had been difficult:

'when you said you wanted to interview, I said, well obviously being an academic and helping with research it's my pleasure, but, but, when you said a lot of people don't want to do it, I could totally understand that, because I was, I was on the verge of thinking, Oh, god, I really don't want to talk about this, because it is, in the past, and erm, you know, it's not nice to think about it' Academic staff.

For others, the experience, whilst difficult, seemed to prove helpful as well:

'I think actually it's been quite cathartic, I mean it's been quite hard to relive some of that, but actually it's been quite an interesting conversation … so it's been good, it's been helpful' Senior leader.

Once again, my observations of staff members' emotional responses during the interview, suggest to me that the experiencing is not over for them. They continue to bear the weight.

5.4.2.6 Cultural Stories

I heard throughout staff members' accounts that their experiences appear to be situated in the cultural stories, the structures, attitudes, and ideas that reside in their teams, departments, and institutions within which the event, and their response to it, is happening. In my reporting of these findings throughout the previous categories I have often highlighted these cultural contexts and influences as I have noted them. I noticed how staff experiences appeared to be affected by the structures of response within the HEI; collective attitudes and ideas about student suicide as an event at the particular HEI; and cultures of work at the HEI, and within staff teams, regarding communication, collaboration, support. Furthermore, it seemed to me that ideas held by staff members about suicide, about responses, about being part of a team, about roles and expectations also informed their experiences. These staff members' experiences also appear to be situated within a wider cultural set of beliefs and ideas about suicide in general, and about student suicide in particular; ideas that are influenced by societal behaviours and belief systems; religious belief systems and media messages and responses to suicide and student suicide.

Organisational Provision

Some staff shared their feelings with me that provision of support was unfairly distributed across teams. For instance, the inference in this participant's account is that one team were seen to be visibly struggling and so were offered extra support; whereas another team may have been

experiencing a struggle of equal proportions, but due to differences in team culture, be less likely to display that struggle openly:

> *'I think one of the things, erm, which grates a little bit is, so I know [another group of staff], … I think they had erm, they had an away day to help them to deal with – which is great, but that's not, that wasn't offered to us, [unclear], … and I think there is a taking for granted when you when you do a good job, that taking for granted that it doesn't have an impact on you*' Student facing staff.

For another staff member, it was the very purpose and structure of an academic institution that prompted reflection, posing the question of whether the HEI itself were the best placed organisation to manage the aftermath of a student suicide:

> *'it's not a criticism, it's just how, the university's not set up, as you probably know, the university's not set up as a crisis team, it's not set up as a mental health team, it's not set up as a support service really, it is set up as an academic institution with student support to help students in their academic life'* Academic staff.

Together, these two viewpoints suggest staff members have perceptions of institutional lack or even failure in responding to a student suicide; the first account focusing on personal experience of a patchy and unequal response toward supporting staff members; the second account taking a more holistic view and identifying that this lack may be explained through understanding the core purpose of an academic institution. In both instances, I heard how the kinds of perceptions that staff hold about their institution further inform their experiences; that is, it wasn't just how they were looked after that affected them, it was the beliefs that they held around their experiences that added either a greater sense of injustice, or provided a clarity of explanation for them to hold on to.

Cultures of support

In terms of team and peer support amongst staff however, I heard stories of positive experiences of being part of a supportive and well-established team. Some staff spoke to me of a sense of belonging and mattering that supported them through the challenges. Accounts like the ones below led me to understand that team cultures were playing an integral part in staff perceptions of being supported:

> *'they're just like, we're one big family here anyway, no matter what goes on at work or at home we support each other all the time … sometimes I would say a, a good cry gets it off your chest, you know you can do that in front of your friends here and your work colleagues because it is like one big family here, and everybody does support everybody'* Facilities staff.

> *'and we look after each other you know, I trust [my colleagues] one hundred percent, [my colleagues] and I have known each other for years, we get on very well, and we kind of manage it in our own way, chatting and, you know again it's actually a really nice part of the job, to work that closely with people'* Academic staff.

Other staff accounts suggested to me that a sense of being supported came from knowing that others shared the same experience:

> *'what is a great help is your colleagues if I'm really genuinely honest, because you are all going through a similar situation, everybody experiences loss in different ways but, you're all in that situation'* Senior leader.

The voices reported in this section are those who spoke of finding their own sources of support by drawing on the culture of their team or their institution even when formal offers of support may have been lacking. When I read these quotes alongside those in previous categories I note a difference of experience between these voices, and those that highlighted lack of access to support such as the facilities staff who lack the professional networks that wellbeing staff might benefit from, and for whom 'supporting' is neither part of their professional skillset or language.

Creating Culture

In some accounts I heard how staff recognised a role for organisational culture in shaping ways of responding:

> *'it's definitely worth saying that the culture within an organisation erm, I certainly know, from working with postvention with [a charity] in [other institutions] is about culture making a big difference in terms of how other people respond and how they manage the situation'* Student facing staff.

Some staff accounts indicated to me that culture was seen as malleable, in that it can be shaped by the choices that individuals and teams make:

> *'and that asking for help is something that we all should do and not feel that we can't, but then I guess part of that is the culture that you create'* Student facing staff.

For some staff it was clear to me that the event triggered aspirations and hopes for how things could be done differently. This staff member is talking about how postvention training might become part of a wide integrated conversation within a culture of responsiveness:

> *'in an ideal world I'd like to make sure that it was embedded all the way through academic induction, that we did regular training and refresher training, we created space for discussion, conversation and we still, we don't do as much as we, as I know we'd all like to do, erm, so there, there's still work to be done for us, yeah'* Senior leader.

I notice here that these accounts come from staff members who may perceive themselves as holding power in terms of being able to influence or shape team and institutional cultures. I heard these ideas expressed by senior or managerial staff members; not by facilities staff or front-line academics. This suggests to me that there are inequalities of perceived power at play in terms of how culture is

experienced and whether or not individual staff members perceive themselves as having any role to play in creating cultures.

Other staff members shared with me that change was already apparent:

> *'we've got broader support now, you know, policies and procedures and institutional buy in, but at that time it was, I mean, what happened last year very much acted as a strong push to change things, so we've recruited way more into our student support, we've got out of hours support, we've got different policies and procedures in place'* Academic staff.

> *'I've worked with the team to massively change the service since I [started working there] in the sense of trying to prevent some suicides, so we now offer students safety plans … we're trying to make the service more accessible, but we're working hard to have different entry routes that are really informal, we've set up an informal … evening … drop-in'* Student facing staff.

Not all staff used the word 'culture' in their accounts, however, in listening to the aspects of their stories that talked about 'how we do things' and 'how we might do things differently' or 'how we are doing things differently', I was prompted, by the collective 'we' in their narratives, to consider that these were 'cultural' stories. Furthermore, these accounts of ideas, actions and change-making, showed me how, for some staff, their behaviours and choices were integral in creating cultures in response to their experiences.

5.4.3 The Core Category: Bearing Witness

The core category in this grounded theory encompasses and draws together all that has been reported in the previous six categories. In recounting the categories above, I have highlighted a number of ways in which the 'bearing' of the event has felt to me to be present in staff accounts. I suggest here that it is in bearing witness to a student suicide that all subsequent responses and experiences are shaped; and it is through the acts of responding and the processes of experiencing

that staff members do 'Bear Witness'. From the beginnings of the experience, the discovery of a body, or hearing news of the death, these staff members became witnesses to the death by suicide of a student. The term 'bearing' feels fitting to me as staff members experience a sense of having to carry this knowledge, the weight of what has happened, the awfulness of the death and the realisation of the implications. Staff shared with me a sense of being burdened by a terribly sad and horrible reality:

> *'It's terrible to think a young adult who I interacted with on a weekly, if not daily basis, was struggling to such an extent that they felt that suicide was their only option.'* Academic staff.

There is no way for them to walk away from this reality. In their accounts I hear no question that it is their job to respond. The bearing appears non-negotiable, as if it is unavoidable.

Being a responder and the ways in which staff members respond are shaped and made more awful or urgent or challenging by the fact that a student, a young adult 'in their care' has felt that their only choice was to end their own life. It is not only that the student felt so awful, or hopeless, but also, that no one was present with them to stop them. For staff who find themselves undertaking tasks in this context there seems to be some kind of amplification to the nature and purpose of the task that wouldn't otherwise be present. In listening to staff accounts of responding and how they responded, there is an urgent desperation present that seems to be not about doing the task, but about doing it in the context of a student's suicide. I felt a sense, from listening to staff, that, if the unsayable is true, that we failed this student, then we must, absolutely must, get this bit right:

> *'we managed to obviously do what we did to get everything done er within the timescale that we sort of had it done with, erm, I don't think there is anything more that we could have done … can't think of anything else that we could have done for [the student] really'* Facilities staff.

As staff see the deceased student, or are present at the place of death, or in the student's flat, with the student's housemates, so the student starts to become a person. Staff accounts illustrated to me

that they start to see, or witness, or learn about the student. As this happens, so their perceptions of awfulness grow and amplify their sense of needing to respond now, quickly, professionally, empathically, discreetly, and as fully as is possible. A weight of responsibility is palpable to me through the accounts; not necessarily for the death, but rather, for having to 'get it right':

> *'I mean I was actually in the end I was quite bossy, cos it was like, right this is what we need to do'* Facilities staff.

This was sometimes in the context of not knowing how to get it right (due to lack of previous experience together with multiple unknowns, such as, what would the parents want us to do?). It felt to me like a precarious tightrope for staff, who try to keep their balance by constantly checking, communicating with each other, meeting with each other, referring to guidelines, seeing what others are doing and taking guidance from the behaviour and responses of others within and beyond the HEI.

In and through these activities and responses staff bear witness not only to the death of a student, but to the beginnings of the impact of that death. To the involvement of emergency services and maybe other agencies, to the presence of media who urgently wish to 'bear witness' on behalf of the public. Also, to the reactions of housemates, their panic, shock, astonishment, disbelief, grief, horror, anger, denial. Indeed, to the impact that this death will have on these students as their lives move on, whilst that of their housemate, their friend, their peer, has stopped forever.

Some staff bear witness to the responses and behaviours of parents and family members as the news is broken to them; witnessing their pain, horror and disbelief; or equally, witnessing their strength, their containment and their ability to face the world. Wider communities throughout the university such as course groups or club mates will also learn the news. It is staff members who inform them of the suicide, who witness their reactions, who support them and guide them through the process of learning that their peer, their friend, their team mate has taken their own life.

> *'It was my responsibility to inform the student's peers what had happened and manage their needs. In particular making sure they knew who to talk to and how to access counselling and bereavement services ... It's vaguely within my job description, though not explicit. I'm in charge of the programme so I had to perform certain duties as part of my duty of care towards the students.'* Academic staff.

What was palpable throughout these staff accounts is that bearing witness, however, doesn't just happen through the doing of things and in the seeing of things. It also seemed to happen in the being of people; in the processing of things; in the construction of ideas; in perceptions of closeness; in feeling and reflecting on their personal responses to what has happened. It was embedded in staff accounts in their processes of recalling what they had to do, how they did it, what they saw, what they said, what others did, and saw and said. This leads me to suggest that as perceptions and reflections are processed it is all borne within the context of a student's death by suicide. This bearing witness shapes the sense of fears and the recognition of needs. Again, it is all within the context. Having just experienced it all, the immediate fears of somehow being responsible, of having missed a sign, got something wrong, failed to do their job, to keep a student safe. These are fears that carry the weight of a student's life. Either that of the student who has died, or those of other students who may be yet to die.

> *'but there's actually no guarantee that there's not going to be three or four [more suicides] coming up and, and that would floor us I think, cos then you just feel, one the awfulness of it and then two you feel quite helpless, you know, that the stuff you've done [has made no difference]'* Academic staff.

Needs emerge, but it may be that they feel selfish, self-indulgent, or superfluous given that somewhere another adult is coming to terms with the loss of their child. Needs, however, may also generate a place to position blame or to offload responsibility, 'I wasn't trained for this'; 'the

university isn't looking after me'; just as 'they' let that student die, so 'they' are leaving me alone with the pain that has come from that death.

> *'Management in many ways treated the death of students as a crisis to be managed and forget that the staff closest to the student are not just their job role but also people impacted by the event. I therefore felt unsupported by my employer in terms of giving me the space I needed to make sense of what had happened. I felt like I was a tool allowing more senior managers to demonstrate their management abilities to even more senior managers. This felt vulgar and upsetting given what had just happened.'* Academic staff.

Experiences of support are shaped by the re-visiting of what has happened, perhaps the re-living or re-feeling, but maybe also the off-loading and feelings of relief and then guilt about that relief. Having borne the burden, been the witness, carried it throughout, is it ok to put it down? Who will remember the student, the happenings, if I don't? Is it ok to put this down when others can't? In attempting to move on am I neglecting this student's needs again? It is the case, for some staff who are witness to the aftermath of a student death by suicide, that the bearing continues long after the death.

> *'This worry about other students continues to this day and impacts most on my life. There is always a concern that anything you do might affect a student, so it impacts on student interactions, teaching practices and generally feeling comfortable in the role.'* Academic staff.

5.4.4 A grounded theory

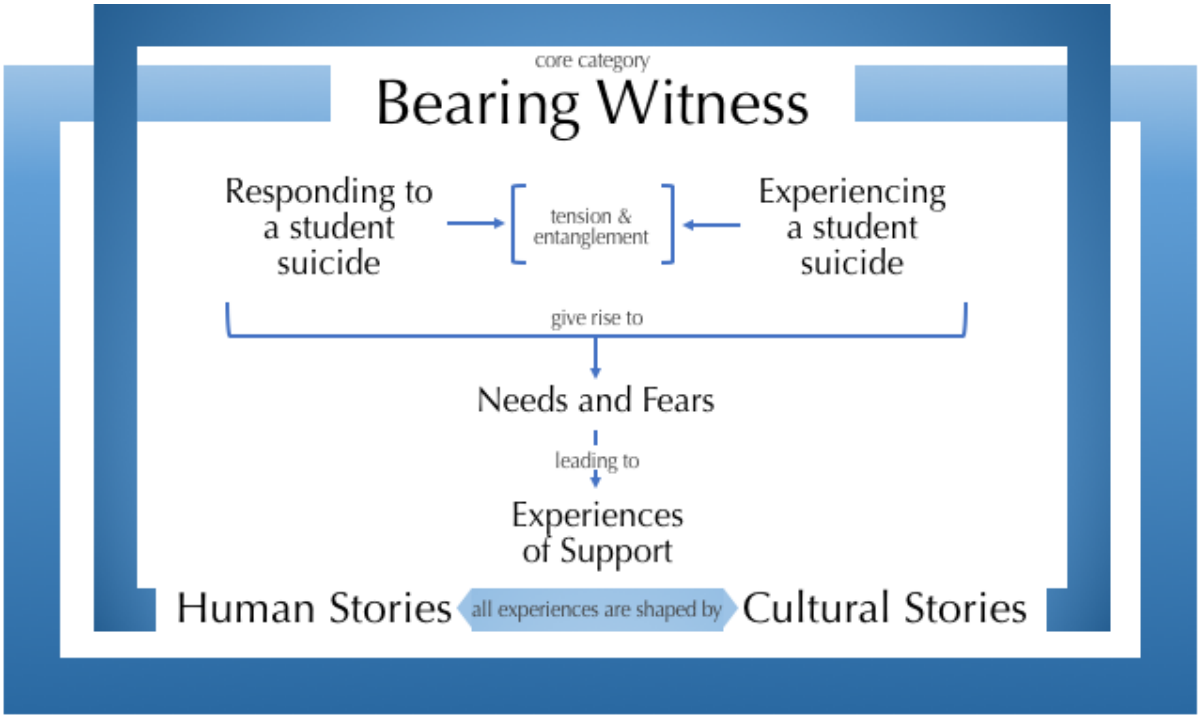

Figure 6: A grounded theory of the experiences of staff in UK HEIs who are exposed to a student death by suicide

Figure 6 illustrates that 'Bearing Witness' is the core category. It is the experience that appears to shape or define all subsequent experiences as detailed above.

The categories of 'Responding to a Student Suicide' and 'Experiencing a Student Suicide' illustrate a tension that is evident between the 'professional' and the 'human', between the tasks and the self, between the needs of others and the needs of the self. There is no time to process, to feel, to respond emotionally as all the time is consumed with the doing of things. Staff members, however, acknowledged their need to do the processing, the feeling, the emotional responding, but, on the whole, they didn't have the time. One respondent writes that 'the university' took care of certain arrangements which 'allowed me to concentrate on dealing with [my own needs]'. However, of course, 'the university' is in fact other staff members, who themselves also have needs that remain unchecked.

As the staff member moves through the experience they appear to switch from one mode of being to the other. This is a process that does not appear to be comfortable or smooth for staff members, who subject themselves to constant self-checking and self-judgement. At the core of this tension appears to lie a fierce sense of professionalism within a culture that prioritises the needs of others over the needs of the self.

The experiencing of a student suicide for staff members appears comprehensively entangled with the undertaking of tasks following the suicide; it is not the tasks by themselves that cause the emotional responses; nor is it the sole fact of a student death by suicide; rather, it is the entanglement of undertaking of tasks within the context of a student suicide, and all the accompanying narratives that are attached to student suicide. So, whilst the staff member experiences the opposing pull of tasks against self; also, it is the undertaking of the tasks that further shape the way that the staff member experiences a student's death by suicide.

This complexity of 'Responding' and 'Experiencing' gives rise to 'Needs and Fears', these are different for each person, but they both come from and shape the staff member's cognitive and emotional responses to the suicide. Fears are often in relation to others, other students in particular, but sometimes staff in other job roles. Other fears arise from the processes of self-scrutiny and checking that nothing was missed. 'Needs and Fears' generate steps toward the staff members' 'Experiences of Support', where they either do or don't engage with support. Staff may experience offers of support, or they may seek it out independently, it may be formal or informal, experiences may be positive or unsatisfactory, and opportunities to access support may be unequal.

The experiences of 'Responding', 'Experiencing', 'Needs & Fears', and 'Support' are all further shaped by the two remaining categories. 'Cultural Stories' and 'Personal Stories' describe the contexts within which staff members are living their experiences. Internal 'personal' contexts, such as personal experiences with suicide and grief shape responses and needs. The staff member's capacity to be self-supporting, to call on personal strategies and networks shapes their capacity for coping and for

recovery. External 'cultural' contexts also shape experiences. These are the cultures that exist within the HEI, for instance, cultures of caring or of community, of responsibility, or of power. Whilst participants, on the whole, didn't talk about 'culture', there were in the data, clear inequalities in experience between people in different job roles, different teams and with different responsibilities. Work place, team, and professional cultures appear to make differences to individuals 'Experiences of Support'; to the availability of support to them (eg. professional networks; informal team cultures); their ability to ask for support; and their choices around accessing the support that was available and feeling that it met their needs. For instance, the role of the manager appears integral to the individual's experience of support, and of availability of support resources. Managers appeared to have accessible support resources available and the knowledge required to access them. However, they appeared to feel unsupported and were stressed that their energy was spent supporting others. Beyond the HEI, further cultural contexts at societal level, for instance, commonly held beliefs about suicide, and about student suicide in particular, might further shape the staff members perceptions of what has happened. This grounded theory suggests that 'Personal Stories' shape the experiencing of the event and 'Cultural Stories' shape the context within which that experiencing happens – which in turn is itself 'experienced'.

Chapter 6

Exploring the experiences of HEI staff following a student death by suicide:

A discussion of findings

6.1 Chapter Overview

In this chapter I present a discussion of the findings from the second study in this thesis pertaining to the experiences of HEI staff following a student death by suicide. I discuss the findings thematically in five sections. The first two sections respond to my two research questions that underpin the thesis. Firstly, exploring how HEI staff members experience a student death by suicide, by discussing their perceptions of impact. Secondly, exploring HEI staff experiences of undertaking tasks following a student death by suicide. In the subsequent three sections I discuss key aspects of the experience that shape staff members perceptions of impact and of undertaking roles. These aspects of experience are rooted in the inductive findings constructed in the grounded theory analysis. They are, the role of participants' personal stories in shaping their experiences; ideas of belonging and perceptions of closeness; and the cultural stories that shape staff members experiences. I discuss the strengths and limitations of this study, including a discussion of the methodological challenges that I encountered in the course of the study. In a brief conclusion I set the scene for Chapter 7, the thesis conclusion.

6.2 Perceptions of impact

In seeking to understand the kinds of impact perceived by HEI staff following a suicide, in this section I discuss the extent of impact felt by participants in line with the continuum of suicide survivorship (Cerel et al., 2014). I will discuss the kinds of responses that staff members described in the context of current knowledge.

6.2.1 Exposed, affected or bereaved?

Eighteen of nineteen participants perceived themselves to be impacted by a student suicide; the remaining participant stated that they felt unsure of whether or not they were impacted. Participants were asked to identify their perceived level of impact following the death by suicide according to descriptors that were adapted from the continuum of suicide survivorship (Cerel et al., 2014). The model describes four levels of impact after a suicide, from those who are exposed to a suicide death, that is, 'anyone who knows or identifies with someone who dies by suicide' (Cerel et al., 2014, p594); through those who are affected, described as those who experience 'significant psychological distress' (Cerel et al., 2014, p 595); to those who are bereaved, with bereavement being either a short- or long-term experience. The continuum is illustrated in figure 7.

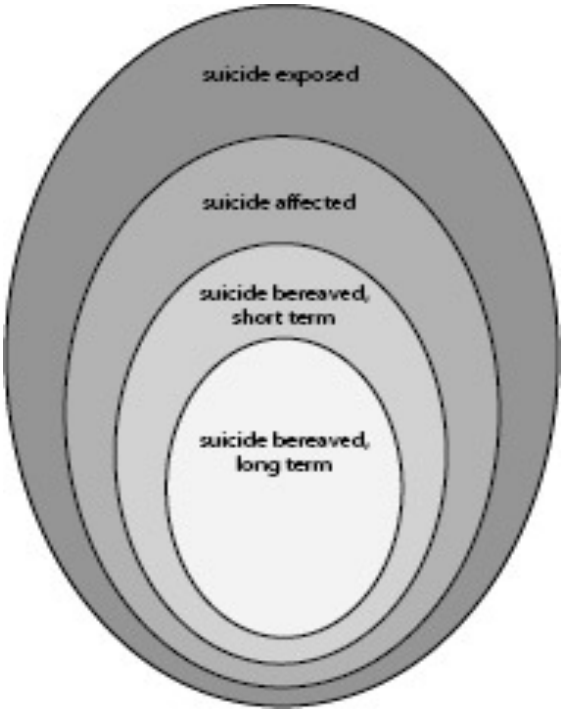

Figure 7: The continuum of suicide survivorship (Cerel, et al., 2014).

Seven participants self-identified as being 'exposed' to a suicide. Those who perceive themselves as 'exposed' will experience responses that are mild and brief (Cerel et al., 2014). Of these seven staff members, four were members of student wellbeing teams, one was a member of the executive

team, one a facilities worker and one an academic. This aligns with Cerel et al. (2014), who state that those who perceive themselves as exposed might include those who are part of the same community, be that a neighbourhood, workplace or educational setting, as well as first responders and those who discover the body of the person who died. The largest proportion of participants, 11 staff members, perceived themselves as being 'affected' by the suicide, this group included two members of student wellbeing teams, four members of facilities teams and five academics. Those who are affected by a suicide death are described as experiencing significant psychological distress (Cerel et al., 2014). According to Cerel et al. (2014) those who are affected might include those who have experienced a previous bereavement by suicide, but who would not be considered bereaved by this suicide, for instance witnesses, housemates, close friends, colleagues, team members, first responders and those who might discover the body of the deceased. So, it appears that Cerel and colleagues are suggesting that the same groups (eg. first responders) may have differing perceptions of impact and that this is likely to be due to the impact of previous experiences with death by suicide, on the experiencing of this death by suicide (Cerel et al., 2014). This wasn't an aspect of HEI staff members experience that was specifically explored in the current study. However, whilst some participants did discuss previous personal or professional experiences with suicide, others, shared that this was their first experience of suicide. It is clear then, that there are other elements of the experience, beside previous exposures to suicide, that lead to staff members feeling affected by, rather than exposed to, the student suicide.

One participant self-identified as being 'bereaved' by a death by suicide, an academic member of staff. The suggested cohorts who may experience a short-term bereavement include family members, therapists, friends and close work colleagues; whilst those who might experience a long-term bereavement include, family members, close friends, and therapists (Cerel et al., 2014). The participant who perceived themselves to be bereaved, was not a member of any of the groups identified by Cerel and colleagues (2014), unless the teacher student relationship could be defined as being that of 'close work colleagues'. Despite the small sample, this is an important finding as it

reveals that some staff at a UK university have potential to experience bereavement following a student suicide. Perceived impact following a suicide death relates to the likelihood of depression, anxiety and experiences of PTSD (Cerel et al., 2017), with those who perceive the greater impact having an increased likelihood of mental ill-health or psychological symptoms. This suggests that HEI staff members affected or bereaved by a student suicide may be susceptible to associated mental ill-health or PTSD symptoms.

The continuum and associated definitions provided by Cerel et al. (2014) were proposed 'as a way of clarifying future research and postvention efforts, both by promoting use of a common language and by inviting attention to the qualitative and quantitative differences in the impact of suicide on others across the continuum' (p 594). The model is presented in a paper that explores the history of postvention in academic literature highlighting a lack of consistency and agreement around the language used to describe those people who have been impacted by the suicide death of another. The model therefore, is a proposal, not based in research evidence, but in the opinion of the authors. In their paper, the authors set out a range of steps that they suggest be taken to authenticate and test the model, however there are no known publications that evidence these further steps have been taken (Cerel et al., 2014). Despite this lack, the model has already had considerable impact as it has subsequently been used as definitional criteria in national guidance for supporting those exposed to suicide in both the US National Guidelines (Survivors of Suicide Loss Task Force, 2015) and the UK Guidance to providing local services after a suicide (Public Health England, 2019). As such, it informs the kinds of support, if any, that may be available to different groups at community level or within organisations. Therefore, it is important to examine the accuracy of the model. The findings of my study show that people other than those identified in Cerel et al's. (2014) categories can perceive themselves to be affected or even bereaved. These findings lead me to question whether the categories are too prescriptive in terms of the kinds of people that may fall into the different positions of being exposed to, affected by, or bereaved by a death by suicide on the continuum model. Recent knowledge has expanded to include wider networks of people amongst those who are

impacted (Honeycutt & Praetorius, 2016). My findings may mark a further expansion of our knowledge, as they suggest that perceptions of impact amongst those in wider networks have potential to be diverse and can include perceptions of being bereaved by a suicide. If national provision is based on meeting the needs of people as categorised by Cerel et al. (2014), it might be that adequate or appropriate support is not accessible to everyone who requires it, for instance, those within a HEI setting. Perhaps, rather than making prescriptive suggestions of who might sit in each of the categories, the model could instead work with the self-defined perceptions of individuals. As such, in informing service provision, a responsive multi-tier model that is accessible to any individual regardless of their relationship to the deceased would provide a more inclusive community level response that would be accessible to all HEI staff members. As I write this there is no known published literature that has utilised these descriptors in a similar way to measure perceptions of impact amongst populations exposed to suicide. This is clearly an area in which further study would be of great benefit to address questions regarding the potential of these descriptors in ascertaining impact, or of refining or further developing the descriptors for specific populations, such as those who come into contact with suicide because of their job role.

6.2.2 Experiencing a student death by suicide

Participants initial responses to the suicide included panic responses, followed by a range of emotional responses such as shock, sadness and bewilderment. Additionally, ongoing physiological responses such as sleeplessness, and psychological responses such as visions and intrusive imagery associated with the suicide were experienced by staff members from across different job roles. These experiences are aligned with those reported by other groups of practitioners, for instance, health professionals experienced emotional turmoil and stress reactions following a client death by suicide (Castelli-Dransart et al., 2017); and therapists experienced severe distress following a patient suicide (Wurst et al., 2013). Processes of questioning, reflecting on their own role or responsibility in the context of the death, and fears of having failed the student, were also evident for some participants.

This aligns to some extent with the experiences of secondary school teachers who increased their use of existing protocols and altered their management of potentially suicidal students following experience of a student suicide (Kõlves et al., 2017). In addition, such experiences of fear, self-scrutiny, blame, professional doubt, and fear of legal consequences are present for other health practitioners (Castelli-Dransart et al., 2017). Mental health front-line staff have also evidenced feelings of responsibility for the death (Gaffney et al., 2009). Therefore, I suggest that the initial emotional and psychological responses of HEI staff are aligned with those of other health and education professionals.

In terms of the undertaking of crisis response tasks, and the impact that they have on HEI staff, there is greater similarity with the experiences of first responders. Security staff in a HEI setting may be the first at a scene and become involved with tasks that stretch them beyond their usual job role, such as performing CPR, or witnessing and having to manage the distressing responses of others, such as housemates, who are also present. Ambulance staff, likewise, experience this sense of being stretched beyond their usual job role in having to inform people of the death of a loved one, or preserving a potential crime-scene (Nelson et al., 2020). Front line health and emergency services professionals experienced feelings of inadequacy when faced with the emotional responses of suicide bereaved people; they felt unable to offer solutions as they doubted their own capacity and lacked supportive guidelines; they reported feeling torn between different responsibilities; and they shared that they used emotional shutdown as a means for preservation (Nilsson et al., 2017). The security personnel in this study who were first responders at a student suicide reported experiences of flashbacks and uninvited imagery after the event, together with sleeplessness and anxiety around performing certain work duties such as safe and well checks. Once again, the experiences of ambulance staff appear to hold similarities. The impact of responding to suicide deaths for ambulance staff includes ongoing salient memories of the events they have witnessed; feelings of being haunted by events; interference with sleep; and feelings of personal distress and vulnerability (Nelson et al., 2020). Findings of the current study show that members of facilities teams, who were

most likely to be involved in crisis response tasks, or who undertook tasks of clearing and cleaning the student's room after the death, were more likely than other staff groups to report psychological needs in connection with the suicide and with undertaking tasks. Indeed, Knieper (1999), affirms that there is a risk of trauma to an individual who witnesses a death or discovers a body following death. In addition, for another group of workers, railway workers, contact with the corpse was amongst the factors that increased negative reactions following a suicide death (Bardon & Mishara, 2015). These findings position the experiences of first responding staff members alongside those of professional first responders, who, despite being specifically trained for their role, continue to experience struggles when faced with incidences of suicide. My study is the first one that has gathered data regarding HEI facilities staff members following a student death by suicide, however, their role in supporting student wellbeing has been recognised by the charity Student Minds (2017). Their report on student living and supporting student mental health in university accommodation acknowledges the skills required and the need for training to develop those skills by facilities staff in order to fulfil this aspect of their role (Student Minds, 2017). Indeed, Student Minds advocate for attention to be paid to the wellbeing of facilities staff who are often on the front line in noticing, reporting and responding to student wellbeing crises (Student Minds,2017). The findings of my study further strengthen such calls for skills training and postvention support for this specific and often over-looked group of HEI staff members.

Participants also engaged in processes of reflection and searching for meaning in seeking to understand why the student had died. One aspect of this reflective wrangling was the perceived challenge of the fact that a young person had chosen to take their own life. It might be in this aspect of participant experience, that a socially constructed idea of suicide, that embraces cultural, political and relational contexts, rather than the dominant individual, psycho-centric construction, might aid staff members in reconciling their struggle for understanding (White, 2012). The search for meaning has been evident as part of the grief process for those bereaved by suicide (Bottomley et al., 2018; Ross et al., 2018). The findings of the current study demonstrate that it is also part of the process for

those who are amongst the wider network of people exposed to and affected by, but not necessarily bereaved by a suicide death. This adds to our current understanding; whilst other groups of practitioners have evidenced processes of rumination around their own role or responsibility in the context of a client or patient suicide (Gaffney et al., 2009) it has not been reported that they experience similar searches for meaning as experienced by family members, close friends or others who are bereaved rather than exposed or affected (Ross et al., 2018; Owens et al., 2008). In this aspect then, the experience of HEI staff may be unique and is more closely aligned with the experience of those who are bereaved rather than with those who are affected or exposed following a death by suicide.

My exploration of the impact on HEI staff members following a student death by suicide has highlighted a number of novel findings. Perceptions of being bereaved by a suicide can be experienced by people who are in the wider networks around the deceased. Additionally, perceptions of being affected by a suicide, rather than exposed to, are not solely connected with previous experiences of suicide. It is clear from my findings, that when asked to self-identify their perceptions of impact, that HEI staff identify more broadly across the continuum of suicide survivorship than might be expected according to the criteria set out by Cerel et al., (2014). Furthermore, experiences of impact for HEI staff members appear complex, including experiences similar to those of other practitioners who had a professional relationship with the person who died, and to those of first responders who had no previous relationship with the person who died. In addition, participants in my study evidenced processes of meaning making similar to those reported for family members who are bereaved following suicide. It appears therefore, that the kind of impact experienced by HEI staff combines aspects in common with all three of these previously studied groups. The result is a complex and unique experience previously unreported for other groups of people who come into contact with suicide because of their job-role. The reasons for the unique nature of the experience may be situated in aspects of the HEI setting and the kinds of relationships that exist within that setting. I will explore these ideas in subsequent sections of this chapter. The

findings I have discussed above highlight that a broad view is needed in supporting HEI staff with regard to the kinds of impact experienced and the ways in which impact manifests. For instance, it is clear for this population, that those who perceive themselves to be exposed or affected may share post-event experiences similar to those who are bereaved. Experiences are not defined by the job-role of the individual nor by the tasks that they undertook following the suicide.

6.3 Undertaking tasks following a student death by suicide

6.3.1 Experiences of HEI staff who undertook tasks following a student death by suicide

The findings of my study show that a small number of HEI staff undertook a large number of tasks following a student death by suicide. Whilst it is unlikely that the data represent a complete record of all tasks undertaken, it is clear that individual staff members took on a range of diverse tasks that included roles or activities that would usually be outside their job-role. Tasks undertaken fell into four broad groups: crisis response tasks; strategic tasks; support tasks; and practical and administrative tasks. When a suicide death occurs in a domestic or public setting it is likely that such tasks are undertaken by a range of different people. For instance, first responders such as ambulance or police personnel would undertake crisis response tasks; family members or health professionals would undertake practical and administrative tasks; family members or those closest to the person who died would also take control of decision making around sharing the news of the death with wider networks; and medical or public health agencies would undertake roles such as providing postvention support for family members and close friends of the deceased. In a domestic or public setting, the kinds of tasks undertaken by HEI staff members, are disseminated across diverse parties who have distinct and specific roles and who are connected to each other only by the death of one individual. As such, HEI staff take on more tasks than individuals involved in responding in domestic and public settings. Additional tasks undertaken by HEI staff, are those that were grouped as the strategic tasks. Such tasks are largely related to the very nature of the HEI as an organisation, in that they are underpinned by organisational policy and guidance. Such tasks might include internal and

external communications; staff management; and response management and planning. A majority of the strategic tasks would not arise if the death were to occur in a domestic or public setting.

HEI staff are positioned as the providers of postvention support following a student death by suicide. This responsibility is evident in existing guidance (Centre for Suicide Prevention, 2016) where the teachers' role following a student suicide is to be informed and skilled and to provide support to the students; there is no acknowledgement in this guidance that teachers or other staff may be impacted and need support. In taking on the role of providing postvention support within the HEI, further tasks are created for staff members who may already be in a position of experiencing stress or trauma impacts from their involvement at the crisis response stage. Provision of postvention is focused on supporting others within the community rather than themselves. Participants in my study evidenced that they felt responsibilities toward other students and to their colleagues in terms of providing support and care, yet at the same time were dealing with their own emotional and trauma responses to the suicide. My findings suggest that it is the very nature of the HEI as a large and complex organisation that creates the situation in which diverse staff members across a range of job-roles come together to co-ordinate a pro-active, hands-on, holistic response to a death by suicide. They do this whilst also needing to find a way to manage their individual responses to the event.

6.3.2 Experiences of other groups of staff who undertook tasks following a suicide

There is a notable gap in the literature regarding the kinds of tasks that practitioners or responders undertake following a death by suicide. As such, it is difficult to set the findings of my study within the context of wider knowledge. I undertook searches to inform this discussion to source studies that explored the experiences of staff members following a death by suicide in settings, that, like a HEI, provide both a service and accommodation to the users. Such settings included residential care, nursing homes, therapeutic settings, supported living settings, and boarding and residential schools. I identified only two studies that explored or reported on responses to a suicide death in a residential setting. Ponce and Smith (1989) report on the impact of the suicide of an adolescent male whilst in

the care of a residential treatment centre; whilst Maas & Ney, (1992) explore the implications for staff in residential child care settings of suicidal behaviour, not necessarily resulting in a death by suicide. In common with HEI staff, staff in residential care settings become the first responders at the point of crisis (Maas & Ney, 1992). Ponce and Smith (1989) detail that staff members undertook crisis response tasks as well as dissemination of information to other children in the treatment centre; considerations around how to disseminate the news, and what aspects of information to share and with whom; supporting other young people in the treatment centre; management of contagion risks; liaison with the family of the deceased child; liaison with the families of other children in the centre; and management of legal and reputational issues. In these accounts, there is commonality with the experience of HEI staff in the type and variety of tasks undertaken. To support them in responding to a crisis and undertaking diverse tasks HEI staff reported the usefulness of having a pre-prepared strategy for response, and those without such a strategy reported that this lack affected their sense of being in control and feeling confident in their response. In a residential child-care setting, the role of policy and procedure are highlighted as tools for supporting staff in being prepared, and knowing what they would need to do in the case of suicidal behaviour (Maas & Ney, 1992). In both settings it seems that a robust procedure removes the requirement for on the spot decision making at the point of crisis, instead providing clear direction and guidance. It was clear however, that for HEI staff access to such a plan was not certain and thus, a clear suicide response plan, that staff are familiar with prior to the event, is vital within HEI settings.

The fact that a limited number of HEI staff members appear to take on a considerable number of diverse tasks might raise questions around the distribution of tasks across teams and individuals. However, there are potential advantages such as containment, efficiency of communication, and providing limited yet consistent key contacts for impacted students, that might promote the involvement of limited staff members. Whilst some staff members shared that they felt over-whelmed by the event, or by individual tasks, none stated that they felt put upon, or expressed resentment at undertaking such tasks. This suggests that if anything needs to be done differently,

that it be in terms of providing support around the staff who are involved, rather than making changes to the nature of their involvement. Staff often appeared to be supporting each other, whilst also undertaking challenging tasks, including supporting students. Indeed, my findings evidence a tension between the categories of responding to a student suicide and experiencing a student suicide.

6.3.3 Tension and entanglement

In responding and taking on tasks, HEI staff shared that there was little space for the experiencing; however, when participants did 'experience' the event, their processes and perceptions appeared to be shaped by their experiences of undertaking tasks. So, there was an entanglement of the doing of tasks within the context of a student suicide, with the experiencing of personal emotional responses to the student suicide, that created a tension within the overall experience. Likewise, in a residential treatment centre, decisions and tasks were all performed by staff members who were also managing their own reactions to the suicide (Ponce & Smith, 1989). As such, the authors report the complexity for staff of dealing with their own grief responses whilst also supporting the residents and their families, suggesting that 'this may be asking too much' of staff (Ponce & Smith, 1989. p. 49). Indeed, they emphasise the importance that any response or postvention plan should include measures to support staff needs as well as those of the residents (Ponce & Smith, 1989). Interestingly, Maas & Ney (1992), report a strategy of response that might go some way to providing a solution to these staff experiences of entanglement and feelings of overwhelm. Recommendations for residential child-care settings are that staff be supported in two aspects of response, firstly in containing the crisis, secondly in processing the crisis (Maas & Ney, 1992). Guidance suggests that staff who are involved in crisis response tasks are then provided the space and support necessary to deal with their emotional and grief responses, whilst other staff are bought in to undertake ongoing tasks pertaining to the other residents, wider communications, liaison, and administration (Maas & Ney, 1992).

Additional individual support should be offered to staff members who perceive that they need it, indeed, the guidance suggested by Maas & Ney (1992) positions the needs and support of staff as being of equal importance as those of their residents. This idea is in contrast to the perceptions of HEI staff, who appeared to place the needs of students before their own. Raising the question of how staff might be encouraged to shift their attention toward their own needs, and engage with support, rather than focussing on offering support to others. Findings of my study evidence that student facing staff and executive staff members who attended the site of the student death were then involved in numerous ongoing tasks in the following days, weeks and sometimes months. The guidance proposed by Maas and Ney (1992), may therefore be helpful in attending to staff needs in a HEI setting, by distinguishing between the crisis response tasks and the subsequent support, strategic, and practical and administrative tasks, and ensuring that each group of tasks are assigned to distinct individuals or teams.

Whilst the findings of these two papers appear to align with the findings of my study, I have noted that this is a very limited and by no means recent literature, that explores the experiences of staff members in a setting that differs considerably from a HEI. It appears that the experiences of staff members undertaking tasks following a student, client, resident, or patient suicide remain largely unexplored across settings and job-roles. Indeed, Ponce and Smith (1989) note that no previous papers had reported on the aftermath of a suicide death in a similar residential setting. It remains currently unknown, therefore, whether the experience of HEI staff in taking on tasks following a student death by suicide is a unique one. However, my findings, in describing the range of tasks undertaken by HEI staff and the experiences of the staff who did undertake tasks are novel and make a considerable contribution to current knowledge, in providing an empirical account from which staff experiences can be understood and supported. Further research could explore whether these experiences are unique or similar across different settings.

6.4 Personal Stories

The findings of my study demonstrated inequalities in staff experiences of impact and support. Indeed, staff accounts evidenced diverse support needs. It appeared that some staff seemed better equipped to access support, for instance, utilising existing networks in both their personal and professional lives, or calling on existing self-care strategies. Other participants appeared however, to be waiting for support to be offered, or appeared unable to engage with the support that was offered or available. In this section I discuss a number of potential explanations for these differences and explore the role of previous life experiences and existing social supports in shaping staff perceptions of impact and support.

6.4.1 Help-seeking

There were noticeable differences amongst HEI staff in their attitudes toward needing or seeking help and support. For instance, some staff members reported that they chose not to engage with the support that was offered despite feeling unsupported. Avoidance strategies may be utilised for what are perceived by the individual to be good or necessary reasons, for instance, ambulance staff have been reported as using emotional shutdown as a means for preservation (Nilsson et al., 2017) and this behaviour aligns with the experiences of HEI staff in this study who reported having to put their feelings 'on hold', whilst dealing with the immediate aftermath of a student suicide. It might be that, having 'put feelings on hold', it is perceived by the individual as too difficult to shift back out of that status and re-engage with the feelings that arose, thus maintaining a strategy of avoidance. To set the experience of HEI staff within the wider context of suicide bereaved adults, it has been found that certain experiences may promote help-seeking behaviours. In a sample of 82 suicide-bereaved adults those who experienced more stigma and guilt associated with a death by suicide were more likely to seek psychological help (Gelzelyte et al., 2020). In addition, the strongest indicator of help-seeking is the attitude held by the individual toward mental health specialists (Gelzelyte et al., 2020). The issue of stigma may be different for HEI staff, who are not dealing with the suicide of close friend

or family member, rather with stigma attached to fears of responsibility and blame at both individual and institutional level. There may be a sense of stigma attached to needing psychological support. Indeed, World Health Organisation data has also shown that individual differences in the shape of attitudinal barriers along with low perceived need are more important than structural barriers in terms of preventing individuals from accessing support for common mental health disorders (Andrade et al., 2014). This idea requires further exploration to fully understand differences in help seeking behaviours in HEI staff.

6.4.2 The pro-active self

In their attitudes and behaviours toward help-seeking, self-care, and engaging with available support, some staff members in my study appeared noticeably more pro-active than others. Indeed, throughout the academic literature there are reports of inconsistencies in accessing support even when it is available, both for those who are bereaved following a suicide (McKinnon & Chonody, 2014; Trimble et al., 2012) and amongst practitioners (Halligan & Corcoran, 2001; Erlich et al., 2017). Proactivity has been defined as seeking new opportunities and promoting personal growth (Greenglass et al, 1999). In the context of my study participants, those that displayed proactive behaviours, did so to seek opportunities for help and support that would promote a sense of feeling better or supported or working toward healing from the impact of the suicide. So, individual differences (John & Srivastava, 1999) in terms of pro-active traits might offer some explanation for the differences in behaviours amongst staff members. This aligns with the reported behaviours of first responders who adopted 'approach' or 'avoidance' strategies toward help seeking that affected their experiences of coping (Arble & Arnetz, 2016). For instance, approach strategies require the individual to purposefully engage their efforts in understanding and processing their experience physically and psychologically. HEI staff members who purposefully sought out help appeared open to facing and talking explicitly about the discomforting emotional and psychological aspects of the event. Other staff members, in my study, who reported that they did not seek help, appeared more

reluctant in interviews to discuss the emotional aspects of the event. It might be that these individuals were using avoidance strategies as a means of evading engagement with threatening feelings or stimuli (Arble & Arnetz, 2016). Avoidance strategies may ultimately result in negative effects such as increased psychological difficulties and a decreased ability to engage with positive experiences (Arble & Arnetz, 2016).

6.4.3 Previous life stories

Previous experiences of suicide, or sudden or recent death shaped the individual's response to the student suicide. Participants shared accounts of their previous personal or professional experiences of suicide or a recent bereavement. They articulated perceptions of connection between such events and of the current experience triggering memories or feelings attached to a previous experience. Cerel et al. (2014), stated that individuals may feel affected by a suicide due to previous experiences of suicide; that is, without the previous exposure to suicide, the participant may have perceived themselves to be exposed to this suicide, rather than affected by it. Therefore, the suggestion is of a cumulative effect. My findings however, indicate that exposure to a recent bereavement by other causes may also contribute to the perception of a heightened level of impact. Thus, previous experiences of death and bereavement, regardless of the cause of death, can heighten the individual's perception of impact following a suicide. In terms of meeting needs this finding indicates that support providers must be cautious about making assumptions regarding staff members experiences of impact. Furthermore, staff members may wish to maintain their privacy around previous experiences of suicide and bereavement, and as such, the reason for their heightened perception of impact may remain unknown to colleagues, line managers and support providers.

6.4.4 Social supports

Links to social supports are also a potential factor in terms of capacity to cope. Informal support utilising pre-existing personal support networks were evident as being helpful, and in some cases,

the main source of support across participant accounts in my study. Indeed, increased social support has been shown to lead to lower levels of distress (Arble & Arnetz, 2016) and provides a route toward increased resilience (Mancini & Bonanno, 2009). Thus, personal networks may affect the individuals' ability to cope and process after the event; for those who are unable to call on social support networks, there is a greater risk of PTSD following a traumatic event (Brewin et al., 2000).

All four of the above sub-sections illustrate how the personal stories of staff members affect their experiencing of the suicide and their ability to seek and access support after the suicide. There are inequalities in terms of personal traits, pre-existing support networks, previous experiences and access to social support networks. I suggest that HEIs would serve their employees well if they considered and responded to the potential impact of such inequalities on their staff members ability to process and recover following the event of a student suicide.

6.5 Perceptions of closeness and belonging

Given the complexity of experience that I discussed in section 6.2; and the individual differences in capacity to cope that I discussed in section 6.4, I will now explore whether any further factors underpin or shape the experiences of HEI staff members. Throughout staff accounts there were stories that spoke of a sense of knowing the student who died, and of feeling a closeness to them, whether or not the student was previously known to the staff member. I explore these perceptions of knowing and closeness in this section within the context of the kind of relationships that exist between HEI staff members and students.

6.5.1 'Knowing' the student and perceptions of closeness

Within the HEI setting, staff perceptions of their roles and responsibilities might shape their experience. From housekeeping staff, through registry teams, careers advisers to senior professors, one shared purpose across roles is to meet student need. For some of my study participants, there were narratives of safeguarding or protection, or even of 'feeling like a mummy' toward the

students. Staff accounts illustrated that roles appeared to place responsibilities on to one group (staff) through a perceived duty of care toward another group (students). Throughout, there was a sense in which the student was felt to be 'known' by staff members. A sense of commonality or of connection was present in the data and findings of the current study. Nearly all of the participants shared stories through which they constructed a sense of connection with the student who had died. They did this whether or not they had known or worked with the student. For some of the participants these perceptions of 'knowing' had been constructed through their personal process of reflecting on the event. In seeking to understand the student's death, staff engaged in a process of constructing stories and explanations. In doing so they invariably constructed stories by calling on their personal frame of reference, and so, perceived similarities or connections between themselves and the student appeared. For instance, in the process of reflecting on the death, or in their responses to seeing a photograph of the student who died, participants seemed to be constructing an imagined persona for the deceased student through which a sense of 'knowing' the student was also constructed. This took various forms, such as, relating the student to a similarly aged or gendered family member; or relating the student to a family member or close friend who is troubled, distressed or deceased by suicide; or calling on the experience of being a parent to develop an empathic sense of 'knowing' this 'troubled' young person. As such, staff members were constructing perceptions of closeness to the student who had died. This process sits within the meaning making processes that staff experienced. It might be that through this constructed sense of knowing the student, the staff member had a place and a reason to grieve.

The concept of 'perceptions of closeness' (Cerel et al., 2013) was coined to describe the finding that people with greater 'perceived psychological closeness' to a person who died by suicide, are more likely than those who have kinship ties to identify as a survivor after a death by suicide. Indeed, greater perceptions of closeness to the person who died increased the likelihood of depression and anxiety and increased the chance of experiencing post traumatic shock disorder (PTSD) by almost four times (Cerel et al., 2016). In the wider literature, the concept of closeness has been shown to be

a relevant factor, a sense of closeness to the patient for mental health practitioners affected impact following patient suicide (Castelli-Dransart, 2015). These studies however, were based on data collected from people who had pre-existing relationships with the person who died. This raises the question of whether a constructed perception of closeness with a person not previously known may also affect the extent to which an individual is affected by a suicide death. In a study of railway workers, it was found that perceptions of the victim's vulnerabilities increased negative reactions for rail workers (Barden & Mishara, 2015). Rail workers, like the participants in my study are less likely to have known the person who died prior to their death, and so this idea that they may also be constructing a sense of the deceased's persona, ties in with the experiences reported by HEI staff members.

Once again, the findings of my study provide a novel insight into the experiences of wider populations following a suicide. Specifically, in this instance, I suggest that those who did not know the deceased prior to their death engage in similar processes of constructing stories or meaning following the death as evidenced for those with a prior relationship with the deceased.

6.5.2 Staff – Student relationships

The student who died was a member of the HEI community, they may have studied within the staff member's academic school or been a student who lived on a residential site under the staff member's charge. The question is raised as to whether staff perceptions of caring, safeguarding, and responsibility; and the process of constructing perceptions of closeness for the student, arise from the shared experience, and the underlying narratives, of belonging to the university. The concept of belongingness (Baumeister & Leary, 1995) describes the need to belong as being a fundamental human motivation. Baumeister and Leary (1995) describe two main features to the concept; firstly, that people need frequent personal contact with others; secondly, that such contacts take place within the context of a bond or relationship marked by stability, concern, and continuation into the foreseeable future. It has been found to be evident, for instance, in a study of nursing students, that

their experiences of the nature of the staff-student relationship were key to the students' sense of belongingness (Levett-Jones et al., 2008). This prompts the question of whether there is an aspect to the nature of the student-staff relationship, that may shape staff experiences in the event of a student suicide.

The literature that explores relationships within HE settings appears to focus only on the teacher-student relationship; and within that, mainly explores the students' experiences of that relationship (Hagenauer & Volet, 2014). In the current study findings evidence a sense that staff members, across all job roles, cared about what happened to their students, and felt a sense of responsibility in terms of the wellbeing of students. This sense of caring about the student is evident in the data even when the student is unknown to staff members. Indeed, the teacher-student relationship in HE has been described as multi-dimensional, consisting of 'closeness, care, connection, safety, trust, honesty, fairness, respect, openness, support, encouragement, availability and approachability' (Hagenauer & Volet, 2014, p. 378). The idea of 'caring' for students is regarded as a humanistic value and a moral responsibility, although the concept has received little attention in the literature (Hagenauer & Volet, 2014). The teacher-student relationship in HE is differentiated from that in school settings as it is an adult-adult relationship (Halx, 2010). As such, there is an expected degree of independency, and so ways or acts of caring might appear differently to how they would for children in earlier stages of primary or secondary education. Young people in the UK have legal adult status on reaching the age of 18, which includes the majority of students in HE settings. However, adolescents and young adults are going through a stage of considerable developmental change which includes changes in risk-taking behaviour (Crone et al., 2016). Studentship is argued as being an important stage in young adults' development into more mature adulthood (Baker, 2006). It might be then, that due to the age and stage of development of the average HE student, combined with the differential status between students and staff member within the HEI, the relationship is not operating on a level playing field. I wonder if staff are not so much 'caring for' HE students as they are 'caring about' them. The findings of my study though, suggest a significant sense of responsibility on the part of staff members toward

students, with a particular emphasis on student wellbeing. Within a setting that nurtures the practice of caring about the students' wellbeing, this perception of responsibility in turn translates into the self-scrutiny and fears of failure and blame that were evident for staff members in my study. Unfortunately, the teacher's perspective of the staff-student relationship is largely absent in the literature (Hagenauer & Volet, 2014).

Some aspects of the teacher's perspective are evident in the findings of my study, for instance, some academic staff members felt out of their comfort zone in having to share the news of a student suicide, or to provide support to other students. Indeed, university teaching staff experience perceptions of stress in relation to student needs (Lahtinen, 2008). Therefore, further consideration needs to be paid to the toll on staff who are not mental health experts. In a qualitative exploration of potential sources of distress for university teachers it was found that experiences of 'coping with the emotional load placed on them by students' (p. 481) was one of three sources of negative emotions, the other two sources being, making decisions under certain conditions and facing conflicting expectations and beliefs concerning the teaching – learning process (Lahtinen, 2008). It might be suggested by the findings of my study, that a student death by suicide exposes teaching staff to all three of these stress sources. Martini et al., (2019), undertook a statistical analysis of the experiences of 550 associate and full professors, to determine whether the demands of students are related to academics' perceptions of emotional exhaustion and work engagement. The study concluded that work overload, conflict, and student demands were strongly related to emotional exhaustion (Martini et al., 2019). Specifically, it appears that it is in facing and feeling the responsibility to deal with student mental health problems that staff experience particular challenges such as maintaining boundaries (Hughes & Byrom, 2019); feeling underequipped, and being untrained to deal with student mental health issues (Gulliver et al., 2018). As such, staff in academic, clerical and support roles need appropriate mental health awareness training and should be encouraged to complete such training if it is available (Margrove et al., 2014).

My findings demonstrate that staff perceive a sense of 'knowing' the students, even when they have not had specific contact with them. In addition, following a student suicide, staff members appeared to be constructing perceptions of closeness to the student who had died, even in instances where the student had been unknown to them prior to their death. In the HEI setting relationships are nurtured and shaped by the cultural norms that are dominant. The literature only explores the teacher-student relationship, and identifies that the concept of 'care' is present (Hagenauer & Volet, 2014). It may be this concept of caring that heightens the perceptions of knowing and closeness. The staff-student relationship might be argued as being an adult-adult one, however, the average-aged student is still experiencing considerable developmental shifts, which include changes in their behaviour around risk-taking (Crone et al., 2016). The presence of care and the sense of responsibility may once again shape staff experiences and perceptions following a student suicide, specifically for those staff members who have no mental health training. However, I have been challenged in discussing these aspects of participants' accounts and experiences by the dearth of literature that explores the kinds of relationships that might exist within a HEI, and none that examines relationships of non-academic staff with students.

Section 6.6 Cultural stories

I showed in the findings presented in Chapter 5 how staff accounts evidenced that cultures within the HEI shaped their experiences. For instance, differences in organisational provision and responses to different staff groups shaped support experiences. At the same time, a perceived culture of 'being a family', created the arena within which a sense of belongingness nurtured feelings of being supported and of 'mattering'. The position of the HEI within the wider community also introduced aspects of experiencing for staff after a student suicide. In this section I will explore these contexts.

6.6.1 The HEI as a community

Throughout the accounts of staff members there was a palpable sense of shared community as being the context within which experiences, needs and perceptions were situated. The idea of the HEI as a community might provide a framework for understanding the multiple purposes, relationships, players, and values that HEI staff reported, and which come together to shape their experience and response following a student suicide. It is important to acknowledge that the nature of individual HEIs are broad in terms of size, design and location. Multiple campus HEIs may have different or multiple communities compared to those that are based at a single campus. Likewise, there may be communities within communities in large HEIs, where the individual may identify with a school or college more than they do with the whole institution.

Certain aspects of the university community or culture appear unique when compared to different kinds of large organisation. For instance, one group of community members, the staff, are present for the purpose of meeting the needs of another group of community members, the students. Additionally, there are physical aspects of the setting such as student accommodation being provided on-site, together with shops and food and drink outlets; there is representation available via the provision of a students' union to 'be the voice' and meet student need; provision of diverse clubs and societies that promote intellectual or physical wellbeing, engagement with interests beyond the classroom, and connection with other students. As such, the university has a multi-dimensional focus of providing not just education, but also, a home, a social life, access to multiple activities, and personal development opportunities for young adults. These aspects, in combination, create a setting that appears to promote to the student a message of being cared about or of being looked after.

When a student takes their own life, within the context of this shared sense of community, it is likely to shape staff perceptions and responses to the death. An example of this is evident for those staff members who took on the role of first responders within the HEI community, there existed a

significant possibility that they might know the student, they were very likely to be familiar with the physical location, and they shared the commonality of being members of the university community. Amongst my study participants, members of staff, who are usually responsible for security, student wellbeing, senior management tasks, and chaplaincy, all became first responders in the moment of crisis. These HEI staff members may have been first on the scene, may have been the person to check for a pulse, to perform CPR, to contain the panic and stress amongst house-mates and neighbouring students, to instigate crisis response procedures. All of this was done on the behalf of a student who, even if not known to them, was a part of their HEI community. This factor differentiates their experiences from those of community based first responders such as paramedics and police officers for instance. For HEI staff there is the complexity of being the responder, whilst sharing commonality with the deceased. This situation appears unique in that it is barely evident in the literature for any other first responder or practitioner. I was curious then, to explore the idea of the HEI as a community, a concept that was evident in the accounts of participants in my study, to establish whether indeed this is a factor in shaping staff experiences.

In literature searches undertaken for this study I found no papers that take a holistic, institution-wide, perspective of the HEI as a community that consists of diverse groups of individuals with specific roles, aims, and intentions, that serve both their own and each other's needs in complex and overlapping networks. Such networks of contribution and belonging may nurture a sense of shared purpose built from joint values; or for others may nurture a sense of isolation and disconnection if their purpose and values feel misaligned with those that are dominant. Mcmillan and Chavis (1986) defined and theorised the concept of sense of community which may be applicable to a HEI setting. They identified four elements that when experienced together, nurture a sense of community within or across a group of individuals who may be linked geographically or relationally. The four elements are membership, influence, integration and fulfilment of needs, and shared emotional connection (Mcmillan & Chavis, 1986). Staff accounts in this study evident strong perceptions of membership through a sense of belonging, which Mcmillan and Chavis (1986) connect to the concept of

membership; staff also have varying degrees of influence within the HEI, which they hold in their ownership of the power within the institution. Regarding integration and fulfilment of needs, Mcmillan and Chavis (1986) point to shared values as underpinning the aspects of community that meet individual need. Finally, the shared emotional connection, once again calls on the idea of belongingness, but also is evident amongst HEI staff accounts in the previously discussed processes of constructing perceptions of closeness; of caring and of the sense of knowingness that staff evidenced.

Mcmillan and Chavis (1986) present a number of examples to illustrate how these four elements might work in conjunction with each other; one of the examples used is the setting of a university, however, rather than apply their concept across the wide community of university, they selected instead to focus on the formation of a sports team within a university. Other scholars have applied this concept to schools (Vieno et al., 2005) and found that across 134 secondary schools there was variation in the sense of community at student, class and school levels. Interestingly, the factors identified that increased a sense of community included increased student participation, especially around making rules and organising events, and freedom of expression (Vieno et al., 2005). It might be argued that within a HEI setting that students are likely to experience an increase in both of these areas. I suggest then that it is plausible that the narratives of community and culture present in staff accounts in my study further shape staff perceptions and experiences following a student suicide.

6.6.2: The socially situated HEI

Wider cultural ideas of suicide may not have been explicitly stated in my participants' accounts, but implicit in their words was the idea that a death by suicide was felt to be somehow worse than a student death by other means. This implicit message was present in the sense of bewilderment and horror that staff expressed that a person so young would chose to end their own life. It was also present in the fears that staff expressed about the potential impact on institutional reputation, and in expressed fears of suicide clusters and of other student's wellbeing and safety. These fears situate

the staff experiences within wider social and cultural contexts. They also differentiate their experiences from other groups of workers, as fears around institutional reputation and suicide clusters arise from the very nature of the kind of institution in which they work. Both sets of fears are valid given the evidence. HEIs are neither exempt nor immune to the political context within which they operate, and as such have been challenged and changed by the neo-liberal agenda that currently dominates UK politics (Alexander et al., 2018; Mahony & Weiner, 2019). For instance, the introduction of a competitive business model and the re-positioning of the student as a customer who needs to be satisfied, have generated new concerns for HEI leadership teams with regards to public image and reputation (Mahony & Weiner, 2019). Additionally, the introduction of a number of rating and ranking processes in the form of the Teaching Excellence Framework (TEF), Research excellence framework (REF) and the more recent Knowledge Exchange Framework (KEF) (Parr, 2020) provide the public with accessible 'league tables' by which universities can be compared. I suggest, in this political and social context that the need to protect institutional reputation may be more keenly felt by staff members than over previous generations. Within this context, there is known reporting bias around the topic of suicide, such that some suicide deaths are more frequently and more widely reported than others (Marzano et al., 2018). For instance, suicides of students are disproportionately reported in print and online news reports in the UK and Republic of Ireland (Marzano et al., 2018).

It is clear that clustering of suicidal behaviour is more frequent in young people and is likely to occur in an institution such as a university for instance (Hawton et al., 2019). A suicide cluster occurs when there are more suicide deaths than expected in terms of time or place, or both (Hawton et al., 2019). There have been recent suicide clusters in a small number of UK HEIs. These have gained high profile and disproportionate media reporting which has included repeated reporting of the names of the HEIs concerned. Reporting has also included intense media speculation around institutional responsibilities toward the student, and the safety of students at UK HEIs. Staff members in my study held the perception that media reporting of student suicide was a causal factor of HEI reputational damage. However, the relationship between media reporting and potential reputational damage of

HEIs remains unexplored. Evidence from participant accounts in my study suggest that there is a misperception amongst members of the public regarding the rates of student suicide as being higher than those of the age-related general population. This perception situates the HEI as an unsafe environment for young people. The most recent research, however, disputes this belief, citing that incidences of student suicide per 100,000 are less than half of those in the age-related general population (Gunnell et al., 2020). However, despite this research evidence, staff continue to fear that individual incidences of student suicide will steer public perceptions toward ideas of increased risk of suicide associated with HEIs. It appears to me then, that the combination of the political context of the neoliberal competitive business model together with the social narratives pertaining to student suicides and suicide within UK HEIs contribute to the experiences of heightened responsibility and fears of failure and blame that are held by HEI staff following a student suicide.

6.7 Summary

In this discussion I have shown that HEI staff perceptions of impact following a student death by suicide are more diverse than might be predicted and can include a sense of being bereaved. Staff experiencing is broad and impactful, and has aspects in common with diverse other groups. Undertaking tasks appears to be a unique aspect of HEI staff members experience and shapes the ways in which staff are impacted. There is a sense of entanglement and tension between the demands of job roles and the needs of the individual. In seeking to contextualise the experiences of these staff members, I have explored the concepts of individual differences, perceptions of closeness and knowing, and the sense of community within a HEI. Finally, I have situated staff experiences within the internal cultures of a HEI, and the wider social and political cultures within which UK HEIs function. Together these concepts and settings create a framework of explanation as to why the experiences and perceptions of impact might be greater than anticipated for these HEI staff members. Throughout the discussion of these findings, I have demonstrated time and again that there is significant lack, and identifiable gaps, in academic literature pertaining to multiple aspects of

these staff members experiences. As such, their experiences have been invisible prior to this study; and even now remain difficult to contextualise and explain.

6.8 Strengths & Limitations

6.8.1 Research topic, aims and objectives

I have undertaken the first study to explore the experiences of staff in UK HEIs following a student death by suicide. The study therefore pays attention to a previously unexplored population. The focus of my study was the experiences of staff following a student death by suicide and their experiences and needs in undertaking roles or tasks following the death. My research questions, aims and objectives of this study, as set out in sections 1.2.3.1; 1.2.3.2; and 1.2.3.3 were developed to explore a specific population (HEI staff members) within clear geographic boundaries (UK HEIs). This study has met those criteria and provides a critical exploration of staff experiences that responds to and answers the research questions, thus generating novel findings. I did not include the experiences of student peers and of family members of a student who died by suicide in a UK HEI in the research questions that underpin this study, and as such, they remain currently unexplored.

6.8.2 Findings

The findings of this study are based on the accounts shared by study participants in qualitative survey questions (n=19) and semi-structured interviews (n=10). The participants were drawn from across departments and job-roles in two UK HEIs. Given the acknowledged partiality of participant voice (see Section 4.4.3) and my role as researcher in interpreting the data and constructing the findings it is important to acknowledge there are limits to potential claims of the generation of new knowledge. It was not the objective of this qualitative study that findings be generalisable in the 'statistical – probability' meaning of the term as such a form of generalizability is not applicable given the epistemological and ontological assumptions of qualitative research (Smith, 2018). However, there are different kinds of generalisability that highlight the unique contributions that qualitative inquiry

can add to knowledge (Smith, 2018). As such, it is my hope that the findings of this study are found to be generalisable by readers in terms of representation (that is, readers recognise familiarity with their own experiences in the accounts of study participants and the interpretations I have made from those accounts); through transferability (readers recognising potential to apply findings or recommendations to their own settings and circumstances); or through analytical generalisability (the application of theoretical outcomes to other research or practice contexts) (Smith, 2018).

Whilst I do not claim these findings to be complete, nor universal, they do report multiple novel insights constructed from the experiences of the staff members who participated in this study. These insights add to current knowledge regarding impact of student suicide within UK HEIs and, more broadly, regarding the impact of suicide in wider networks around the person who died. The experiences of UK HEI staff following a student death by suicide have now been explored for the first time and are reported. My findings are relevant in informing the development of postvention support for UK HEI staff following a student death by suicide; in addition, my findings are also relevant in informing postvention needs and provision amongst wider populations, such as those who work in secondary education, further education, or vocational training settings. These findings may also prove informative to those who work in other settings that include provision of a residence to their client, service user, patient or student. I hope that these findings provide a springboard for any subsequent research, adopting either qualitative or quantitative methodologies, that may seek to explore further the impact of student death by suicide in UK HEIs.

Specific, important, contributions to knowledge are made by the findings of my study. For instance, the findings add to existing knowledge by identifying the process of 'constructing perceptions of closeness' to a deceased person who was previously unknown before their death. This process may be rooted in a sense of relatedness that comes from shared ideas of belonging or a sense of community. Currently literature around perceptions of closeness (Cerel et al., 2017) refer only to those who had a pre-existing relationship with the person who died. My findings also identified that specific, unique aspects of the HEI setting may further shape the experiences and perceptions of

impact for staff members. The literature regarding the undertaking of tasks following a suicide death is sparse and dated. My study provides strong evidence of the complexity that tasks and additional roles or responsibilities introduce for staff to the emotional processing following a suicide in the workplace. My findings situate staff experiences socially both within and beyond the HEI, thus acknowledging the potential for wider cultural and social contexts to shape experience.

In this study I sought to explore experiences; further research is needed to understand causation and relationships, or longitudinal outcomes. My study specifically focused on HEIs in UK settings. Due to differences in Higher Education cultures and processes internationally, findings may not be completely transferable across international settings.

6.8.3 Methods

The application of a mixed-method design in the form of a survey followed by an opt-in interview provided a robust combination of methods to gather a range of data from a previously unexplored population. This has produced findings that give insight to who amongst HEI staff perceived themselves as being impacted, as well as how they perceived that impact, and what that was like for them. Therefore, a fuller picture is provided than would have been possible had the study utilised solely quantitative or qualitative methods. By utilising a point of integration across methods for data analysis (that is, combining data from survey and interviews) I was able to perform a more comprehensive analysis of the kinds of tasks undertaken and by whom they were undertaken; I was also able to utilise two data sources for the grounded theory analysis, enabling a deeper theoretical construction to be developed.

In using mixed-methods I was able to apply novel means of seeking to understand participants experiences and to understanding the work being done by the accounts that they provided. For instance, I believe that this is the first study to make use of the continuum of suicide survivorship (Cerel et al., 2014) in measuring participants perceptions of impact following a death by suicide, this

resulted in the generation of new knowledge regarding potential impact amongst wider networks around the person who died. In addition, the qualitative aspects of the enquiry have resulted in findings that consider the personal traits and experiences of individuals rather than of a group. This contributes to our understanding of individual factors and how they impact on responses to sudden unexpected events; and to having to respond to a crisis in the workplace.

I selected grounded theory as the method for the qualitative element of the study. I did so as it is particularly suited to un-researched topics or populations (Charmaz, 2014). It allowed me to develop theory inductively from the data, thus, from my interpretations of the experiences of my participants. My findings can now become a starting point for future qualitative or quantitative research projects.

6.8.4 Recruitment, sample size, and data collection.

I designed a site-based recruitment process (Arcury & Quandt, 1999) for this study so as to capture stories across a range of staff members relating to their experiences of a specific student death by suicide. My aims being to gain a collective account of staff experiences within the socio-cultural context of the institution, and to compare experiences across job roles and between institutions. In navigating an ethical and logistical approach toward achieving site-based recruitment it was necessary to gain institutional consent and identify a key contact at the HEI prior to embarking on recruitment of individual participants. Research that recruited HEI staff by approaching them directly reported that those staff were concerned about potential repercussions should they be identified (Mahony & Weiner, 2019); it was my hope in obtaining site-based consent for recruitment that staff would not be deterred by similar worries. The engagement of HEI sites from which to recruit participants, however, was a particularly challenging and drawn out stage of recruitment. I have detailed the process in Table 4.1 (Chapter 4) which illustrates that I began the process of engaging HEI sites in August 2017. Eleven HEIs expressed initial interest in the study, of which I sent formal invitations to five to participate. Of those five, site one gave consent in February 2018 and site two

gave consent in January 2019. My liaison with the potential sites sometimes continued for months before eventual withdrawal on the part of the HEI. The challenges of engaging HEI interest and senior level participation that I experienced can be situated within the political context of HE in the neo-liberal era. The introduction of a competitive business model; the growth of managerialism; the re-positioning of the student as a customer who needs to be satisfied; cultures of bullying; and the subsequent increase in staff stress and anxiety levels (Morrish & Priaulx, 2020) are all outcomes of the neo-liberal turn in HEIs over recent decades (Mahony & Weiner, 2019). Association with student suicide, in part due to media reporting bias (Marzano et al., 2018) may be perceived as a dangerous prospect for HEI leaders. Therefore, I could hypothesise that potential barriers to HEIs participating in the study might include concerns on the part of senior leaders regarding fears of repercussion and reputational damage; or simply, a perception on the part of the key contact about not having the time or availability to liaise and support the recruitment of participants at their site.

Given these struggles, it is pertinent to reflect on and consider any limitations of the recruitment strategy that I designed for this study. The methods of recruitment are detailed in section 4.5.1 and relied on a 'top-down' process of dissemination of the study details to be emailed to potential participants. This design was adopted to ensure that there was institutional support of the study. However, on reflection, it may be that prioritising the institution (and potentially engaging with hierarchical and power-imbalances within the institution), could have been at the expense of paying attention to the individual. Indeed, when HEIs declined the invitation to participate, or who withdrew from participating, individual staff members at that institution did not get the opportunity to make an individual choice. I acknowledge that a significant imbalance of power is evident here as the decision of an individual staff member at senior level effectively denied access to participation for all other staff at that institution. For those HEIs that did participate, it is possible that the study information was not disseminated thoroughly or effectively and that potential participants did not receive the invitation to participate. In addition, other participants may have been discouraged from participating simply because the information arrived from a senior colleague, potentially a line

manager or department lead. The experiences of stress and anxiety, bullying, busyness and the impacts of the demands of a business model are not restricted to leadership staff and conceivably shape the decision making of staff across HEI departments and job-roles (Mahoney & Weiner, 2019). It might be that the cultural-political agenda affected potential participant's sense of having autonomy in making an independent decision around whether or not to participate. Additionally, some participants did share that the decision to participate was difficult due to the sensitivity of the topic and so it must be considered that some potential participants made the personal decision not to participate because of the perceived impact of responding to questions regarding their experience with student suicide.

Given the potential limitations of the recruitment design for this study combined with the current political climate within which HEIs are operating, it is worth considering whether alternate routes to recruiting participants might have incurred fewer delays and invited greater uptake amongst HEI staff members. One such alternative could have been the utilisation of social media platforms such as twitter, facebook, reddit and so on, to advertise the study to targeted audiences, and as such, rather than recruit participants by institution, instead recruit them as individuals. Another strategy might have been to engage with professional organisations or workers unions to mail out details to their members. In taking an individual, rather than institutional, approach to recruitment this study might have gathered data pertaining to multiple student deaths by suicide, incorporating broader and more diverse experiences. These alternate routes to recruitment however, would not have generated the site-based data collection that helped to develop an understanding of the site-specific socio-cultural contexts within a HEI.

The sample size for this study was n=19 participants engaging with the survey and n=10 participants taking part in the interviews. This was smaller than my anticipated numbers of n=50 for the survey and n=20 for the interviews. Therefore, the sample size did inform the kinds of analysis that I could undertake with the survey data. For instance, analyses of participants perceptions of impact

according to their job role or their gender, or by age would not have provided meaningful and transferable findings as the small subset of the sample meant that comparisons were not possible. Throughout my study I paid attention to potential issues that may arise during the course of the study due to the sensitive nature of the topic and potential vulnerabilities of the population. Robust risk assessment; participant inclusion criteria; participant information sheets and consent processes ensured that all potential participants (HEIs and individual staff) had ample information and opportunity to make an informed, autonomous, choice about taking part in the research at each stage of data collection. The HEI staff members who did participate in my study were open and generous in sharing their experiences which resulted in rich data from both the survey and interview phases of data collection.

I conducted interviews in 'blocks' of two to four interviews over the course of one or two days at a time. This practical solution resolved the issue of time and cost constraints. Both HEI sites were a considerable distance from the University of Worcester, and so data collection involved overnight stays. I decided to arrange interviews in 'blocks' to ensured that the project remained within budget. I interviewed two participants by telephone due to the challenges of availability. Utilising different interview methods, that is, face to face and telephone interviews, within one study may be seen as a limitation if the nature of the interview differs due to the different means. However, I used the same topic guide, and the data that I gathered from participants by telephone shared the depth and breadth of detail as that gathered from face to face interviews. In both instances, the use of a telephone interview was suggested in the first instance by the participant. As such, these necessary issues of practicality impacted on my application of grounded theory method to my process of data collection and analysis. Data collection in grounded theory would usually take the form of interview – transcribe – code – interview – transcribe – code and so on (Charmaz, 2014). As such, the outcomes of the process of initial coding inform subsequent interviews either by informing the topics or questions explored; or by informing the selection of participants. This process is designed to ensure that each subsequent interview can provide an opportunity to either check early findings, or to fill

apparent gaps in early findings. Thus, the process is one of theoretical sampling, whereby, decisions are made in selecting participants so as to answer questions that are arising through the analytic process (Charmaz, 2014). In this study, two factors impinged this process. Firstly, the issue of budget and practicalities as outlined above. Secondly, the challenges in recruiting participants meant that there was a limited and finite sample of participants. There is little or no acknowledgement in grounded theory literature that the researcher might experience challenges in this area, and no suggestions of possible solutions or 'work arounds' should the sampling process hit blocks or challenges. This leads us to the question 'how can we use grounded theory methods when sampling is limited and finite?' The rationale adopted in this study around theoretical saturation was outlined in Chapter 4, Section 4.5.5.3**.**

I sought solutions to the challenge of following the method that took the following form. After each interview, I made extensive notes, which took the form of reflections and memos. The focus of this note taking process was to capture my initial impressions and to highlight key moments or topics from the interview. In some instances, this process informed my development of the interview topic guide as outlined in appendix 4.16. I transcribed and coded interviews at the earliest opportunity following each block of interviews. So, for instance, my process resembled the following pattern; interview – notes – interview – notes – transcribe – code – transcribe – code – interview – and so on. The pattern was as close as practicably possible to that outlined in grounded theory methods texts, and ensured that as I coded data, subsequent interview or transcriptions were informed by the knowledge I gained from the coding process.

6.9 Conclusion: Bearing Witness

My study shines a light on the previously unexplored experiences of HEI staff members following a student death by suicide. Experiences are shaped by staff members sense of connection with and 'knowing' of the student who died, thus elevating their perceptions of impact from the expected sense of being exposed to a death by suicide, to feeling affected by or even bereaved by a student

death by suicide. The experiencing reported by staff members incorporates aspects previously reported as being typical for other groups of professional workers, as well as for first responders, and for those who are bereaved by suicide. Experiences of individual staff members differ according to their role and the nature and range of tasks they took on following the student death; their previous experiences of suicide or bereavement; and whether or not they previously knew and/or worked with the student; and by team and departmental cultures. It is clear, that whilst there are shared aspects of experience across staff members and groups, there is also a wide range of potential responses that staff may or may not experience, and as such each member of staff may have a unique experience.

In constructing the grounded theory core category, 'Bearing Witness', I capture that, despite these unique experiences amongst HEI staff, there is an over-riding shared experience. Bearing Witness tells the story of the weight that staff bear in being witness to a student suicide; and in being responsible for undertaking tasks within the context of a student suicide. The category describes how the acts of responding to a student death by suicide and experiencing a student death by suicide placed staff members in the roles of witnesses to the aftermath of the death. A sense of 'bearing' describes the physical and mental efforts required by staff to carry the experience whilst also undertaking key tasks, supporting others, and trying to find a route toward managing their own needs. In bearing witness, all other aspects of the staff members experience are shaped by the awful truth that a student has taken their own life. Whether staff members knew the student prior to the suicide, or not, this sense of carrying the weight of knowing, of seeing, of being present was part of their experience. The 'bearing' of the experience is palpable throughout their accounts. As such, the experience of HEI staff appears unique when compared to other groups of practitioners who experience a suicide because of their job role. It appears that the nature of a HEI as an organisation and a community; and the kinds of relationships that are formed between staff and students within that community contribute to the unique aspects of staff experiences.

The findings that I have discussed here evidence adverse emotional responses and trauma symptoms, together with ongoing impact on work practice. They inform my conclusion that HEI staff members do require fit for purpose postvention support that ought to be distinct in design and means of delivery so as to specifically meet the range and complexity of HEI staff needs. I draw full conclusions and make recommendations for research and practice in Chapter 7, where my findings from both studies, the qualitative research synthesis and the mixed-methods study, are bought together to inform a comprehensive thesis conclusion.

Chapter 7

Concluding the thesis

7.1 Chapter Overview

In this final chapter of my thesis I aim to draw together the threads that run throughout. Firstly, I draw conclusions in light of the methodological paradigm applied and the place of postvention in critical suicidology. Secondly, I present recommendations and implications for research, policy and practice. Finally, I take an overview of both studies with the purpose of drawing a set of conclusions informed collectively by my research findings.

7.2 Methodology

7.2.1 Social constructivism in postvention research

I outlined a social constructivist paradigm in chapter one as providing a methodological framework for the studies in my thesis. This approach is rooted in the idea that individuals construct their own ideas and interpretations of reality (Guba & Lincoln, 1982). I selected methods that that would privilege and value individual accounts and interpretations by developing theory from data. Each study took a different route toward the construction of theory. Study one via the synthesis of findings and researcher interpretations in published studies; study two via a constructivist grounded theory analysis of participant accounts that I had gathered in open text survey data and in semi-structured interviews. The findings that have been developed and constructed across both studies are deeply rooted in the experiences of individual practitioners and HEI staff members. Current knowledge regarding the postvention needs of those who are in the wider networks around the person who died is informed by a sparse, yet growing, body of research. My findings in this thesis evidence that practitioner and staff experiences can be markedly different from those who are in closer networks around the person who died. Therefore, the application of existing theoretical frameworks that seek to explain experiences of loss or bereavement after suicide would be unhelpful

and would fail to capture the specific experiences that are evidenced by my research. The social constructivist approach has enabled me to engage a process whereby the voices and experiences of my participants underpin new theory that describes practitioner and staff experiences as being distinct from those who are bereaved by suicide. The development of theory that specifically describes practitioner experiences will serve to inform ongoing development of postvention models, guidance and delivery that stretch beyond ideas of loss and bereavement and address experiences of trauma, and professional impacts to identity and ongoing practice; and acknowledge the social and cultural contexts within which practitioners and staff members operate and experience a death by suicide.

7.2.2 Postvention in critical suicidology

In chapter one I established that experiences of loss and grief are socially situated (Thompson et al., 2016). Key to this is the idea that meanings are developed as much between people as they are within them (Neimeyer et al., 2014). Thus, the process of meaning making is a social one as well as, or instead of, being an individual endeavour. Critical suicidology challenges dominant ideas of suicide as being an individual 'failing' (Marsh, 2010). Positioning it rather as a symptom of social, political or cultural breakdown, disconnection or inequalities. As such, ideas of suicide are culturally and historically embedded, and generate the ideation of suicide as a possibility (White, 2017). This is a concept already acknowledged in the postvention literature which recognises that exposure to suicide heightens our risk of dying by suicide. Postvention, therefore is already incorporating the idea that wider contexts contribute to the formation and perpetuation of ideas. Currently, guilt and shame, connected to perceptions of stigma and subsequent experiences of 'silencing', are reported by those who are bereaved by suicide as being a significant aspect of their experience (Peters et al., 2016; Gall et al., 2014). I pose the question therefore, as to whether a shift in collective ideas around suicide, a concept of collective ethics maybe, whereby suicide is no longer problematised as an individual issue (White, 2017), might change, in any way, the current complexity of the grief

experienced by those who are bereaved. For instance, trauma responses, such as those experienced by my participants, might be clearly connected to experiences of close contact with, or having sight of, the deceased. However, evidenced in the findings of both of my studies, trauma responses may also be connected to ideas held by practitioners or staff members around ideas of suicide, or of their personal responsibility in connection with a suicide. These thoughts and constructions may in part be connected with 'ideas' of suicide that are currently prevalent in society. As White (2017) highlights, a rethinking of suicide as a public trouble rather than an issue of individual agency, might open the door to new and creative actions and responses to the problem.

In postvention responses to suicide, the focus on individual agency takes two forms. Firstly, the positioning of suicide as being from 'within' the individual, may also position individual 'others' as being responsible for intervening or saving the person who died. Thus, giving rise to professionals' perceptions of failure, which trigger experiences of rumination, flash-backs and fear of future practice scenarios. A socially or publicly rooted conceptualisation of suicide might serve to remove the individualisation that is currently experienced by those who were 'too late' to save the individual, or who fear that they 'missed something' or 'got it wrong'. Secondly, it is the individual who is the target for bereavement or trauma support. Postvention is currently, even when offered in group settings, focused on healing the bereaved or traumatised individual. This raises the question of whether there is a place for a more community or socially situated model to postvention activities. Expanding on White's (2017) 'rethinking' it is pertinent to pose the question, is postvention best positioned as something that we 'do' to individual people, or could it be something that we integrate into our organisations, communities and societies? Critical suicidology urges a shifting of the focus away from individual agency and the suicidal individual as the problem to be fixed (White, 2012). This conceptualisation also translates to the design and delivery of postvention. It is evidenced that postvention can be prevention (Andriessen, 2009), however, this idea is rooted in the individual model of suicide. If suicide is in fact a social problem rather than an individual one, then postvention needs to take the form of not so much healing individuals, but of healing the social wounds and

chasms that underpin suicidal ideation and behaviour. If the impacts of suicide are socially and culturally situated, ought then, routes toward support and postvention also be positioned as such?

Evidenced throughout this thesis is the utilitsation of qualitative methodologies across postvention and suicide loss research. This is in contrast to the account of Hjelmeland & Knizek (2010) who draw attention to the dearth of qualitative methods in suicidology. However, their observations are based on the literature pertaining to suicidal behaviour and suicide prevention. Whilst postvention research hasn't yet engaged in broader socio-cultural and political conceptualisations of the experiences of those who are impacted, it might be held up as an example that qualitative methods in suicidology do have a place and do contribute meaningful knowledge to the conversation.

Throughout my thesis I have paid consideration to ideas drawn from the school of critical suicidology and based within a social constructivist paradigm. I have done so in order to situate individual experiences in social and cultural contexts. However, in this conclusion, I revisit Fitzpatrick's concept of 'silences and absences' (2014, p14) within conventional suicidology literature to highlight my own observation. That even within critical suicidology there remain 'silences and absences'. The topic of postvention is notable specifically by its absence. I believe that critical suicidology is currently overlooking the potential contributions of postvention concepts and knowledge to the conversation. Postvention research has a role to play in demonstrating the value of incorporating qualitative methods into suicide research more broadly. Additionally, postvention research has yet to expand its viewpoint beyond individual impact and experiences toward socio-cultural, economic, political and community-based impacts of suicide loss and bereavement, meaning that we don't yet fully understand the impact of suicide in these contexts. Therefore, I suggest that an inclusion of postvention in the conversation would enable a more holistic exploration of solutions, and most importantly, may encourage postvention scholars to embrace the paradigms and conceptualisations of social, cultural, political, economic and historic contexts and learning to further their own branch

of suicidology. Thus, the topic of postvention would both contribute and benefit if included in the critical suicidology conversation.

7.3 Recommendations

7.3.1 Recommendations for research

In study one I identified the processes of incrimination and absolution as impacting practitioners experience; there is currently no known literature that has previously identified these mechanisms or explored them, and so, further exploration of them and of their potential to shape experience would add to knowledge in this area. In study two I utilised the continuum of suicide bereavement (Cerel et al., 2014) as a measure to understand participants perceptions of impact. My findings from this study evidenced that further exploration and testing of the model is required to ensure that it encompasses the breadth of experiences and perceptions held by those in wider networks around the person who died. Application of this tool to gain greater insight to the perceptions of diverse groups of individuals would inform future development of the tool; in addition, widespread utilisation of the continuum as a self-report tool would inform knowledge regarding the level of support required by individuals regardless of their relationship with the person who died.

My second study was the first study to explore the impact of student suicide on staff in UK HEIs. There is need for further diverse studies be undertaken to gain greater insight to staff experiences in HEIs and answer some of the many questions posed by this study. Specifically, to answer the question of whether the experiences reported by participants of this study are typical of those of HEI staff across the UK sector or whether there are, currently unknown, variable factors that might influence the kinds of experiences of staff in other HEIs? Additionally, studies designed to explore the experiences of other groups affected by a student death by suicide in a HEI setting, for instance, student peers and family members would contribute to developing a holistic understanding of the impacts of a student death by suicide across the whole community of a HEI. Further questions arising

from my findings might include those that ask how can we best support staff who, due to their roles, are focused on supporting others before themselves; and how can we encourage staff to engage with choices and activities that might meet their own needs?

Exploration around the experiences of other staff groups with regard to undertaking tasks following a death by suicide would provide a context within which the experiences of HEI staff might be better understood. In addition, such studies might highlight existing good practice in similar settings from which HEIs can learn and develop strategies for staff support. Further exploration around the role of individual differences in help-seeking behaviours and pro-activity in shaping engagement with support and coping mechanisms might further inform the ways in which support ought to be offered and delivered. Moving forward, evaluation studies designed to measure the uptake and efficacy of any existing or newly developed postvention support interventions for HEI staff. Similarly, development and subsequent evaluation of pre-event training designed to prepare HEI staff or other groups of practitioners, both practically and emotionally, for the event of a suicide, would inform the efficacy of such a strategy.

In discussing the findings of study two, I found there to be gaps in current knowledge regarding perceptions of belongingness and community within HEI settings and what the impact of such perceptions might be on staff (or students) in both their day to day lives and when an unexpected and stressful event occurs such as a student death by suicide. There is also a related gap in current knowledge regarding student – staff relationships within a HEI setting beyond that between students and teaching staff (and that which does exist is largely from the student perspective). Therefore, comprehensive research into perceptions and experiences of relationships between and across all groups within a HEI would bring great insight to those who are concerned with leading and shaping HEIs; to those who work and study within them; to policy makers and to educators; to sociologists and scholars of psychology and human behaviour; and to researchers who are exploring any phenomena that may occur within a HEI setting. Such research should include staff across all

departments and job-roles and should seek perceptions and experiences from both staff and student perspectives.

There is currently no known research that explores the impact of media reporting of student suicide in UK HEIs on public perceptions of student suicide; nor on the impact such reporting has on institutional reputation; nor on perceptions and experiences of staff and students within UK HEIs; nor on suicidal ideation and behaviour of students within UK HEIs.

In looking beyond the HEI, further research is needed to compare the experiences of HEI staff to other groups of staff in residential or care settings, be they for young, adult, or older populations. Research in wider communities following a death by suicide might further explore this concept of 'constructing perceptions of closeness', for instance, in online communities, in sporting communities, church communities, following the suicide of high profile celebrities, and high profile suicide deaths in localities or other large institutional settings such as schools, hospitals, public sector institutions where there might also be a shared sense of belonging or of relatedness to other unknown members of the community of institution. Furthermore, research to establish whether, in constructing a perception of closeness, the individual does experience a greater perception of impact, as is suggested in by Cerel et al. (2017) for those with a pre-existing relationship with the deceased.

More broadly, the challenges in contextualising the findings of my studies point toward a need for broader and deeper understanding of the nuanced experiences of those in wider networks who are impacted by a death by suicide, specifically those who do not experience grief or loss symptoms, but rather other, currently unexplored, responses. Qualitative studies would be well placed to explore the experiences of groups that have not previously been researched. Current research in the area of postvention pays attention to processes of grief and loss, therefore future research might also explore the experiences of trauma, self-incrimination, professional guilt or failure, professional overwhelm, and the experiences of taking on tasks following a death by suicide with a focus on the wider networks that are exposed to or affected by a suicide.

7.3.2 Recommendations for the design of postvention for people who experience a suicide because of their job role.

Pre-suicide training and preparation should be provided to health and social care practitioners who are at a higher risk of experiencing a client suicide to prepare them for the kinds of thoughts, feelings and behaviours that they might experience following a client suicide. Postvention response and support policies should be developed that recognise that practitioners may also be potentially impacted by a client suicide, the aim being to mitigate trauma symptoms, adverse emotional responses and any subsequent adverse impact on future practice. Support ought to be provided to practitioners and HEI staff that is sensitive to the social and cultural context within which a suicide occurs and the ethical and organisational cultures in which staff members are operating, ensuring that support, for instance, responds to specific cultural needs or social norms. Individual traits and experiences should be considered when designing support / postvention for staff groups. The experience of staff is not generic. Offers of support should be pro-active, and repeated. Support offered should take different forms, including for instance, formal and informal, group and individual, psychological and practical support, so as to engage staff with different preferences and needs.

7.3.3 Recommendations for Policy and Practice within HEIs

Current postvention provision with UK HEIs has been designed and is being delivered without a context specific evidence base. The second study in my thesis provides the evidence that underpins the following recommendations for postvention support for staff members. Personnel who are responsible for planning procedural responses to student suicide might consider structuring postvention response teams so that there is clear delineation between those staff who provide crisis response support, and those who provide ongoing postvention support. This would enable crisis response staff to have time and space to process and be supported following a potentially traumatising experience. Staff who were part of the crisis response element, should not be responsible for then providing support to others, be they staff or students, when in fact they

themselves need support. One route toward supporting this delineation of roles would be for HEIs to consider engaging external support experts to deliver purpose-designed postvention support to those staff who were engaged in crisis response roles, thus freeing student wellbeing teams from responsibility toward their colleagues, so that their expertise be used to support both the closely affected students (housemates/course-mates) as well as the wider student body including other potentially vulnerable students who might be triggered by such an event. Academic staff who have not been trained to offer mental health support to students should not have responsibility for sharing the news of a student suicide to wider groups of student peers, such a task should be undertaken by a member of staff who understands the potential risks attached when talking about or sharing information about a death by suicide. It is imperative for the safety and wellbeing of other students that language and messages around suicide are shared appropriately and safely. Academic staff members could, however, be trained to take on such a role.

Postvention support policies within HEIs should include acknowledgement that staff members may need support whether or not they knew the student who died, and should include specific trauma-focused support to staff members who were involved in crisis response tasks. HEI provision can be designed to be pro-active in aligning support offered with that being sought elsewhere by the individual; and in combining formal and informal support offers to meet individual need, and to meet more than one support needs for the individual (eg: one person may benefit from sharing experiences with others & a psycho-therapeutic intervention).

There is further work needed as outlined in section 7.4.1 to provide the evidence needed to design postvention response strategies to meet the needs of student peers and of the wider HEI community following a student death by suicide. Postvention response strategies and programmes ought to be evaluated to measure uptake, ongoing engagement and perceived helpfulness; and well as ease of implementation and capacity to meet the perceived needs of the target population.

7.4 Drawing conclusions from across two studies

As I outlined in Chapter 1, I designed this body of work to critically examine the experiences and perceptions of a cross section of staff working within UK HEIs where a student suicide has been a recent event. My exploration was underpinned by two research questions:

- How is a student suicide experienced by staff members within a UK HEI and what are the features of that experience?
- Do staff members undertake specific postvention roles following a student suicide, if so, what kinds of role, and are there any staff needs attached to delivering them?

The aims being to:

- Identify how a student suicide is experienced by staff members within a UK HEI and highlight the features of that experience
- Explore whether staff members undertake specific postvention roles following a student suicide, if so what kinds of roles, and are there any staff needs attached to delivering them?
- Undertake a critical exploration of the experiences of a cross section of UK HEI staff members following a student suicide
- Understand whether staff members feel they need postvention support, whether support is offered, how the support is experienced, and whether existing postvention models suit the needs of a UK HEI community context.

I have met these aims; firstly, by undertaking a systematic review of the literature in the form of a qualitative research synthesis. The synthesis explored the experiences of practitioners in health, social care and education roles following the death by suicide of a patient, client, service user or student. Secondly, by undertaking a mixed methods study and employing a grounded theory analysis to explore the experiences of staff in UK HEIs following a student death by suicide. In the first study I

bought together the experiences of practitioners across a range of professional roles and work settings in diverse global locations. In the second study, in contrast, I explored in greater depth the experiences of staff members in just one, previously unexplored, work setting in one country. Together, the studies form a body of work that adds to current knowledge regarding the impact of suicide on people who are exposed to suicide due to their job-role; and specifically, those who work in HEI settings. The combined findings reveal that experiences are not uniform, but rather, that they differ across job-roles, work settings, social and cultural contexts, and according to the personal traits and experiences of the individual. I have presented and discussed the findings of each study earlier in this thesis (Chapters 3, 5, & 6). It remains now for me to take an overview of the findings of both studies in order to draw out similarities, differences, and key conclusions.

7.4.1 Perceptions of impact

In study one I highlighted that there are both similarities and differences of experience for practitioners across a range of professional roles. The same can be concluded for HEI staff whose experiences were complicated and diverse. The majority of HEI staff perceived themselves as being 'affected by' rather than 'exposed to' a death by suicide (Cerel, 2014), thereby perceiving a greater impact than might have been anticipated. Furthermore, my findings from study two demonstrated that people in wider networks can perceive an experience akin to bereavement following a death by suicide. My findings expand our current knowledge about the kinds of impact that might be experienced by staff members who experience a death by suicide because of their job role. The experiences of HEI staff members were complicated because they combined aspects in common with health and social care practitioners, first responders, and those who are bereaved by suicide. Therefore, I propose that a unique strategy of support will be needed, within HEI settings, to respond to the specific needs of staff, that may take aspects from pre-existing support interventions for other groups of practitioners or from those bereaved by suicide.

Some similarities were evident between the practitioners in study one and those in study two: the experiencing of emotional and trauma responses such as the experiencing of visions and imagery; sleeplessness; fear of re-visiting the location of the death; and processes of trying to make meaning of the event. Experiences of self-scrutiny and fears of professional failure were more evident in study one, where practitioners had worked with, and had some degree of professional relationship with the person who died. For HEI staff in student wellbeing teams, these processes were also evident, either through an initial fear that they may have worked with the student and overlooked something, or in raising their sense of responsibility to 'get it right' for other students. Academic staff who knew the student, also experienced processes of self-scrutiny and fear of having missed something or of somehow failed the student. For HEI staff who did not know the student who died however, these processes were not so evident. For them, a process of meaning making appeared to involve the construction of a perception of closeness to the student who died, and through this constructed sense of knowing they found reason to feel a sense of loss or grief. For some HEI staff members, such as those who took on first responder roles, their experience appears to be closer to that of workers in emergency services roles or railway workers who come into contact with suicide deaths of people who are previously unknown to them. These workers experience the trauma of seeing the body and witnessing the responses of others who are present, and of having the experience or responsibility of having to try to 'save' the life of the person who may already be dead. Some nursing practitioners in study one shared the traumatising experiences of being present when the death occurred or of interacting with the dead or dying body of their patient. However, the main differentiation for HEI staff is that even in not knowing the student who died, they still experience significant traumatic and emotional responses to the experience.

7.4.2 Undertaking tasks

A notable difference in experience appears to be that other groups of practitioners do not speak of undertaking tasks in the same way that university staff do. Staff experiences of undertaking tasks in

crisis response or subsequent postvention roles stretched them beyond their usual job-roles; created discomfort and overwhelm; and complicated their experiences of emotional and psychological processes following the event. One exception here is school counsellors (Christiansen & Everall, 2008) who demonstrated the difficulty of attending to their own needs whilst taking on the responsibility of meeting everyone else's needs. Even so, the range and diversity of tasks undertaken by HEI staff members does not appear to be matched in any literature that explores the experiences of other practitioners. Some members of HEI staff, such as those that took leading roles in the response to a student suicide, or those who were in team leader roles, the range and diversity of tasks stretched their capacity and their resilience far beyond the usual limits of their job roles.

The most significant difference that appears to shape the experiences of all of the HEI staff, regardless of their job-role, is in the tension and entanglement that is evident when they are taking on roles and tasks in response to a student suicide. They do so whilst also having to process their personal response to the idea that a student in their university, maybe 'on their watch', has chosen to take their own life. A complexity is evident for these staff members in the taking on of roles within the context of a student death by suicide that introduces a unique experience not previously reported for other groups of practitioners or professionals. My findings with regard to this experience are novel, and set apart the experiences of HEI staff from existing knowledge regarding other groups of professionals or workers who come into contact with a suicide death because of their job-role.

7.4.3 Individual differences

HEI staff experiences are underpinned and shaped by personal traits, previous experiences and external factors such as support networks. The impact of previous experiences with suicide or a recent death of someone significant was one of intensifying the perceived response to the student death by suicide. Thus, staff members who undertook similar tasks might experience very different reactions. However, for some staff, these previous experiences were private and therefore not

known by colleagues or line managers. This is a circumstance that might be pertinent to practitioners beyond the HE sector; and so, it is important that consideration is given to individual circumstances and needs when support is planned and offered. Additionally, some HEI staff appear more pro-active than others in terms of seeking out support or self-supporting through engaging pre-existing strategies and utilising pre-existing professional and personal support networks. It is also clear that HEI staff utilise informal support networks both within and beyond the HEI either to supplement, or instead of, formal support. It is important therefore that any support offered be flexible so as to meet individual need and to complement other forms of support that may be accessed by the individual.

7.4.4 Cultural and social contexts

In study one I evidenced that practitioner experiences are contextualised socially and culturally, according to the settings in which practitioners operate and experience client suicide. For these practitioners, perceptions of incrimination or absolution on the part of diverse 'others' shaped the way in which they experienced and responded to the death by suicide of a client. In study two I demonstrated that HEI staff members' experiences following a student death by suicide were also shaped by external factors. It was evident that wider cultural contexts within which the suicide occurred impacted on staff members experiences. In both sets of findings individual experience is situated within cultural and social settings that inform belief systems and behavioural responses to a death by suicide. These findings affirm that needs are likely to differ between individuals and that support ought to take account of these wider contexts so that it be suited to individual need.

The nature of inter-personal relationships and the culture within a HEI setting appear to nurture a pre-conceived sense for staff members of 'knowing' the student, whether or not they were personally known to the staff member. Furthermore, after a student death by suicide, processes of meaning-making appeared to include the construction of perceptions of closeness on the part of staff to the student who had died – whether or not that student had been known to them prior to

their death. This sense of relatedness, even to the 'unknown' student may go some way to explaining the depth of impact experienced by some staff members (eg: perceptions of being affected or even bereaved, when this population might be expected to self-identify as 'exposed')

The concept of a 'sense of community' goes some way to explaining the sense of belonging and connectedness that was present in HEI staff accounts, and may explain the extent of impact perceived by participants. The kinds of relationships that exist between staff and students within a HEI may also contribute toward perceptions of impact. This may be connected to a perceived sense of responsibility on the part of staff members, toward the wellbeing of the student, and, in turn, the sense of failure when a student dies by suicide. Practitioners in study one evidenced complex processes of self-scrutiny and perceptions of professional failure, that were aligned with professional cultures of caring and healing. Socially held perceptions and constructions of suicide as an individual and pathological problem may also feed into practitioner and staff perceptions of responsibility in terms of 'saving' the suicidal client or student, thus perpetuating these feelings of failure or fears of having missed something. Ideas of responsibility and of having failed in that responsibility contribute to more complex processes of impact, loss and psychological or trauma symptoms. This is particularly pertinent for HEI staff members who are not experts, nor trained in providing emotional or mental health support to students. However, such staff members do find themselves in positions of having to support students; either before a student has died by suicide, for instance, the student's personal tutor might fear having missed a sign; or afterwards in having to take on tasks such as sharing the news of the suicide or supporting personally affected students, for instance, in tutor groups.

Wider social and cultural contexts might also shape staff experiences. Study one showed how litigious cultures in the US shaped practitioners experiences of support and introduced unique experiences of fear, that were not evident for practitioners in other countries. For HEI staff, media reporting of student suicide in UK HEIs has led to socially embedded misconceptions about rates of suicide death amongst student populations; such socially situated narratives might lead to

perceptions of fear and failure for HEI staff and to fear of loss of reputation at an institutional level. In the neo-liberal climate of the competitive market place, where the student is the customer and funding Is linked to performance criteria, loss of institutional reputation stands to hold economic consequences for the institution, and as such, this fear is rational and understandable.

7.4.5 Implications for postvention support

In light of my findings, across both studies, it is clear that current postvention provision for workers who are exposed to a suicide because of their job-role is inadequate. My literature review in Chapter 2 demonstrated that current postvention programmes are largely targeted at families and those closest to the person who died and are designed on the assumption that the emotional experience is one of grief and bereavement, often complicated by stigma, shame, guilt and silencing. Of course, it is imperative that postvention interventions continue to meet the needs of the bereaved by suicide population. However, my findings in this thesis demonstrate that practitioners and HEI staff members are more likely to experience trauma symptoms together with processes of self-scrutiny, perceptions of being blamed and fears of failure or of having missed something. Ongoing affects may include sleeplessness, nightmares, visions and imagery; workplace and job-related anxiety; changes to practice, or the desire to leave or change job-role; fears of being present at the scene where the death occurred, and continued self-doubt and feelings of guilt, or responsibility; as well as ongoing fears of encountering another suicide in the future. Workplace postvention packages need to be equipped to acknowledge and respond to these experiences and needs.

My findings have also demonstrated the need for a broad view of postvention in terms of purpose and strategy. There is need for postvention, for those who are exposed, affected and bereaved by suicide, that acknowledges how the complexities of such impacts are shaped by and embedded in social and cultural settings. There is an opportunity for postvention, as a healing intervention, to work within wider community, social and political contexts to challenge the narratives that further complicate the experiences of individuals who are impacted by suicide.

An ongoing theme throughout my thesis has been the positioning of the practitioner or staff member as the provider of postvention, when they, equally, may need to be the recipient. This positioning in both the academic literature and in postvention guidance has served to further complicate the experience of practitioners who are impacted by a suicide because of their job role. Further, such positioning has served to make invisible this wider network of people who are exposed to, affected by, and sometimes bereaved by, suicide due to their job role. In my literature review and discussion sections of this thesis I have evidenced multiple gaps in existing knowledge around a milieu of specific aspects of the experiences of practitioners, carers, and staff in health, social care, educational or residential settings. If, in the mindset of researchers, the practitioner is the provider of postvention support, it might be posited that there is no motivation to discover or understand that the practitioner themselves might also be impacted. As such, their experiences are invisible because their voices have been silenced by a lack of research. This creates an additional challenge, in that the practitioner, because they are invisible and unheard, is also absent within current postvention strategy and guidance. Thus, posing a dilemma for any employers who do wish or need to provide postvention support to employees, as there are, as I write, no evidence-based guidance or programmes available. One current study is evaluating and seeking to improve a postvention programme for professionals after a patient suicide (Leaune et al., 2020). It is the first known study that has aimed to evaluate a purpose designed postvention programme for practitioners. It would seem then, that the research and knowledge needed by this group of practitioners and staff members is at the very earliest stages.

7.5 Closing words

In Chapter 4 of this thesis I shared the following reflection from my academic journal:

> *'As I am coding this transcript I become aware of a heavy feeling in my chest – it is as if I am feeling the participant's anxiety, sadness, feeling their struggle to process and reconcile and make sense of their experience – just as I am also trying to make sense of it through my*

process of coding and analysis. This isn't just academic work, this isn't just science, it is feelings work; it is an internal presence; it is a weight. It is emotional work. And it comes with a sense of responsibility, to do justice, to reflect and respect and value my participants' words, experiences and feelings and to value their process by taking the greatest of care with my process'.

I return to that reflection now, in closing this thesis. It is a reminder of my own role in this work, but it is also a reminder of the participants' role, of the hopes that rested on the potential outcomes of their personal efforts to take part in this research. I believe that I have taken the greatest of care with my process. I hope that readers of this thesis will also, at some points, have felt that weight in their chest; have gained a sense of the participants' anxiety, sadness and struggle. Whilst this thesis serves to tell the stories of socially constructed complexities in suicide loss, and the mis-placement of practitioners as only the providers, rather than the recipients, of postvention. It would not have been possible to understand those stories if nineteen members of staff from two UK HEIs had not given their time and engaged their energy in sharing their own personal stories. I would like to close this thesis by returning our attention to those individuals, by noticing that we can feel alongside them, some of whom continue to bear witness, even now.

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Appendices

Appendix 3.1: Study 1: Published Paper

Review

What Is the Experience of Practitioners in Health, Education or Social Care Roles Following a Death by Suicide? A Qualitative Research Synthesis

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Abstract: Recent research has highlighted that the number of people impacted by a death by suicide is far greater than previously estimated and includes wider networks beyond close family members. It is important to understand the ways in which suicide impacts different groups within these wider networks so that safe and appropriate postvention support can be developed and delivered. A systematic review in the form of a qualitative research synthesis was undertaken with the aim of addressing the question 'what are the features of the experiences of workers in health, education or social care roles following the death by suicide of a client, patient, student or service user?' The analysis developed three categories of themes, 'Horror, shock and trauma', 'Scrutiny, judgement and blame', and 'Support, learning and living with'. The mechanisms of absolution and incrimination were perceived to impact upon practitioners' experiences within social and cultural contexts. Practitioners need to feel prepared for the potential impacts of a suicide and should be offered targeted postvention support to help them in processing their responses and in developing narratives that enable continued safe practice. Postvention responses need to be contextualised socially, culturally and organisationally so that they are sensitive to individual need.

Keywords: postvention; suicide; suicide loss; suicide bereavement; practitioner; systematic review; qualitative research synthesis

1. Introduction

Postvention has been described as activities developed by, with, or for people who are impacted by a death by suicide [1]. The aim of postvention is to facilitate recovery amongst those impacted by a suicide and to prevent adverse outcomes, including suicidal behaviour [1]. In order to appropriately implement postvention, it is vital to accurately identify those who perceive themselves to be impacted by a death by suicide. Authors have debated the definition of 'impact' in relation to a death by suicide: Andriessen [1] spoke of a person who has lost a significant other (or loved one) by suicide, and whose life is changed because of the loss; whereas Jordan and McIntosh [2] identify someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to a suicide as impacted. The latter definition does not specify the kind of relationship that may exist between the deceased and the person impacted. As such, a broader network of individuals could be considered as having been impacted by a death by suicide. Indeed, it has been estimated that every death by suicide impacts up to 135 people [3]; this includes people drawn from broader networks including health and social care professionals, colleagues, neighbours, social networks in addition to family and close friends. Despite increased recognition of a wider circle of individuals impacted by a death by suicide, postvention research to date has focused narrowly on the experiences of family members and friends after a suicide [4,5]. Although undoubtedly important, it may also be important to consider the wider impact of suicide on those who may potentially be impacted within their working lives and to consider specific postvention needs of this broader group.

Health, social care and education workers form part of a wider network of practitioners who may be impacted by a death by suicide. Studies suggest that 86% of GPs encountered at least one patient suicide in the previous ten years, [6]; 55% of nurses working in psychiatric settings in Japan encountered at least one patient suicide [7]; 43% of psychiatric trainees experienced one or more suicides [8]; nearly 36% of teachers were exposed to at least one student suicide [9]; and 33% of

social workers had been exposed to suicide in the course of their job [10]. A recent meta-analysis of population-based studies has shown that exposure to suicide amongst the general population is 4.31% for past-year prevalence and 21.83% lifetime prevalence [11]. This indicates that health, social care and education workers are at an increased risk of exposure to death by suicide at least once during their working lifetime, compared to the general population.

The range of responses that people exposed to suicide may experience following a death by suicide can be considered along a 'continuum of suicide survivorship' [12]. This nested model illustrates that people may perceive themselves to be exposed to suicide (i.e., those who knew or, identified with, or came into contact with the individual), affected by suicide (i.e., those who experienced significant distress following exposure), or bereaved by a suicide death (i.e., those who shared a close connection with the deceased and experience a clinically significant negative impact in the short or long term). In principle, health, social care, and education workers exposed to suicide may fall at any point within this continuum. Indeed, Cerel et al. [13] suggest that perceptions of closeness, as described by the suicide survivor, are key to understanding perceived impact of the death, and that those who feel impacted by a death by suicide may include individuals across a range of relationships with the deceased. Furthermore, perceptions of greater closeness and impact relate to higher incidences of depression, anxiety, post traumatic stress disorder (PTSD) and prolonged grief [13]. As such, a number of adverse effects have been reported by health, social care and education practitioners following a death by suicide. These range from professional doubt and fear of legal consequences [14], to feelings of responsibility for the death [15], emotional turmoil and stress reactions [14], and severe distress [16]. For some mental health professionals, post-traumatic responses such as intrusion, avoidance and hyper-arousal have been reported as being so severe and persistent that they fell within a clinical range [17]. Thus, health, social care, and education workers may perceive themselves to be affected or even bereaved by suicide and may also require postvention support.

To develop and implement appropriate postvention support, it is important to better understand the differential experience and impact of suicide on specific sub-groups [18]. Qualitative research is well suited to providing an in-depth account of an individual's personal experience [19]. Indeed, there is a growing body of qualitative literature that explores health, social care and education worker experiences following a death by suicide [20–31]. This literature provides a rich insight into practitioners' experiences following a death by suicide; however, these findings are dispersed across the literature. This systematic review has been designed to further add to this literature by bringing together knowledge that has been generated by existing independent qualitative studies of health, social care and education practitioners' experiences following a suicide death to contribute to our understanding of these individuals postvention needs as professional workers.

The research question underpinning this review asks, 'What are the features of the experience of workers in health, education or social care roles following the death by suicide of a client, patient, student or service user?'

2. Materials and Methods

This systematic review took the form of a qualitative research synthesis [32]. Evidence that describes the experiences of health, social care and education professionals following a client death by suicide was reviewed and subjected to an interpretative synthesis [33]. Numbers of qualitative studies have increased over the past few decades, however qualitative research continues to face the challenges presented by a narrative that it lacks validity, value and is difficult to apply to real world settings [34]. Synthesising qualitative studies offers a means of making the most of existing research by examining literature across the breadth of a topic with the aim to generate a greater depth of information [32]. This synthesis brought together a diverse, yet topically connected group of studies with the aim of generating greater depth of knowledge of the experiences of particular groups to a particular event within a particular setting. Knowledge of the particular, in this instance, the individual, their experience and their responses, has an important role in developing best-practice in practice-based disciplines [34]. The enhancing transparency in the reporting of qualitative research statement (ENTREQ) provided a guiding framework in the reporting of this study [35].

2.1. Search Strategy

Comprehensive database searches were conducted in February 2018 by H.C. The databases were purposively chosen to screen articles published in psychology, health, nursing and education journals and included PsycInfo, CINAHL, SCOPUS, ERIC and Medline. The reference lists of relevant studies

were hand searched for additional references. Database alerts were set up to identify subsequently published studies and an additional study was included in the synthesis in March 2019 [25].
Search words were used as follows:
Medline: Suicide AND [client OR patient OR service user OR student] AND [impact OR effect OR influence OR experience] AND [qualitative research OR qualitative study OR qualitative methods OR interview]
PsycInfo; CINAHL; SCOPUS; ERIC: Suicide AND [client OR patient OR service user OR student] AND [impact OR effect OR influence OR experience]
Searches limiters were used as follows:
Medline: Journal Article
PsycInfo: Peer Review; Qualitative Studies
CINAHL: Peer Review
SCOPUS: Journal Article; Peer Review; Qualitative; Interview
ERIC: Journal Article; Peer Review

2.2. Screening the Literature

Lead author, H.C., undertook article screening; all the articles were collated and duplicates removed. Remaining articles were screened by (i) title (ii) abstract and (iii) methods, research question and presentation of data and (iv) whether the study question and data usefully contributed toward answering the synthesis question. The screening process is summarised in Figure 1.

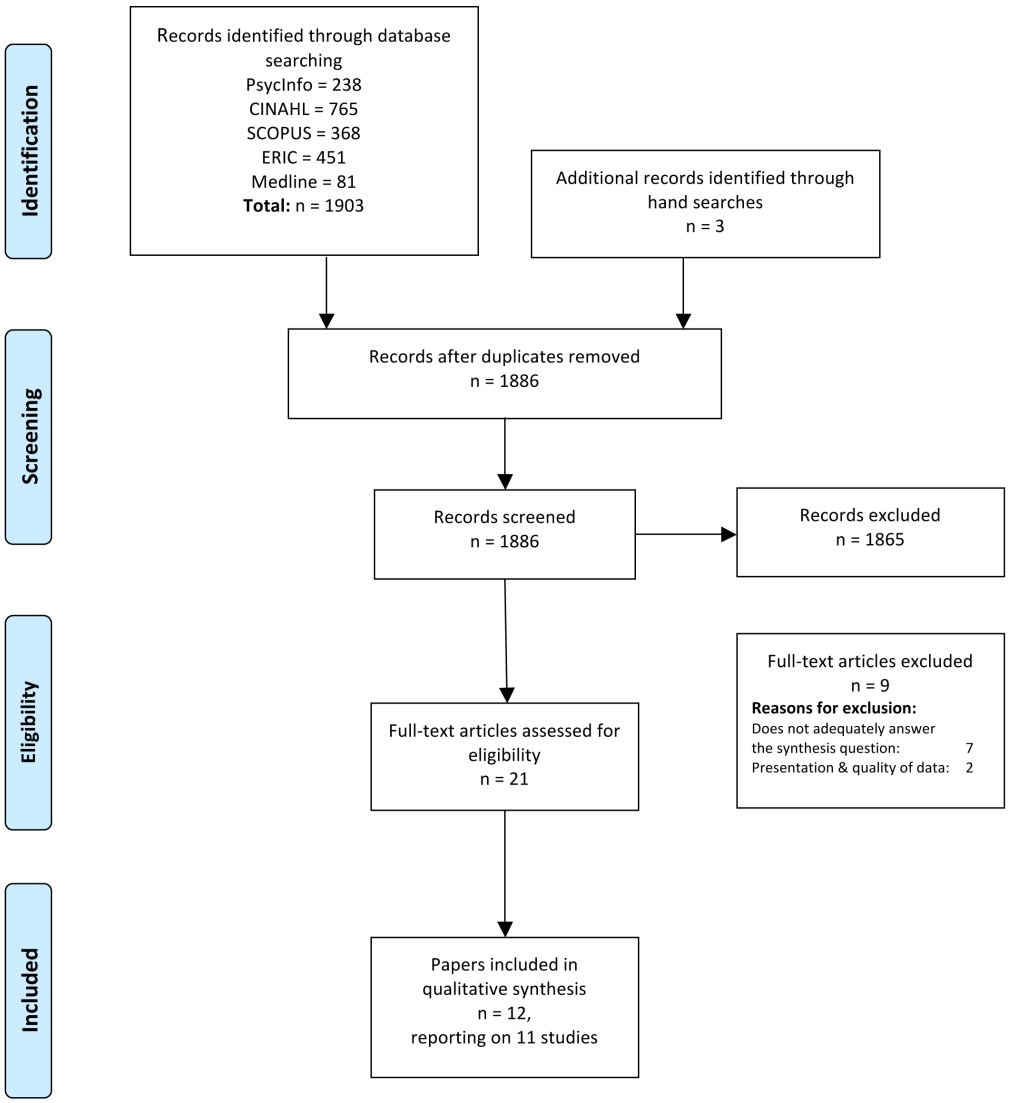

Figure 1. PRISMA flow diagram of the selection process. Adapted from the Preferred Reporting Items for Systematic Review and Meta-analyses (PRISMA) flow diagram [36].

2.3. Study Eligibility

Studies were included if the article was (i) published in a peer review journal; (ii) published in the English language; (iii) reported on the subjective experience of health, social care or education professionals following a client death by suicide; (iv) data collection and analysis methods were reported as qualitative, or as mixed methods if the qualitative data were reported in a distinct section of the article; Noblit and Hare's [33] definition of qualitative research as being that which seeks to generate understanding of participants' subjective experiences and uses an interpretative framework was applied; (v) reported findings were evidenced with the inclusion of verbatim quotes.

Studies were excluded if they (i) employed solely quantitative data collection and analytic methods; (ii) sought participants' views on the topic of suicide, organizational responses to suicide, participants' experiences of suicidal ideation or behaviour that did not result in a death by suicide or (iii) were non-empirical case reports or opinion pieces.

2.4. Quality Assessment

The study used the Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist [37]. The CASP tool has been subject to evaluation and has been found to take a generic inclusive approach that is helpful when working with a body of literature that includes diverse methods, populations and sample sizes [38].

All of the studies included in the review met all of the criteria in the checklist with the following exceptions: Tillman [29] lacked clarity in describing the process of recruiting participants. Two further studies, Sanders et al., [28] and Ting et al., [30] used participants selected from a larger sample who, in both cases, had participated in a larger quantitative study. Consideration of the relationship between the researcher and the participants was only explicit in Kim [25] who acknowledged that the researcher shared the same profession as the study participants. Five of the studies made no mention of ethical considerations or approval for the research [23,24,28–30]. Bohan and Doyle [20] did not report any process of oversight of the analytic process. Taking these exceptions into consideration, there remained demonstrable consistency in quality across all of the studies in relation to their aims, methods and reporting. CASP quality ratings are reported in Supplementary Table S1.

2.5. Data Extraction

The studies that addressed the synthesis question and met the inclusion criteria were eclectic in terms of research question and aims, location of study, participant groups, methodology and quality of reporting. Lead author (H.C.) extracted data to inform an overview of the studies consisting of study location; authors and date of publication; qualitative method; participants; study aims or question; methods for qualitative analysis; key themes or domains that were found. The overview is reported in Table 1.

H.C. extracted all data under the headings of Results or Findings and Discussion for the purpose of the synthesis [32]. The inclusion of the authors' interpretations produces the triple hermeneutic that typifies an interpretative synthesis [32]. Inclusion of the discussion sections as data gave an opportunity to embrace not just the findings of diverse research studies, but also the important work undertaken by diverse researchers in understanding, contextualising and interpreting their findings.

Table 1. Attributes of included studies.

Author and Date	Location of Research	Participant population and number	Aim of Study	Data Collection	Data Analysis	Results/Findings
Bohan and Doyle (2008) [20]	Ireland	Psychiatric nurses on acute inpatient units within three large hospitals *N* = 9	To describe psychiatric nurses' experience of suicide and suicide attempts in an acute unit and explore their perceptions of the support they received after the incident.	Semi-structured interviews—audio taped and transcribed	Burnard's [39] method of data analysis – detailed systematic description of themes.	Four themes: Nurses' experiences of patient suicide/suicide attempts Nursing care following an incident of suicide/suicide attempt Feelings experienced by nurses following a suicide/suicide attempt Support for nurses following a suicide/suicide attempt
Christians on and Everall (2008) [21]	Canada	School Counsellors *N* = 7	To gain an in-depth understanding of school counsellors experiences of client suicide from their perspective.	Telephone semi-structured interviews. Digitally recorded and transcribed.	Grounded Theory	Three themes related to training, resources and self-care: National training/practice standards Support resources Self care
Christians on and Everall (2009) [22] Reports the same study as Christian and Everall (2008) [21]	Canada	School Counsellors *N* = 7	To explore the experiences of school counsellors who had lost clients to suicide. Qu's = 'What are school counsellors' experiences of client suicide?' 'What impact do participants believe client suicide had on their lives?'	Telephone interviews (geographically diverse population) – two interviews per participant.	Grounded Theory	Four themes: Taming the control beast Wearing the mask Interpreting the dance Staying in the game

Author and Date	Location of Research	Participant population and number	Aim of Study	Data Collection	Data Analysis	Results/Findings
Darden and Rutter (2011) [23]	US	Clinical Psychologists *N* = 6	An in-depth exploration of the clinician's experience in losing a client to suicide.	In-person semi-structured interview.	Consensual qualitative research (CQR) methods followed—themes, domains and categories.	Six domains: Psychologist's view of suicide Clinical aspects of the case The suicide Impact Recovery Client's Family
Davidsen (2010) [24]	Denmark	General Practitioners *N* =1 4	To investigate how GPs were affected by patients' suicides and whether their reaction was linked to their inclination to explore suicide risk in the patient who died by suicide, and whether the GP's current inclination to explore suicide risk has been influenced by their experience of a patient death by suicide.	Semi structured interviews—conducted as part of larger study (Davidsen, 2009) [40]	Interpretative Phenomenologic alAnalysis (IPA)	Super-ordinate theme: patients' suicides. Underlying themes: Emotional impact Self-scrutiny Talking about suicide
Kim (2019) [25]	Korea	School Teachers *N* = 5	To explore the bereavement experiences of teachers and the challenges they face in coping with student suicide.	Semi-structured interviews	Colaizzi's [41] Phenomenologic al approach	Four themes: Examination of the suicide Suspension of grief Tolerance of the suicide Renewed perception of role in preventing student suicide
Matandela and Matlakala (2016) [26]	South Africa	Nurses in General Hospital *N* = 6	To present the experience of nurses who cared for patients who died by suicide while admitted in a general hospital	Interviews audio recorded and transcribed	Manual general qualitative content analysis.	Five themes: Experience of disbelief and helplessness Feelings of blame and condemnation Feelings of guilt and inadequacy

Author and Date	Location of Research	Participant population and number	Aim of Study	Data Collection	Data Analysis	Results/Findings
						Emotional reaction Fear of reprisal
Saini et al., (2016) [27]	England	General Practitioners *N* = 198	To explore GPs views on how they are affected by a patient suicide and the formal support available to them following a patient suicide.	Semi-structured interviews, audio recorded and transcribed.	Descriptive statistics and a framework thematic approach	Three inter-related themes: Part and parcel Failing patients Informal support systems
Sanders et al., (2005) [28]	US	Mental Health Social Workers *N* = 145 Sample taken from a larger quantitative study—this sample being all participants who responded that they had experienced a completed client suicide.	To expand the understanding of the reactions of social workers to client suicide. Three research questions: 1. What professional and personal reactions do social workers experience immediately following a client suicide completion? 2. What professional and personal reactions do social workers experience long term, following a client suicide completion? 3. What is the relationship between time since the client suicide completion and the social workers' reactions? The first two being relevant for this study.	Two open-ended questions at the end of a questionnaire. • Please describe how you felt in the seven days immediately following the client suicide. • Please describe how you feel now when you think about the client suicide.	Coding and constant comparative methods by two researchers working independently and comparing their results. Reviewed by third researcher.	Major themes immediately following client suicide: Deep sadness and depression Trauma and shock Feelings of professional failure Anger and Irritability Self blame Worries and Fear Major themes at time of survey: Continued emotional reactions Changes in practice Reconciliation Power and control issues Nothingness

Author and Date	Location of Research	Participant population and number	Aim of Study	Data Collection	Data Analysis	Results/Findings
Tillman (2006) [29]	US	Psychoanalysts/psychoanalytic psychotherapists *N* = 12	Interview question: 'I am conducting a study about the effect of patient suicide on clinicians; I am interested in how this event has affected you. Would you tell me, in as much detail as possible about you're your experience?'	Semi-structured interviews. Transcribed and audio recorded.	Coded by two researchers—using a psychoanalytic lens—'a synthesis was made of the categories to arrive at a 'best fit' thematic analysis.'	A research vignette is presented in the paper to 'illustrate the depth and range of experiences reported by the clinicians' Eight themes: Traumatic responses Affective responses Treatment specific relationship Relationships with colleagues Risk management Grandiosity, shame, humiliation, guilt, judgement, blame A sense of crisis Effect on work with other patients Sit within three domains Traumatic loss and grief Interpersonal relationships Professional identity concerns
Ting et al., (2006) [30]	US	Mental Health Social Workers *N* = 25	What are the reactions experienced by a group of mental health social workers after a client suicide.	Semi-structured telephone interviews. Audio recorded and transcribed.	Constant comparative method with open coding.	Twelve Themes: Denial and Disbelief Grief and Loss Anger at client Agency and society Self-blame and guilt Professional failure and Incompetence Responsibility Isolation Avoidant behaviours Intrusion Change in professional behaviour

Author and Date	Location of Research	Participant population and number	Aim of Study	Data Collection	Data Analysis	Results/Findings
						changes in practice Changes in the professional environment Justification Acceptance
Wang et al., (2016) [31]	China	Nurses in a General Hospital *N* = 15	To explore the impact of inpatient suicides on nurses working in front-line, the patterns of regulation and their needs for support.	Semi-structured in-depth interviews	Colaizzi's seven-step phenomenological method by two interviewers.	Four 'centre themes' and associated 'sub-themes' were identified. Nurses' cognition about inpatient suicide Inpatients are at a high risk of suicide Inpatient suicide is difficult to prevent Shortage of suicide preventing skills Psychological reaction Shock and panic Sense of fear Self-accusation or guilt Frustrated or self-doubt Impact on practice Stress Excessive vigilance Burnout Patterns of regulation Pouring out bitterness Avoidance

2.6. Analysis

Analysis of the data started with an initial comparison of themes across the studies followed by an in-depth coding of the extracted data to generate the synthesis and interpretation [32].

2.6.1. Comparison of Themes

To develop an understanding of how the findings of the studies sat alongside one another, it was helpful to look in greater depth at the themes identified within each of the studies [32]. An iterative reading of the articles was undertaken that included note-taking and reflection in order to identify themes, shared features, but also where they differed. This was the first stage of moving from the idea of working with twelve individual articles toward a sense of working with a large and detailed collective data set. Themes were identified from each article and entered by name on a table. This process enabled the themes to be organised across the articles by commonality and difference. Taking an overview of the themes from each article enabled identification of groups of themes across articles. Groups of themes that were developed in this process were:

What happened—experiencing the event
Emotional response—experiencing the feelings
Impact on practice—how do I practice now?
Internal responses/self scrutiny—Am I ok?
Responses of others—do they blame me?
Experiences of support—who will look after me?
Self care/maintenance—can I look after myself?
Training needs—what do/did I need to know?

2.6.2. Coding, Synthesis and Interpretation

Articles were read in depth and notes were made pertaining to the researcher's initial impressions regarding the organisation of the findings; inclusion of verbatim data; style of reporting findings and discussion. Initial coding took a descriptive form; codes were noted onto a template and then assimilated into each other to identify concepts and themes that described commonality or differences across articles. This was an iterative process as the researcher moved between data, notes, the groups of themes identified by the article authors and the developing table of codes.

The synthesis and interpretation were developed iteratively by working between the concepts, themes, transcripts and the review question. The researcher sought to move beyond the comparison and aggregation of the results from the included studies toward the revelation and development of an interpretation [32]. Throughout the analytic process, each stage was discussed by the lead and co-authors, providing the opportunity for reflection, testing and checking of categories, themes and concepts as they were developed. It was imperative throughout to stay close to the voices of the participants from across all the published studies.

3. Results

The analysis resulted in the development of three categories of themes and concepts. All three categories were evident in the data across all studies:

Horror, Shock and Trauma
Scrutiny, Judgement and Blame
Support, Learning and Living With

Each category contained a number of themes that, in two of the category groups, contained a range of concepts. The relationships between the concepts, themes and categories are illustrated in Table 2.

Table 2. Categories, themes and concepts.

Category	Theme	Concept
Horror, Shock and Trauma	Witnessing suicide	The horror
		In the moment responses
		Shock and trauma
	Responses to suicide	Loss and grief
		Mind and body responses
	Dealing with suicide	Connections and closeness

		Absence and distance
		The dual role
Scrutiny, Judgment and Blame	Thinking about responsibility	Am I responsible?
		The un/expected death
		Professional failure—guilt, reprisal and reputation
		The autonomous client
	Having to carry on	Aloneness
		Issues of control
		Avoidance strategies
		Hyper-vigilance
	Dealing with others	The organization and colleagues
		The family
		Cultural and social norms
Support, Learning and Living with	Experiences of support	
	Learning	
	Living with	

3.1. Horror, Shock and Trauma

The category 'Horror, shock and trauma' described the practitioners' experiences at the moment of and following their client's death by suicide. It described their immediate cognitive and emotional responses and the psychological and physiological responses that were experienced in the moment and over time. The themes within this category included 'Witnessing suicide', 'Personal responses to suicide' and 'Dealing with suicide'. They described three ways in which the practitioner experienced the horror of a client suicide through shock responses and experiences of trauma in the immediate moments following the death (or receiving news of the death) and over the subsequent hours, days and months.

3.1.1. Witnessing Suicide

This theme described the experiences of participants who were present at the moment of, or immediately after a suicide death occurred. These experiences can include multiple aspects of horror; perceptions of the event as horrific; the horror of seeing the suicide happen or of seeing the physical trauma that a suicide has caused the body; the horror of being present with a dying or dead body:
"I had to do CPR with the inpatient vomiting blood. Bleeding profusely from the inpatient's head, terror of the death scene made me all of a quiver" [31].
'The horror' also included experiences of recalling or imagining the event of the suicide:
"I have incredible nightmares. To this day, at night-time, it's like his face exploded and all I remember was blood and remnants" [22].
There was also the horror that someone known to the practitioner had made the decision to die by suicide:
"A mother of two small girls, she jumped in front of a train, she wasn't very old, it was awful." [24].
'In the moment responses' to the suicide were felt deeply and included feelings of disbelief, bewilderment and numbness:
"[I] had trouble conceiving that he had actually followed through" [28].
For some practitioners, the fact of suicide presented a challenge to their core professional value to keep people alive, even when faced with the fact of death:
"to work as a team with all the other nurses to try and save this person" [20].

Feelings of 'shock and trauma' and of being 'shaken' were complex; the sense of being overwhelmed was palpable in the words of some practitioners:
"I was absolutely stunned and completely and immediately traumatised. I was absolutely shocked." [29].

3.1.2. Responses to Suicide

This theme evidenced the range of emotional responses that practitioners described following a death by suicide. This group of themes reflected the impact of the event on the self of the practitioner and their feelings in response to that impact.
'Loss and grief' described practitioner recognition of such feelings and their perceptions of the ways in which the feelings impacted upon them:
"I could not control my crying. I mean, I was grief-stricken. When I say I came undone that's when I really let myself open up and sob and cry." [30].
'Mind and body responses' also took the form of physiological and intrusive thoughts, sometimes presenting as trauma symptoms and potentially leading to burnout:
"the night he died, I got deathly ill: I had to go to the emergency room. I thought I was having a heart attack." [30].

3.1.3. Dealing with Suicide

This theme evidenced how the event shaped the ongoing thoughts, experiences and behaviours of practitioners.
Perceptions of 'connection and closeness' with the deceased impacted the kinds of feelings practitioners experienced following a death by suicide.
The concepts of 'absence and distance' described challenges in building a relationship with a client or the perception of a professional distance that shaped the responses of practitioners:
"I had a patient who took his life. Something was wrong, but I couldn't find out what. I couldn't get him to talk about it … I asked him 17 times if he was depressed, but he said that he was fine. It was terrible." [24].

3.2. Scrutiny Judgement and Blame

The category 'Scrutiny, judgment and blame' was the largest in terms of number of concepts within it and how many studies evidenced those concepts. It describes the processes of reflective examination of both the event and the practitioners' role and responsibilities in the context of the event. These processes took place for both the practitioner and for others, including the deceased's family; colleagues; agencies and organisations; and social and cultural contexts. Themes within this category included 'Thinking about responsibility', 'Having to carry on', and 'Dealing with others'. These themes illustrated that practitioners' experiences spanned the cognitive, emotional and behavioural. Perceptions of incrimination and absolution were evident in the data throughout this category.

3.2.1. Thinking about Responsibility

This theme described the range of cognitive processes experienced by practitioners following a suicide death. Thoughts included those about self as a practitioner; about the person who has died; and about perceptions of other peoples' thoughts, behaviours and responses.
The question 'am I responsible?' was present across all of the studies in the synthesis. The concept of responsibility was integral with practitioners' job-role; keeping people alive or mentally well is a core value as a practitioner and as such triggered practitioners' deepest fears:
"It feels like an incredible responsibility. I know when I started with this woman, she was suicidal on and off; I spent a lot of emotional energy worrying if I screwed up on my decisions." [30].
Some practitioners sought out justification in attempts to absolve themselves of responsibility:
"I told myself I wasn't responsible for this – that his social worker was away. I was merely covering her caseload. All in an attempt to distance myself" [28].
Practitioners anticipated that others might perceive that they held responsibility:
"I was just so stunned, and worried what people thought … would think 'she did a terrible job or else her client wouldn't have killed herself'" [30].
The question of responsibility often took the form of intense self-scrutiny, doubt and self-incrimination by practitioners:
"I scrutinized like mad if he had – was there something special about him, was he miserable, was there something I completely overlooked – I really tried to rewind the film as well as possible. I really

tried to scrutinize if there was anything in that consultation which I ought to have picked up, have caught …" [24].
Practitioners often asked themselves 'what did I miss?', and in the asking of the question found themselves wrestling with the implications of self-incrimination:
"… did I give him the medication he then killed himself with?" [27].
Fears and feelings arose for practitioners from their concerns about 'professional failure' and any subsequent guilt, reprisal and impact on reputation:
"Well this is an awful failure, I think, as a doctor to have experienced that. It is horrible. I think, there we have actually failed" [24].
It was evident that the practitioner felt and feared incrimination by self and others:
"… a fear that I will be accused of screwing up somehow … I was afraid the [students] wouldn't ever want to talk to me again. That they would be really angry with me, and that nobody would trust me" [22].
Ideas of 'the autonomous client' allowed practitioners to recognise the limits of their control over client choices:
"It's a fact of life I'm afraid, you can't stop some people from taking their own lives" [27].
In some cases, this idea of autonomy led to frustration for the practitioner:
"I was pissed [at the client]; felt like why the hell couldn't they have called me? Why couldn't they have talked to me?... They have not thought to turn to me?" [30].
In other instances, practitioners found a route toward absolution:
"it's not my responsibility because if they're going to kill themselves they're going to kill themselves. I have absolutely no control over that" [30].
Some practitioners sought to understand the autonomous clients' motivation to die:
"sometimes a person feels the only way they can attain complete autonomy is through their own demise" [28].
In some cases, this led to a sense of understanding and compassion about their clients' choices:
"She did what she felt she had to do. She was tired of trying to cope with life and never quite succeeding. Suicide was her first real success in life and she proved to everyone she was capable of doing it" [28].

3.2.2. Having to Carry on

This theme described the ways in which a client death by suicide may impact ongoing practice. Feelings and experiences of 'aloneness' and isolation with their experience were evident:
"*I don't think anybody would be different in the amount of aloneness you feel about it all … it would have been nice to have someone to guide me through all of that"* [21].
For other practitioners, isolation came about due to the impact of trauma:
"Clinicians reporting dissociative phenomena were also those who experienced more isolation from colleague support, feeling alone with the trauma of their patient's suicide and cut off not only from others, but also, in the dissociative experience, from themselves." [29].
'Issues of control' were evident. The experience of a client death by suicide left practitioners feeling powerless:
"there is a lot that is not under our control given the population of clients that is worked with in mental health treatment facilities" [28].
For some, control meant containing their emotional response:
"I've been a GP for 30 years and you just have to deal with it and accept it" [27].
For other practitioners, work place processes were helpful in supporting them to re-gain a sense of control over the events that occurred:
"It was very important for all of us involved in his treatment to share the last contacts we had with him and what he had said, what we had said, and where we were left. Not so much pointing the finger but searching for anything that could help us make sense of it" [29].
However, for some practitioners the process of understanding the limits of their control was challenging:
"I think that eventually I had to understand that there is no control in a lot of those situations and in that whole process that I had to take ownership of myself and let everything else go" [21].
'Avoidance strategies' took different forms but a common theme appeared to be that practitioners were seeking ways of absolving themselves from further risk or future experiences with suicidal clients:
"We came up with this policy, if a person has been actively suicidal within six months, we send them elsewhere. We used that six months I think to distance ourselves somewhat, to make us less involved in the most at-risk clients. It has impacted my practice. I try to create a little more distance from being that first responder" [30].
Avoidance of triggering memories was also evident:
"I won't enter the ward the patient lived if it was not really needed, lest recalling the suicide scene and making me nervous" [31].
'Hyper-vigilance' evidenced practitioners' perception of having or needing to make increasingly frequent or thorough checks; either with clients who had known risk or those who had no record of risk; practitioner responses could impact upon subsequent practice:
"when I have a patient who is getting closer to thinking about suicide, my anxiety goes through the roof more than it did before, and I am clear that suicide is just not an option. I'm not open to bargaining … and I demand the patient seek hospitalisation" [29].

3.2.3. Dealing with Others

This theme described the ways in which the ideas and behaviours of others are perceived and experienced by practitioners. 'Others' may be colleagues, managers, organisations, family of the deceased, and social and cultural contexts. It was evident that some of the most explicit perceptions of incrimination were experienced in the relationships and interactions that practitioners had with third parties.
Experiences within 'organisations and with colleagues' evidenced that cultural or behavioural boundaries impacted upon the practitioner's experiencing of the event from the moment of a client death through to processes of healing:
"All teachers weren't caught talking about it for it was a top secret for the school. And the principal forbade the news about it from leaking out to anyone… Suicide brings about school … shame … [t]hat's why schools tried to hide the news" [25].
It was evident that the nature of some job-roles called upon practitioners to provide support for others who are impacted by the event whilst also dealing with their own experiences of impact, thus requiring them to manage a 'dual role' of being both a supporter while also bereaved:

"I had to be strong for everybody else right? I had to be strong for the students and I had to put my grieving aside so I could do that" [21].
Practitioners experienced the raw and immediate responses of 'family members' during contact with them after the person had died:
"I remember this woman who pointed a finger at me and said I will make sure that you will never work again … this woman said you are responsible for my brother's death. Actually your cruelty caused my brother to choose to jump through a window than be taken care of by you" [26].
The process of judgment was not only one-way, as participants themselves passed judgment on the ways in which family members behaved following a client's death:
"*I just broke down and cried in the meeting [with the family] and there was nothing from them, nothing at all. This had been their daughter, and their coldness and indifference … was terribly uncomfortable, painful, and confusing"* [29].
Experiences of 'social and cultural norms' were evident across six studies; four being from the US, one from Canada and one from South Korea. Participants' fears and responses in the context of the legislative implications of a client death by suicide were evidenced for practitioners in the US and Canada:
"I felt angry about having to consider legal implications when I was trying to deal with my own grief and help others deal with their grief" [29].
Legal advice might result in practitioners feeling silenced, and in turn, feeling conflicted about imposed silence:
"There's so much litigation that even sitting down and talking about a case you're concerned that whatever is said might be somehow subpoenaed … some attorney will if they hear about a discussion, they'll subpoena everyone that was there …" [30].
In South Korea, cultural ideas about suicide as shameful shaped the way practitioners framed and responded to the event:
"Teachers assumed that mentioning the suicide is an insult to the deceased and their family who broke the social norms. And school community members accept it as a disgrace to the school." [25].

3.3. Support, Learning and Living with

The category 'Support, learning and living with' described practitioners' experiences both prior to and after the event and the choices and strategies that they called upon to facilitate a process of recovery, acceptance and moving forward professionally and personally. The theme of 'Experiencing Support' evidenced that practitioners had support needs from the moment of the suicide through the forthcoming weeks, months and even years. The inputs of others could shape the kinds of experience the practitioners had. 'Learning' commenced after a short time had lapsed, when reflection and review processes began to take place. 'Living with' was about the ways in which practitioners made choices and developed strategies that enabled them to find the best route forward from the experience. This category illustrated the diversity of experience across professions and practitioners.

3.3.1. Experiences of Support

Experiences of support were evident across all studies through a wide range of experiences. Support was accessed in a variety of places; sometimes it was offered to practitioners, while others had to seek it out or accept whatever was available:
"I had a fiancé and I had one roommate, so they gave me whatever support they could, but they weren't professionals either … they weren't trained in dealing with grief or anything like that" [21].
The ways practitioners defined 'support' varied across studies, with differences evident between 'peer', 'professional' and 'formal' support in terms of what was perceived as support and what was found to be helpful. For instance, when nurses are asked about support, they talked about peer support [20,23]. For other groups, the support received from colleagues was not seen as 'support' as it was not provided through a formal process:
"No, we don't receive any support, we're good at supporting each other within the practice … so we have a supportive network within the practice and talk it through ourselves but we don't have any formal back up or counselling involved." [27].
There was great diversity across the studies in terms of the support that was available and offered to participants:
"Our immediate line managers came in and we were offered basic counselling, a debriefing session immediately … we were allowed to go off work, to go home, we got follow-up phone calls at home to

make sure that everything was ok and everything, and we were offered debriefing over the next few days" [20].

3.3.2. Learning

The theme of Learning was largely evidenced in the discussion sections of the papers. It illustrated how the event of a client suicide highlighted practitioners' gaps in and lack of knowledge, as well as their recognition of their need for training:

"[Participants stated] that they felt "poorly prepared for a client suicide", through their [professional] education, and that the event left them "aware of how untrained and naïve I was …" [28].

One study identified that as well as knowing how to support and respond to suicidal ideation and behaviour, practitioners also needed to feel personally prepared for the event of a suicide.

3.3.3. Living with

This theme described the ways in which practitioners moved forward after a client suicide. As with many models of bereavement, the process was shown to be not just about 'recovery' but also about 'living with' the ongoing effects of the event:

"I still feel sorry that she is gone. Still occasionally go over and over the events leading up to the suicide wondering if I could have done something different" [28].

Other practitioners found a way to mark closure of the experience either through practical rituals or cognitive processes:

"I have acknowledged that I can not possibly save all my clients. I try to do my best always and be on top of things" [28].

Taking care of the self was a strategy evidenced by some practitioners, for example, giving themselves some space or time alone:

"I take care of myself and take quiet time for myself"; "one of my personal supports is prayer and a spiritual community where we are all working on our spiritual growth" [22].

For some practitioners, moving on involved questioning their career options and considering the possibility of change:

"I spent a good year seeing a career counsellor because I wasn't sure I wanted to stay in this job" [21].

4. Discussion

The synthesised findings of 12 papers published from 11 studies describe the experiences of practitioners across a range of professional roles after a client, patient, student or service user has died by suicide. Despite the diversity of professions; the range of relationships that practitioners had with the deceased; and the global spread of the studies, the findings evidence similarity of personal and professional experience. Three categories illustrate that the experience can be horrific, shocking and has the potential to cause trauma responses; that practitioners experience intense scrutiny and perceptions of judgement and blame coming from themselves and from others; and that their experiences of support and of learning prior to and after the event shape their processes of living with the experience.

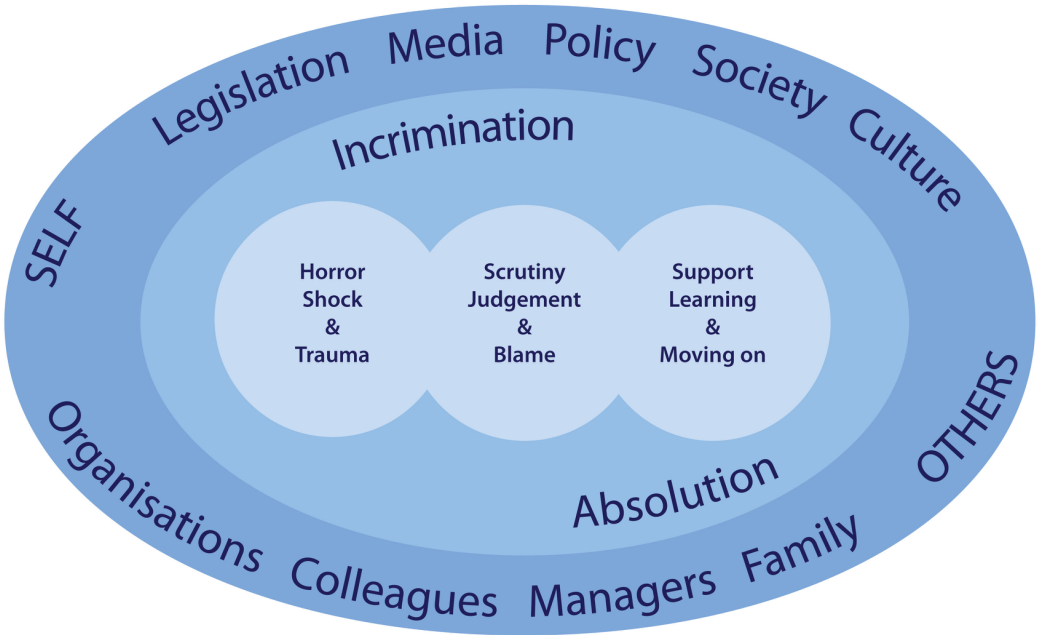

Figure 2. An overarching framework of the context surrounding practitioner experiences.

The framework in Figure 2 presents the overarching context within which practitioner experiences sit. It demonstrates that the complex experiences of practitioners that are described in detail in the findings of this review are not autonomous and that social processes beyond the suicide of a client shape practitioners' experiences. There is flow and interaction between and across the three categories of findings. The experience of practitioners in any one of these categories may shape or influence their experience in the others. For instance, initial responses of shock and horror may be compounded by blaming or judgemental responses from colleagues or family members. The synthesis also highlighted that practitioners' experiences are shaped by the social contexts within which practitioners operate. The processes of interaction between personal, professional and social contexts create the diversity and complexity of experience shown throughout these findings. The behaviours and responses of others, including colleagues, supervisors, family of the deceased as well as social and cultural factors, including legislative processes and cultural beliefs around suicide, are all important considerations within this wider context. Two further concepts were present throughout the findings of this synthesis: absolution and incrimination. Clark [42] identified that therapists experienced periods of absolution and recrimination after a client suicide. In contrast, this analysis demonstrated an experience akin to incrimination rather than recrimination; and suggests that practitioners experienced both incrimination and absolution on the part of others and themselves almost immediately following a suicide, and throughout the ongoing processing and experiencing of the events that followed in the subsequent days, weeks and months. So, it seems that the actions or behaviours of 'others', which may be family, managers, colleagues, organisations, are perceived as incriminating or absolving, thereby shaping practitioners' experience within and across the three categories.

Findings from this review demonstrate a range of adverse emotional responses to a client death by suicide and therefore lend support to the idea that any individual exposed to suicide may experience a mild, moderate, or severe reaction [12,43]. Indeed, following a client death by suicide, some practitioners experienced trauma responses such as intrusive thoughts, nightmares, sleeplessness, sickness and heightened aversion to risk in their contact with clients. This aligns with previous research, which found that post-traumatic symptoms may be a response to suicide, in wider circles beyond family members, including therapists and mental health professionals [17,44]. Some of the most tangible of these trauma experiences were reported by those practitioners who were either present at the time of the death, who interacted with the body of the deceased, or who imagined what the death may have looked like. Previous research has found that train drivers who witness a death find the visual experience to be the most distressing aspect and law enforcement officers exposed to suicide scenes experience increased post-traumatic symptoms [45,46]. This suggests that visual experience may heighten trauma responses.

Practitioners may experience moral and ethical dilemmas following a client suicide and employ a number of different strategies to preserve their own wellbeing and reach a sense of absolution. A sense of moral- or value-led anguish was palpable for practitioners as they struggled to reconcile clients' suicidal actions with their professional drive to preserve life; this was vividly evident in their self-scrutiny as they asked 'what did I miss?', 'what did I get wrong?' This self-incriminating behaviour was apparent across professions in this synthesis and appeared to deepen the sense of responsibility and blame that practitioners perceived, sometimes to a level that they felt unable to contemplate the possibility of a repeat experience, should a subsequent client die by suicide. The practitioner strived to develop strategies to preserve their own wellbeing, for instance by absolving themselves of responsibility by formulating ideas of the 'autonomous client' and the 'client's choice' to die. These conceptualisations of client autonomy align with professional codes of ethics and practice that promote the concept of client autonomy as an important underpinning value in practice, such as the British Association for Counselling and Psychotherapy (BACP) ethical framework [47]. Narratives such as 'you can't save them all' and 'if they're going to do it they are going to do it' illustrate how practitioners may frame client autonomy in the instance of suicide. Testoni et al., [48] found that self-blame and other-blame were mutually excluding amongst suicide survivors who accessed support via self-help groups, that is, when survivors attention were oriented toward the social processes that may have contributed to a suicide the experience of self-blame was absent. It may be that the concept of the 'autonomous client' provides practitioners with the means to absolve themselves of a self-blame narrative. However, the concept of client autonomy does not appear congruent with a sense of blaming the client; rather practitioners, in this review, seemed to be seeking a means of accepting or even feeling compassion for their clients' actions. However, the 'autonomous client' concept presents a problem if we are to understand that people who behave in suicidal ways are not operating from a place of full autonomy; and, therefore, suicide is not a choice [49]. This leaves a gap in the narrative for a new 'story' to be developed that both mitigates the practitioner from misplaced blame and acknowledges that the suicidal individual may be highly distressed and as such, compromised in making clear and rational autonomous decisions. To move away from ideas of blame, Clarke [49] suggests a narrative of 'understandability' and 'respect for the person', which feels more comfortably aligned with the processes demonstrated by practitioners in this synthesis. Practitioners also seek to absolve themselves of the potential for future client death by suicide. This might include the adoption of practice habits that identify subsequent clients as risky and engaging in choices and behaviours that affect clients' experience of the service, even affecting their treatment through early hospitalisation [29]. This aligns with previous findings that suggest the impact of client suicide on professional practice may affect clinical assessment and treatment decisions including changes in assessing suicide risk, the frequency of referrals to other colleagues and choices of treatment including increased hospitalisation [50].

The findings of this review demonstrate that postvention responses are needed for this population of practitioners. In contrast, a significant narrative in the postvention literature situates practitioners as the providers of postvention and support rather than as those who are impacted and potentially in need of support themselves [51,52]. Those who have been impacted by a suicide death are often identified in the role of 'client', that is, the person who will be supported by a practitioner. The practitioner who has been impacted and who needs to be supported appears to be largely absent in the research literature about postvention need and provision. National postvention guidelines in the UK and US are underpinned by the Continuum of Suicide Survivorship model, with recommended responses guided according to the level of impact experienced by the individual [12]. In the UK, guidelines suggest that practitioners are likely to sit in the 'affected' category of the continuum, and recommend that all people bereaved or affected by suicide should at the very least be given guidance via a 'Help is at Hand' information leaflet or signposting to sources of support [53,54]. US national guidelines identify that everyone exposed to a suicide should be offered some level of postvention support; and this should be offered around three levels of care relating to immediate needs; ongoing support and clinical treatment [55]. It is clear that whilst these guidelines recognise the potential for trauma responses at all levels of exposure to suicide, they are constructed around the experience of the individual. This review has shown how social and cultural contexts may shape the individuals experience and, as such, it is important that postvention responses are rooted in these same contexts so that they are fit for purpose to meet need within diverse social and cultural settings. For instance, in settings where there are

greater taboos and stigma associated with suicide, it may be important not to be led by prescriptive generic, usually western, ideas of 'what works' [56]. It might be suggested therefore, that responses and support strategies could be developed locally. Indeed, Ting et al., [30] appeared to evidence how team cultures and the kinds of postvention support offered to practitioners may help them in developing a stronger sense of clarity that client actions and choices are distinct from practitioner actions and choices, which may be helpful in practitioners' own process of reconciling the event. Given that the findings of this synthesis situate the practitioners' experience within social contexts, this raises an opportunity for teams, managers and organisations to play a role in developing targeted and nuanced postvention responses that are specific to practitioner roles, practitioner relationships with clients and to practice settings. These findings align with Grad's [57] guidelines for mandatory and optional postvention responses for assisting clinical staff after a suicide.

As well as providing postvention support for practitioners, organisations may also have a role in preparing practitioners for the event of a client suicide. We know that practitioners have a higher likelihood than the general population of encountering suicide death that raises the question of whether support could begin before an event occurs [6–11]. This may take the form of preparing/training practitioners for a potential client suicide; talking about the possibility that it may happen and what it may be like, and what the organisational postvention policy and procedures would be. Juhnke and Granello [58] presented a six-point 'pre-suicide preparation plan' for Mental Health Practitioners; the plan addressed the things that can be put in place before an event to support practitioners if a suicide should happen, so, in essence, it is a postvention plan. However, the existence of a set of strategies may also nurture a culture in which exploratory conversations can take place before a suicide death occurs. Given the findings of this review, it might be suggested that pre-suicide preparation takes the form of educating practitioners ahead of the potential event around expected impact, strategies for coping and helpful narratives with the aim of supporting them to avoid the pitfalls of self-blame and incrimination.

4.1. Strengths and Limitations

This is the first review to bring together and synthesise the qualitative literature that reports the experiences of health, social care and education practitioners following the death by suicide of a client, patient, student or service user. This review adds to current knowledge of the experiences and postvention needs of this group of people after a suicide. The synthesis developed findings that moved beyond the individual experiences reported in the studies to situate those experiences socially and culturally. A strength of this review lies in the rigorous methodology applied to searches, quality appraisal, analysis and synthesis, guided by the ENTREQ statement [35]. However, findings must be considered in the context of the limitations of the study. This review set out to synthesise qualitative literature with a focus on experiences and perceptions, and as such has not included studies that considered causal relationships. Whilst the studies included in the review are situated globally, it is worth noting that four of the studies were undertaken in the US; and that two of the papers came from a single study in Canada. The review also only included studies published in the English language and is limited by the exclusion of research published in other languages. The diversity of professions, organisational settings and cultural contexts may also be seen as a limitation in terms of enabling generalisations to be made in the analysis; however, they identified a number of unifying experiences and together generated a synthesis that highlighted how social and cultural contexts shape individual experience.

4.2. Implications and Recommendations

Pre-suicide training should be provided to practitioners to prepare them for the kinds of thoughts, feelings and behaviours that they might experience following a client suicide. Postvention response and support policies should be developed that recognise that practitioners may also be potentially impacted by a client suicide: where the aim should be to mitigate trauma symptoms, adverse emotional responses and any subsequent adverse impact on future practice; and support be provided that is sensitive to the social and cultural context within which a suicide occurs and the ethical and organisational cultures in which practitioners are operating.

The challenges in contextualising the findings of this study point toward a need for broader and deeper understanding of the nuanced experiences of practitioners following a suicide. Qualitative studies would be well placed to explore the experiences of practitioners that have not previously been researched; for instance, by focusing on the experiences of specific professionals such as education

providers, or within specific settings such as Higher Education. Future research might also explore the experiences of trauma as opposed to bereavement following suicide with a focus on the wider networks that are exposed to or affected by a suicide. The processes of incrimination and absolution were identified in this review as impacting practitioners experience; the authors are not aware of these processes being previously identified in postvention literature, and further exploration of them and of their potential to shape experience would add to knowledge in this area. A meta-analysis of the quantitative literature that addresses the impact of suicide on practitioners would increase knowledge and contextualise the findings of this review by providing a more holistic overview of practitioner experiences.

5. Conclusions

This review explored the existing qualitative literature that reported on health, social care and education practitioners' experiences following the death by suicide of a client, patient, service user or student. This review highlighted both commonality and diversity of experience and has contextualised those experiences socially and culturally, by acknowledging the potential influence of settings in which practitioners operate and experience client suicide. The responses and behaviours of diverse 'others' are perceived by practitioners as incriminating or absolving and this can shape the ways in which a suicide is experienced. Within the broader postvention literature, the practitioner is often identified as a postvention provider supporting others who are impacted by suicide; this review demonstrated that practitioners can experience traumatic and adverse emotional responses to a suicide and that targeted postvention is needed to support practitioners in processing the impact and in developing narratives that enable continued safe practice. Postvention practice and policies should be contextualised socially, culturally and organisationally so that they are sensitive to individual need.

Supplementary Materials: The following are available online at www.mdpi.com/xxx/s1, Table S1: CASP appraisal of articles.

Author Contributions: Conceptualization, H.C. E.B. K.M. and J.S.; methodology, H.C. E.B. K.M. and J.S.; validation, H.C. E.B. K.M. and J.S.; formal analysis, H.C.; investigation, H.C.; data curation, H.C.; writing—original draft preparation, H.C.; writing—review and editing, H.C. E.B. K.M. and J.S.; visualization, H.C. E.B. K.M. and J.S.; supervision, E.B. K.M. and J.S.; project administration, H.C. E.B. K.M. and J.S.

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Appendix 3.2: Study 1: Details of searches undertaken; Article Screening and Exclusions.

Search undertaken – 08.01.18

PsycInfo:
Search Terms
Suicide AND [client OR patient OR service user OR student]
AND [impact OR effect OR influence OR experience]
Searching peer reviewed; English language; qualitative studies.
Returned 238 articles
Title screening rejected 223
Total 15 selected for further screening as detailed below.

Article	Abstract	Methods	Research Question	Presentation of Data	Further Appraisal Needed
Anthony (2017) (Awaiting full article)	No. Explores attitudes and experiences of nurses related to suicide. Not personal experiences of patient loss to suicide.	Focus Group			No
Christianson (2008)	Yes	Yes	Yes	Yes	Yes
Christianson (2009)	Yes	Yes	Yes	Yes	Yes
Darden (2011)	Yes	Yes	?	?	Yes
Davidson (2011)	Yes	Yes	?	Yes	Yes
Fairman (2014)	? Survey.	Online open-ended qual survey – coded and analysed using GT	Yes	?	Yes
Figueroa (2013)	No. Research evaluation of a retreat model to support clinicians who have experienced a client suicide.				No
Kendall (2010)	No. Exploration of GPs experience of using the Critical Incidence Review				No

Article	Abstract	Methods	Research Question	Presentation of Data	Further Appraisal Needed
	model following a patients death by suicide.				
Knox (2006)	Yes	Yes	Yes	?	Yes
Lasrado (2017)	?	No. Participants inc. survivors of suicide attempts.	No. Study explores perceptions of current interventions.		No
Plakun (2005)	Yes	No. Lit review and response to data presented is a separate study (Tillman, 2006).			No
Saini (2016)	?	Mixed methods. Questionnaires and semi-structured interviews. N=198 Analysis = descriptive statistics & qual framework analysis		Yes – rich data presented in qual findings section with three relevant themes.	Yes
Sanders (2005)	Yes	A sub-sample taken from a larger quant study. N=145 ppt were asked to complete two open questions about reactions following a client suicide. Data was written not spoken.	Yes. 'describe how you felt/feel'	?	Yes
Tillman (2006)	Yes.	Yes	Yes	?	Yes
Ting (2006)	Yes	Telephone interviews	Yes	Yes	Ues

CINAHL
Search terms as above: eng lang; peer review
Returned 765
Title screening rejected = 713
Total 52 selected for further screening as detailed below.

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
Alexander (2000)	No. Questionnaire survey n=247				No
Bohan (2008)	Yes	Yes	Yes. Experiences and reactions. Support received	Yes	Yes
Castelli Dransart (2014)	?	No. Questionnaire n=314.			No
Chritianson (2009)	See above.				Yes
Collins (2003)	?	No. Article – not research.			No
Combs (2007)		Lit Review			No
Cooper (1995)	No. Not a research article.				No
Darden (2011)	See Above				Yes
Davidson (2011)	See Above				Yes
Draper (2014)	? Interviews n=300+	No. Responses coded and statistically analysed.			No
Erlich (2017) Request copy RG	No. Explores general need for postvention via impact of a suicide death on care-givers ie. family/friends.				No
Fairman (2014)	See above				Yes
Farrington (1995)	No. Not a research article.				No
Figueroa (2013)	See above				No
Gaffney (2009)	No. Survey n=447				No
Gill (2012)	?	No. Discussion based in the literature.			No
Gulfi (2016)	Questionnaire n=271.	No. Statistical analysis			No
Halligan (2001)	No. Survey n=152	Statistical analysis			No
Hendin (2000)	? Semi-structured questionnaire	Open ended questions n=26	Yes	?	Yes
Hirschfeld (1998) ILR on 19-02-18	?	No. Two case studies with discussion.			No

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
Jacobson (2004)	?	No. Survey IES Scale			No
Jadhav (2011)	?		No. Explores Preparedness.		No
James (2005)	?		No. Personal reflection		No
Kendall (2010)	See above				No
Kolves (2017)	No.	Survey IES scale. N=138. Statistical analysis.			No
Kozlowska (1997)	?	No. Survey			No
Landeen (1987)	?	No. Case study.			No
Links (2001) Request copy RG	Same title as Hendin (2000) article??? Article is a summary of Hendin (2000).				No
Matandela (2016)	Yes	In depth interviews – content analysis	Yes. Experiences of nurses.	Yes.	Yes
Matthieu (2014)	No. Concerned with 'at risk' population				No
Mendes (2015)	No.	Editorial piece			No
Midence, K. et al. (1996) No copy – The effects of patient suicide on nursing staff. Journal of clinical nursing.					Not able to source article
Phillips (2013)	Yes	Interviews – thematic analysis	Suicidal behaviour – may touch on suicide as well – need to see full article.	?	Yes
Plaken (2007)	No. Q&A style article.				No
Pompili (2003)	No.		Suicidal behaviour		No
Robertson (2010)	?	Interviews n=2 Discourse analysis	Nurses asked to 'tell their story' of the event of a patient suicide.	Yes	Yes
Rothes (2013)	No. Self-report questionnaire	Content and statistical analysis		No rich data – all stats.	No

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
Rycroft (2005)	No. Personal account of client death by suicide.				No
Sanders (2005)	See above.				Yes
Schultz (2005)	No. Focus on supervisory relationship.				No
Scocco (2012)	No.	Questionnaire			No
Spiegelman (2005)	No. Case studies.				No
Thomyangkoon (2008)	No.	Questionnaire. Statistical analysis			No
Tillman (2014)	No.	Editorial piece			No
Ting (2006)	See above.				Yes
Tzeng (2005)	No. Explores medical workers views on causes of suicidality, compatred to those of family members and patients.				No
Walmsley (2003)	No.	Editorial piece			No
Welton (2006)	No. Anonymous survey n=97.				No
Whisenhunt (2017)	No.		Does not explore experience of suicide loss		No
Wurst (2010)	No. Questionnaire plus aggregated data from previous studies.	Statistical analysis.			No
Yujin (2013)	No.		Does not explore experience of suicide loss		No

Articles already returned in PsycInfo search = 8

Search – 02.02.18
SCOPUS
Search Terms: As above: Screening by Eng Lang; Journal Article; Qualitative; Interview

Returned 368
Title Screening rejected = 358
Total 10 selected for further screening as detailed below.

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
An Fhaili (2016)	? Focus group interviews	No. Ppts = suicide bereaved family members.			No
Chritianson (2009)	See above				
Clark (2014)	? Explores role of ritual for therapists following client death by suicide	Interviews		Data taken from original study (Clark, 2009). Unpublished doctoral dissertation. Emailed researcher to request copy.	Yes
Davidson (2011)	See above				Yes
Hunt (2016)	Mixed methods	Data of all patient suicides in England. Plus semi-structured interviews n=21.	3 research ques. No.3 = experiences of clinical staff.	?	Yes
Matendela (2016)	See above				Yes
Phillips (2013)	See above				Yes
Saini (2016)	See above				Yes
Tillman (2006)	See above				Yes
Wang (2016)	Yes	Semi-structured interviews	Yes	Yes	Yes

Articles already returned in PsycInfo & CINAHL search = 6

Search – 06.02.18

ERIC

Search Terms: As above: Screening by Eng Lang; Journal Article; Peer Review
Returned 451
Title Screening rejected = 432
Total 19 selected for further screening as detailed below.

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
Bachta (2007)	No. Personal reflection				No
Christianson (2008)	See above				Yes
Chritianson (2009)	See above				Yes
Ellis (2012)	No.	Lit review & commentary			No
Fang (2007)	No. Lit review and responses to training programmes				No
Foster (1999)	No. Lit Review & scope/impact of problem				No
Franson (1988)	No. Discussion of problem & strategies				No
Gaffney (2009)	See above				No
Juhnke (2005)	No. Review & commentary based on literature.				No
Lerner (2012)	No. Description of a training programme				No
McAdams (2000)	No.	Survey n=1000			No
Roberts (1995)	No. Details of a postvention case study				No
Ruskin (2004)	No.	Survey n=239			No
Thomyangkoon (2008)	See above				No
Ting (2006)	See above				Yes
Wurst (2010)	Yes.	No. Survey n=172. Statistical analysis.			No

Search – 06.02.18
Medline
Search Terms: As above: Plus Qualitative research OR qual study OR qual methods OR interview. Screening by Eng Lang; Journal Article
Returned 81
Title Screening rejected = 78
Total 3 selected for further screening as detailed below.

Article	Abstract	Method	Research Question	Presentation of Data	Further Appraisal Needed
Darden (2011)	See above				Yes
Fairman (2014)	See above				Yes
Ting (2006)	See above				Yes

Appendix 3.3: Study 1: Articles for final appraisal

The following articles have already been screened by title and abstract and a brief overview of their methodology; research questions and presentation of data.

Search Details	Authors	Title	Research Question/Aim	Method – Data Collection	Method - Analysis	Does the data address the Synthesis Question?	How is Data Presented?	Include in Synthesis?
CINAHL	Bohan,F., & Doyle, L. (2008)	Nurses' experiences of patient suicide and suicide attempts in an acute unit.	The study 'explores psychiatric nurses' experiences of and reactions to a patient suicide or suicide attempt to elicit their perceptions of the support they received after the incident.	Semi-structured, audio recorded interviews n=9	Burnard's (1991) method; detailed systematic description of themes.	Explores suicide attempts as well as suicide deaths. Explores nurses experiences; care; feelings and needs for support.	Short article = limited data, but includes rich verbatim quotes	Yes
PsycInfo	Christianson, C. L., & Everall, R. D. (2008)	Constructing bridges of support: School Counsellors' Experiences of student suicide.	Two questions: "What are school counsellors' experiences of client suicide?" and "What impact did the participants feel client suicide had on their lives?"	Semi-structured interviews – two interviews conducted per participant. N=7	Grounded theory using ATLAS program.	Yes.	By theme including verbatim quotes.	Yes
PsycInfo	Christianson, C. L., & Everall, R. D. (2009)	Breaking the silence: School counsellor' experiences of student suicide	Same study as above.	As Above	As Above	Yes.	Themes named differently – findings are presented with a different focus and include data distinct from that in the above article. Email sent to researcher to clarify reasons for this.	Yes
SCOPUS	Clark, J. (2014)	Engaging in ritual after client suicide: the critical importance of linking objects for therapists	Data taken from phd thesis that 'sought to explore the impact of client suicide on therapists.'	In depth, unstructured, open-ended Interviews	Narrative-type narrative enquiry and paradigmatic-type narrative enquiry.	No. Looks specifically at rituals following the experience of client death by suicide.	Data taken from original study (Clark, 2009). Unpublished doctoral dissertation. Emailed researcher to request copy.	No. Does not answer synthesis question
PsycInfo	Darden, J. A., & Rutter, P.A. (2011)	Psychologists' experiences of grief after client suicide: A qualitative study.	'we sought an in-depth exploration of the phenomeno-logical experience of psychologists who navigated a client's suicide'	Demographic questionnaire followed by in-person semi-structured interview. N=6	Qualitative analysis of themes, core ideas, categories and domains following CQR guidelines (Hill, 1997, 2005).	Yes.	Domains with illustrative verbatim quotes presented as a table. Interpretation of domains illustrated with further verbatim quotes.	Yes
PsycInfo	Davidson, A. S. (2011)	'And then one day he'd shot himself. Then I was really shocked': General practitioners' reaction to patient suicide.	"how GPs were affected by patients' suicides and whether their reaction was linked to their propensity to explore suicide risk in the patient who committed suicide, and how the GPs' current propensity was to explore suicide risk"	Semi structured interviews. N=14	IPA	Yes	Rich with verbatim quotes.	Yes
PsycInfo	Fairman, N., Montross Thomas, L. P., Whitmore, S.,	What did I miss? A qualitative assessment of the impact of patient suicide on hospice clinical staff.	'to examine the impact of patient suicide on hospice staff, and to elicit their recommendations about what support services may	Online open-ended qualitative survey. N=186. Questions included in table.	Coding, consensus, co-occurrence and comparison.	Yes	Some statistical data reported, followed by brief section of qual analysis	No. Online survey.

Search Details	Authors	Title	Research Question/Aim	Method – Data Collection	Method - Analysis	Does the data address the Synthesis Question?	How is Data Presented?	Include in Synthesis?
	Meier, E. A., Irwin, S. A. (2014)		be helpful after such events occur.'				illustrated with verbatim quotes.	
CINAHL	Hendin, H., Litschitz, A., Maltsberger, J. T., Pollinger Haas, A. & Wynecooop, S. (2000)	Therapists' reactions to patients' suicides	'we expanded our study to consider the therapists' ex-periences and to integrate them with the detailed information we collected about the patients, the therapy, and the patient-therapist relationships'	Data comes from a 'Suicide Data Bank' project in US. Inclusion involves completion of narrative description of the case; demographic and psychodynamic questionnaires and a semi-structured questionnaire + attendance at a full day workshop at which therapists discussed their cases. Open ended questions n=26	No details.	In part	Some info presented in a table. Themed sub-heads include some verbatim quotes.	No. Analytic method not reported. Findings include minimal verbatim quotes. Only addresses synthesis question in part.
SCOPUS	Hunt, I. M., clements, C., Saini, P., Rahman, M. S., Shaw, J., Appleby, L., Kapur, N., & Windfuhr, K. (2016)	Suicide after absconding from inpatient care in England: an exploration of mental health professionals' experiences.	3 research ques. (1) identify the numbers and trends of inpatient suicides following absconding in England; (2) describe key features of these patient suicides; and (3) examine the experiences of clinical staff who cared for the patients.	Data of all patient suicides in England. Plus semi-structured telephone interviews n=21.	Inductive thematic analysis	Not directly – findings address the question 'why' the events happened rather than 'what was it like' for staff when the events happened.	Verbatim quotes presented in tabular style.	No. Does not answer the synthesis question
PsycInfo	Knox, S., Burkard, A. W., Jackson, J. A., & Schaack, A. M. (2006)	Therapists-in-Training who experience a client suicide: Implications for supervision.	'to investigate therapists'-in-training experiences of a client suicide, focusing on the experience itself as well as on the role of supervision in coping with such an event.'	Demographic form followed by a semistructured interview in three parts: thoughts about suicide; experience of client suicide; experience of and motivation for participating in the interview. N=13	Analysed according to 'consenual qualitative research methods (Hill, 2005, 1997) ie. domains, core ideas, cross analysis.	In part – focus is in 'implications for supervision of trainees.	Lack of verbatim quotes. Domains/themes clearly illustrated. Use of an 'illustrative example' provides some rich data.	No. Does not adequately address the synthesis question. Findings section contains few verbatim quotes.
Hand search	Lazenby, R. B. (2006)	Teachers dealing with the death of students: A qualitative analysis.	"How do teachers deal with the death of a student?" Does not include any participants who experience a pupil death by suicide.	Informal interviews N=13	Cross case analysis.	No	Includes verbatim quotes.	No

Search Details	Authors	Title	Research Question/Aim	Method – Data Collection	Method - Analysis	Does the data address the Synthesis Question?	How is Data Presented?	Include in Synthesis?
CINAHL	Matandela, M., & Matlakala, M. C. (2016)	Nurses' experiences of inpatients suicide in a general hospital.	'to present the experiences of nurses who cared for patients who successfully committed suicide while admitted in a general hospital in Gauteng Province, South Africa.'	In depth interviews N=6	Content analysis to identify participants' narrative of their experience.	Yes	Short results section but includes high proportion of verbatim quotes.	Yes
Hand Searches	Moore, H., & Donohe, G. (2016)	The impact of suicide prevention on experienced Irish clinicians	'how does suicide prevention impact Irish mental health professionals who work solely with these vulnerable populations?'	In- depth, open-ended, semi-structured interviews. N=7	IPA	No.	Verbatim quotes included.	No
CINAHL	Phillips, L., Tannis-Ellick, S., & Scott, B. (2013)	Student nurses' experiences of support in relation to suicide or suicidal behaviours of mental health patients: an exploratory study.	To describe student nurses' subjective experiences of witnessing suicidal behaviours in their placements on acute inpatient wards; ' to highlight issues that were beneficial/unbeneficial to student nurses in terms of support following suicidal behaviour by patients; and ' to make recommendations for education and practice in terms of support structures for student nurses.	Semi structured interviews N=10	Thematic analysis	Indirectly. Focus is on 'suicidal behaviour' and participants experience of support. One participant shares her experience of a completed patient suicide.	Brief. But includes some verbatim quotes.	No. Does not adequately answer the synthesis question. Findings section brief. Includes experiences of suicidal behaviour. No clarification of how many ppts have experiences a patient death by suicide. Focus on experience of being a student rather than experience of a patient suicide.
CINAHL	Robertson, M., Paterson, B., Lauder, B., Renton, R., & Gavin, J. (2010)	Accounting for accountability: A discourse analysis of psychiatric nurses' experience of a patient suicide.	Nurses asked to 'tell their stories' of the event of a patient suicide.	Interviews n=2	Discourse analysis	Exploration more of the event than the impact upon the nurses.	Limited verbatim quotes and contextualised within other literature throughout findings section.	No. Does not adequately address the

Search Details	Authors	Title	Research Question/Aim	Method – Data Collection	Method - Analysis	Does the data address the Synthesis Question?	How is Data Presented?	Include in Synthesis?
								synthesis question.
PsycInfo	Saini, P., Chantler, K., While, D., & Kapur, N. (2016)	Do GPs want or need formal support following a patient suicide?: A mixed methods study	The specific objectives of this study were to: 1) investigate whether GPs were affected by patient suicide and what levels of formal support were available following patient suicide; 2) compare the characteristics of those GPs who were and were not affected by patient suicide; 3) compare the characteristics of those GPs who did or did not have access to formal support services following a patient suicide; 4) describe GP views on what support was needed following patient suicide.	Mixed methods. Questionnaires and semi-structured interviews. N=198	Analysis = descriptive statistics & qual framework analysis to identify key themes	Qual section = yes.	Yes – rich data presented in qual findings section with three relevant themes.	Yes
PsycInfo	Sanders,S., Jacobson, J., & Ting, L. (2005)	Reactions of mental health social workers following a client suicide completion: A qualitative investigation.	Please describe how you felt in the seven days immediately following the client suicide. Please describe how you feel now when you think about the client suicide.	A sub-sample taken from a larger quant study. N=145 ppt were asked to complete two open questions about reactions following a client suicide. Data was written not spoken.	Qual analysis of data = coding & constant comparative analysis to create thematic categories	Yes	In depth with verbatim quotes	Yes
PsycInfo	Tillman, J. G. (2006)	When a patient commits suicide: An empirical study of psychoanalytic clinicians.	'I am conducting a study about the effect of patient suicide on clinicians; I am interested in how this event has affected you. Would you tell me, in as much detail as possible, about your experience?'	Open ended interview N=12	Data interpreted via a psychoanalytic lens.	Yes	A 'research vignette' is presented to illutrate the depth and range of experiences – includes verbatim quotes. Also a thematic write up of findings which is contextualised in the literature.	Yes
PsycInfo	Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006)	Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide.	What are reactions experienced by mental health social workers after a client suicide completion?	Telephone interviews N=25	Constant comparative method & open coding.	Yes.	Full reporting including rich verbatim quotes.	Yes
SCOPUS	Wang, S., Ding, Z., Hu, D., Zhang, K., & Huang, D. (2016)	A qualitative study on nurses' reactions to inpatient suicide in a general hospital.	To explore the impact of inpatient suicides on nurses working in front-line, the patterns of regulation and their needs for support.	Semi-structured in-depth interviews. N=15	Colaizzi's 7 steps analysis method to identify themes	Yes	Includes ample verbatim quotes.	Yes

Key: Green = Include in synthesis Red = Exclude from synthesis

Appendix 3.4: Study 1: CASP Appraisal of studies

	Bohan & Doyle (2008)	Christianson & Everall (2008)	Christianson & Everall (2009)	Davidsen (2011)	Darden & Rutter (2011)	Kim (2019)	Matandela & Matlakala (2016)	Saini et al. (2016)	Sanders et al. (2005)	Tillman (2006)	Ting et al. (2006)	Wang et al. (2016)
1. Statement of Aims	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Appropriate methodology	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	y
3. Appropriate design	Y	Y	Y	Y	Y	y	Y	Y	Y	?	Y	y
4. Appropriate recruitment strategy	Y	Y	Y	Y	Y	Y Acknowledgment of challenges of recruiting teachers into the study	Y	Y	Ppts selected from a larger quant study – being the 145 ppts who had experience a completed client suicide.	Not described	Y – Ppts responded to an earlier quant study and indicated their interest in this study. Previous study anonymous so no ability to check whether a representative sample from the whole.	Y
5. Data collection method justified and clear	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y – national sample so T/C appropriate	Y
6. Consideration of relationship b/tw researcher & ppts	-	-	-	No. check other papers from same study		Acknowledgement that the researcher is a teacher	-	-	-	-	-	-
7. Consideration of ethical issues	Y 'ethical approval	Y	Y	No. check other papers		Y	Y	Y	-	-	-	Y

	Bohan & Doyle (2008)	Christianson & Everall (2008)	Christianson & Everall (2009)	Davidsen (2011)	Darden & Rutter (2011)	Kim (2019)	Matandela & Matlakala (2016)	Saini et al. (2016)	Sanders et al. (2005)	Tillman (2006)	Ting et al. (2006)	Wang et al. (2016)
	was also sought and granted from the hospitals concerned where required'			from same study								
8. Rigorous data analysis	No mention of oversight by other researcher	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Clear statement of findings	Y	Y – reported only findings relating to training & practice standards, support resources and self-care. Other findings relating to more personal impact are reported in Christianson (2009).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. Is the research valuable?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Date of Appraisal	15.03.18	22.03.18	21.03.18	13.03.18	16.03.18	11.04.19	12.03.18	14.03.18	21.03.18	21.03.18	20.03.18	15.03.18

Appendix 3.5: Study 1: Comparison of themes across studies

	Bohan (2008)	**Christianson (2008)**	**Christianson (2009)**	**Darden (2011)**	**Davidsen (2011)**	**Kim (2019)**	**Matandela (2016)**	**Saini (2016)**	**Sanders (2005)**	**Tillman (2006)**	**Ting (2006)**	**Wang (2016)**
What happened (experiencing the event)	Nurses' experiences of patient suicide/suicide attempts			The suicide	patients' suicides.	Examination of the suicide	Experience of disbelief and helplessness	Part and parcel	Trauma and shock			Nurses' cognition about inpatient suicide
Impact on practice (how do I practice now?)	Nursing care following an incident of suicide/suicide attempt			Clinical aspects of the case	Talking about suicide	Renewed perception of role in preventing student suicide			Changes in practice	- Risk management - Effect on work with other patients	Change in professional behaviour - changes in practice - Changes in the professional environment Intrusion Avoidant behaviours	Impact on practice
Emotional response (experiencing the feelings)	Feelings experienced by nurses following a suicide/suicide attempt		Taming the control beast Interpreting the dance	Impact	Emotional impact	Suspension of grief	Emotional reaction		Deep sadness and depression Anger and Irritability Continued emotional reactions	Traumatic loss and grief -traumatic responses - affective responses	Denial and Disbelief Grief and Loss Anger - at client - Agency and society	Psychological reaction

									Reconciliation Nothingness			
Experiences of support	Support for nurses following a suicide/suicide attempt	Support resources	Staying in the game	Recovery				Informal support systems				
Training needs		National training/practice standards										
Self care/ maintenance (survivor mindsets)		Self care	Staying in the game	Psychologist's view of suicide		Tolerance of the suicide					Acceptance	Patterns of regulation
Internal responses Self Scrutiny (am I ok, am I good enough)			Wearing the mask (pers/prof)		Self-scrutiny		Feelings of guilt and inadequacy	Failing patients	Feelings of professional failure Self blame Power and control issues	Professional identity - professional crisis - grandiosity, shame, guilt, humiliation, judgment, blame	Self-blame and guilt Professional failure and Incompetence Responsibility Justification	
Responses of others (Do they blame me?)				Client's Family			Feelings of blame and condemnation Fear of reprisal		Worries and Fear	Interpersonal relationships - treatment specific - relationships with	Isolation	

										colleagues		

Appendix 3.6: Study 1: Table of First Stage Codes

	Bohan (2008)	Christianson (2008)	Christianson (2009)	Darden (2011)	Davidsen (2011)	Kim (2019)	Matandela (2016)	Saini (2016)	Sanders (2005)	Tillman (2006)	Ting (2006)	Wang (2016)
What happened (experiencing the event)	The shared experience											
	The horror		The horror		The horror		The horror		The horror	The horror		The horror
		Panic & confusion		It must be a mistake					Bewilderment		This is a mistake	
		The dual role										
		Creating a response plan										
		Out of control										
		I need to do this										
				Seeing the body			Seeing the body					
					An appalling experience							
							The brutality					
							Providing the means / access to means	Did I prescribe the means?				Did I provide access to means?
									Disbelief	numbness	disbelief	
Emotional response (experiencing the feelings)	Shock			shock	Shock – the shock of the event		Shock & Disbelief		Shock	Shock & denial	shock	Shock & panic
	A traumatic event	trauma	Feeling trauma				trauma		trauma	trauma	trauma	

	overwhelm		'crawling on my knees'		A destabilizing impact		overwhelm		overwhelm		I came undone The outpouring	
			Feeling the loss			Needing to grieve	'my heart was painful'	Grief	Grief stricken	Deep intense grief	Grief stricken	
									Sadness, tearful, full of sorrow	Sadness, anger, fear	Anger	fear
									Anger with self			
									Anger with others			
		Am I allowed to grieve?				Grieving 'not affordable' No time to grieve						
		The feeling of aloneness	Other don't 'get it'							Feeling alone	Feelng alone	
		Isolation	Isolation							Isolation		
		Physiological response – sleeplessnes s & sick days	Physiological response - nightmares				Physiological response – I was shaking. Sleeplessnes s			Physiological impact - sleeplessnes s	Sleeplessnes s I felt deathly ill Sickness	Physiological impact – not eating - shaking insomnia
		Intrusive images – flashbacks/ night terrors					Hallucinatio ns		Intrusive images, flashbacks & memories	Intrusive images & thoughts Dreams	Intrusive memories & thoughts Feeling tormented by thoughts	Inrusive images
									Hearing voices			

			The personal within the professional						Feeling a personal loss	Missing the patient – Losing the patient		
			Delaying the grief/emotions	Acknowledging impact on others – not on self								
			'being swept back into the loss'			loss				Experiencing loss		
			Relationship with the client		Relational factors			Depth/ Longevity of patient/GP relationship	Relationship with client/and client's family	Feeling connected to patient		
			Perceptions of closeness					Perceptions of closeness		Perceptions of closeness		
				Absence of emotional reaction		Emotional oppression		Professional distance	No feelings			
				Gendered responses	A universal impact	Cultural impact on emotional responses		Age-related responses				
Impact on practice (how do I practice now?)	Unable to cope/burnout										Increased stress The anxious professional	Burnout Professional fatigue
	Hypervigilance			Hypervigilance	I am more vigilant	Hyper-vigilance				Hypervigilance	Hyper-vigilance	Hyper-vigilance
	Weight of responsibility					Feeling the burden						
										Self-castigation		

	The dual role – the harmed and the healer	The dual role – the harmed and the healer	The dual role – the harmed and the healer			The dual role – obligations before grief					The dual role – the harmed and the healer	
			The dual role – being leaders and grievers									
		"I just didn't have the energy"										
		Can I stay in this job?	Re-assessing client group (to work with)						Leaving the profession	Leaving profession Distancing self from intervention	Leaving private practice Moving location	Thought of resigning Changing job departments
			Will the clients still trust me?						Will other clients die by suicide?		Fear of another suicide Avoiding suicidal clients	Avoiding job tasks
		Impact on professional capacity	Professional growth from loss					Learning from practice	Making changes to practice Raised awareness Inspired learning	Greater sense of fallibility	Working more closely with colleagues/ within the team	
		Suicide as the most stressful client issue		'the most dangerous event'			A critical event			A professional crisis		

			Carrying on									
									Questioning professional values eg: self-determination	Re-visiting values & beliefs	Re-visiting practice	
										Professional doubt about model of practice		
				Increased use of risk assessments		Labeled as 'over-reacting' Fear or risk 'over-sensitive'				Heightened responses Risk anxiety	Increased agency use of risk assessments Fear of risky clients	
											Practice leaking into personal life	
									Increased confidence			
									Improved my practice		Organisational practice improvements	
										Questioning professional judgement 'my patients are being cheated'		

					Avoiding the 'suicide' word with patients	Avoidance and hesitation				Avoiding suicidal patients		Avoiding the location
					Talking more with patients							
									Greater trust in intuition			
						Work-place conflicts over response strategies					Changes to organizational policy Increase in post-vention activities	
Internal / cognitive responses Self Scrutiny (am I ok, am I good enough)	The autonomous client			The autonomous client			The autonomous patient	The autonomous patient	The autonomous client 'she wanted to die'		The autonomous client	The autonomous petient
				Client did what he had to do					The client in control The client's will		The client's choice	I could not help him
								You can't save them all	You can't save them all		'If they're going to kill themselves they're going to kill themselves"	You can't prevent them all Hard to prevent
									Empathy toward client			

	Responsibility	Responsibility	Responsibility	responsibility		Blaming self	Responsibility and self-blame	Am I to blame?	Responsibility Feeling repsonsible Blaming self	Responsibility Am I to blame? Self blame Self judgement	Responsibility – managing risk Self blame Am I to blame?	Am I to blame? Self-blame
			Am I responsible	Is it my fault	Did I miss something? Was there a sign?	Feeling regret	'I have killed the patient'	Did I miss anything?	Could I have done more? What did I miss? What else could I have done?	What did I miss?	What else could I do? What did I miss? I missed it	What did I miss? Did I do something wrong? I should have known
					Was I wrong?	Reflecting on own role		I thought he was getting better		Searching for answers	Trying to make sense	
	Life or death											
	"to keep them safe"						Letting others down – they trusted me	Failing the patient			Remorse & guilt	
				We cared for the patient		Not preventable			I couldn't have done more		Couldn't have done anything differently	We can't always be there
	Blaming the patient			Client gave no clues	Frustration with the patient	No clues	Patient didn't warn us – there were no clues		He left no clues	Anger toward patient	Angry with client	Patients don't give clues

									Regret for the client		Empathy with the client	
	Investing time and effort					I did my best		I put myself out/went the extra mile			I did all I could	I did what I could
						Questioning intent to die They made a mistake A resented death					Judging the client & their choice	
											Left to pick up the pieces	
	Professional failure			Questioning own practice	professional failure	Recognising limits of ability	Professional failure		Professional failure		Professional failure	Professional failure
				Self scrutiny	Self scrutiny	Self scrutiny	Self scrutiny	Self scrutiny	Self scrutiny	Self scrutiny	Self scrutiny	
									Ongoing scrutiny			
					The labour of self scrutiny				Rumination	Shame	Shame and weakness	
				What could I have done differently?	What could I have done differently?				What should I do differently?		What could we have done differently?	
			Questioning professional identity	Professional identity – the healer	Here to help				The helper	Questioning professional beliefs		
			Who am I now?							Dissociation – cut off from self		
			Am I good enough?	Am I good enough	Self-expectation		Was I good enough		Was I good enough?	Am I good enough?	Am I good enough	Am I good enough

	The expected death	The expected death	An expected event	An expected event	The expected death			An expected death 'part and parcel'		A risk of the profession	The expected death	
					The unexpected death	The unexpected death	The unexpected death		The unexpected death	The unexpected death	The unexpected death	The unexpected death
		I had to be strong										
			Needing to feel in control			Seeking understanding		You just have to deal with it	Seeking understanding	Needing to make sense		
						Part of the job		The distress is part of the job				
			Feeling out of control						Feeling powerlessness & out of control			Powerless
											Bearing the weight	
											I followed procedure	
					Guilt							Guilt
												Avoidance – not thinking about it
Responses of /towards others (Do they blame me?)	Organisational frameworks		Un/helpful Professional frameworks	Organisational structures as barriers to healing		Formal processes as absolving				Private practice as isolating		
												Managerial responses - blaming v learning

			Anger toward the organisation	Organisational failing		Blaming others Anger towards the family	Institutional responsibility		Others let the client down Blaming others Others got it wrong	Anger toward colleagues	Organisational failing Anger toward senior staff	
			Systemic failure	A systematic failure			Risk factors					
						Cultural codes of behaviour Suicide shame						
	The angry family						The patient's family Being accused / being threatened			The gracious family		Fear of family response
										I deserved for them to be angry		
									Concern for clients family			
										Family contacts as a source of comfort		
	What will others think?			What will they think of me?			Fear of the responses of others			Judging others responses	Fear of the responses of others	Fear of others responses

												Expectations of others
										Feeling judged	Fear of being judged	Fear of being judged Feeling judged
			Do they blame me?	Fear of being blamed		Being blamed	Fearing, Being & feeling blamed	Others blame you	Being blamed Do others blame me?	Being blamed by family Feeling blamed by colleagues 'you fucked up'	Feeling blamed Being blamed by colleagues	Being blamed by colleagues
			Fear of professional judgement				'You should have kept him safe'			Professional judgement/ insecurity		
		Fear of professional repurcussions for seeking support	Fear of reprisal	Fear of reprisal			Fear for job security					
			Fear of litigation	Fear of legal involvement					Threats of litigation	Litigation/ Legal implications Persecutory anxiety	Fear of litigation	
				Don't talk to anyone		Culture of silence Being silendced				Being silenced	Being silenced	
						Not talking about suicide				Not telling others	Not talking about it	

			De-valued by other professionals			Institutional reputation Institutional shame	Fear for professional reputation			Fear for professional reputation		
									Unhelpful comments of co-workers	Peer scrutiny	Fear of scrutiny	
			Supporting the community of grievers									
				Availability of resources at organisational level								
				Don't contact the family								
				Fear of the media								
											Validation from colleagues	
											Others knew him differently – 'who is this?'	
Experiences of support	Support is crucial							Valuing support		Supervisory support to seek answers		
	Peer support	Peer support						Peer support		Peer support		
										When support isolates		

	Talking support	Talking support		Talking support				Talking support			Talking support	
	A shared experience	Sharing experiences		A shared experience	Sharing the experience					A shared experience	A shared experience	
	Personal support networks		Support networks					Personal support				Personal support networks
												Spiritual support
	Formal support	Formal & Informal support	Informal support	Informal support – colleague support				Informal support networks				Support from managemen t
	Recognise my needs										Seeking support elsewhere	Psychologica l support
	Feeling supported	Experiencing support	Seeking support					Where does support come from?		Feeling supported		
		Someone by my side										
		Professional isolation	Professional isolation	Isolation as a barrier to recovery				Professional isolation			Professional isolation	
		Lack of support – organisation al lack	Lack of resource for learning and growing					Not sure If support is available	Agency didn't know how to provide support			
		Professional challenge										
		Needing someone to take care of me								Needing support	Needing support	Needing support

		Unmet needs	Unmet needs	Unmet needs			Unmet needs			Lack of support	Unmet needs Lack of support from team	
		"what about me?"	Caring for others / neglecting self									
			Duty first									
				Not talking about it	Not talking about it							Not wanting to talk
					Not seeking support			Not seeking/ needing support		Avoiding support		
				Others don't 'get it'						Feeling let down by colleagues		
				Process hinders grief				Procedure/ Process is helpful		Process as helpful	Process (litigation) hinders support	Process as unhelpful
Training /resource needs	Being skilled matters				Knowledge and skills could save lives							
	Team learning needs							Learning needs	Training needs		Training around the impact of client suicide on self and colleagues	Learning neeeds Postvention training
		We were unprepared			Feeling unskilled	No training Improvement in	Not having the skills		Feeling unprepared			The unskilled nurse

						responses in skills						"I should learn about patient suicide"
		Lack of national direction										
		Self care as a learning need										
		Lack of resource		Lack of resource								
							Institutional training needs					Professional training needs – the psychological patient
											Support groups for professionals impacted by client suicide	Diverse support resources to meet different needs
Self care/ maintenance (survivor mindsets)	Needing space		Quiet time								Needing to be alone	
	Strategies for coping											
		Self-healing	Self-care									
			Self care – spiritual healing									
		Being strong – putting own grieving aside to care for others	Focus on work tasks / others needs	Maintaining professional confidence							Regaining a sense of professional competence & control	

			Endurance							Feeling more 'solid'		
		Using ritual to heal				Using rituals to say goodbye					Rituals for closure	
		Being active in own healing	Working hard to move on			Seeking acceptance					Acceptance of the clients choice and actions	
						Forgetting the suicide/student Forgetting as an achievement						
			Maintaining a connection to the experience									
			Hopefulness									
						Perception s change over time			Personal and professional growth	A transforming experience		
			Impact over time	Ongoing impacts	Engraved on the mind		Ongoing impacts		Ongoing feelings & impact	Ongoing impacts & grief		Ongoing impact
									Does time heal?			
									Impact of previous experiences of suicide deaths			
									Long-term recall of details	Heightened sensitivity		

Appendix 4.1: Study 2: Certificate of Ethical Approval

University of Worcester

HEALTH AND SCIENCE RESEARCH ETHICS COMMITTEE (HSREC)

FULL REVIEW OUTCOME

6 November 2017

HSREC CODE: SH17180008-R

A CRITICAL EXPLORATION OF STAFF EXPERIENCES AND ROLES FOLLOWING A STUDENT DEATH BY SUICIDE WITHIN THREE UNITED KINGDOM HIGHER EDUCATION INSTITUTIONS

Dear Hilary

Thank you for your application for full review ethical approval to the Health & Sciences Research Ethics Committee on the 28 September 2017.

Your application has been reviewed in accordance with the University of Worcester Ethics Policy and in compliance with the Standard Operating Procedures for Proportionate Review.

The Committee has now completed its peer review of the project work and is happy to grant this project ethical approval to proceed.

Your research must be undertaken as set out in the approved application for the approval to be valid. You must review your answers to the checklist on an ongoing basis and resubmit for approval where you intend to deviate from the approved research. Any major deviation from the approved application will require a new application for approval.

As part of the University Ethic Policy, the University Research Committees audit of a random sample of approved research. You may be required to complete a questionnaire about your research.

Yours sincerely

John-Paul

DR JOHN-PAUL WILSON
Deputy Pro Vice Chancellor Research
Acting Chair of the Health & Sciences Research Ethics Committee

Appendix 4.2: Study 2: Application for Ethical Approval

Details of the Research

Context and Rationale

Student Suicide

The death by suicide of a young adult is a premature and potentially preventable death that carries significant personal and socio-economic cost. A single suicide can adversely affect up to 60 people (Berman, 2011), the economic cost of a suicide death has been estimated at £1.67 million [figure updated to 2009 prices] (Platt et al., 2006). Student suicide within United Kingdom (UK) Higher Education Institutions (HEIs) can have a detrimental impact on the emotional wellbeing of student peers and staff members (Stanley, Mallon, Bell, Hilton & Manthorpe, 2007).

Available figures demonstrate an increase in the number of UK deaths by suicide amongst full-time students aged 18+ from over the past ten years as illustrated in Figure 1 below, (mwproject.org, 2016).

Figure 1.

UK total deaths by suicide amongst full time students aged 18+ (Office of National Statistics; National Records of Scotland; Northern Ireland Statistics and Research Agency)

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
118	120	97	121	129	158	149	139	128	166	163

It is difficult to establish an accurate figure for the number of student suicides that occur within UK HEIs. This is due to combining higher and further education students within the statistics; identification of part-time students as being employed (Stanley, Mallon, Bell, Hilton & Manthorpe, 2007; Mallon et al., 2009; Hawton, Bergen, Mahadevan, Casey, & Simkin, 2012); use of open or narrative verdicts by coroner's offices (Gunnell, Bennewith, Simkin, Cooper, Klineberg, Rodway et al., 2013); and lack of clarity around student status at the time of death if a suicide occurs during a planned leave of absence due to ill health (NUS Disabled Students, 2016). Therefore, the figures above are likely to be an underestimation of student deaths by suicide.

In the UK, the rates for student suicide within HEIs are in line with the equivalent age group in the general population (Universities UK & SCOP, 2002). This is supported by findings from two university-based studies that present longitudinal comparisons of student suicides with the equivalent age group in the general population for Oxford (Hawton et al., 2012) and Cambridge Universities (Collins & Paykel, 2000). This data is not representative of student cohorts at all UK HEIs; however, it is the only data that explores these comparisons. These figures suggest a need for caution about identifying the HEI or student status as a protective or risk factor for suicide amongst the young adult population.

Risk Factors

Mallon et al., (2009) found individual risk factors across a sample of student suicides in common with the age-related population, Including diagnosed mental health problems that may be compounded by associated stigma; combined mental health problems and substance misuse; break-up of a

relationship; doubts around sexuality; and the trait of perfectionism (Mallon et al., 2009). The study also found specific suicide risk factors within the student population: the challenges presented by regular transition periods within the academic year and across an academic course of study (evident in 15 of the 20 suicide deaths in their sample); and a fear of failure within a culture that is focused on academic achievement (evident in 10 of the 20 student suicide deaths in their sample). Students with suicidal ideation also fail to engage with services sufficiently early or in sufficient depth (Stanley, Mallon, Bell, & Manthorpe, 2010). Whilst the rates of death by suicide amongst the student population are in line with those in the general population, and some identified risk factors are shared with the wider population, the transitional nature of student life and the culture of achievement within HEIs introduce different risk factors.

Maple, Cerel, Sanford, Pearce, & Jordan (2016) highlight that the risk of suicidal behaviours among those exposed to a suicide is significantly higher than those unexposed. This phenomenon, when concentrated by time and proximity is known as contagion, whereby a death by suicide heightens the risk of a further death by suicide. Zenere's (2009) model of contagion highlights three factors that heighten an individual's risk: geographical proximity, psychosocial proximity and pre-existing vulnerabilities. Within a student population, and across a HEI community, where high-density campus-based living, learning and work activities occur, there is potential for more than one of these criteria to be met.

There are distinct and specific features or risk factors pertaining to student suicide, and to the community of a HEI, that may be unique and different from those within the general population. This PhD will explore the question of whether the impact of a suicide within a HEI context also has unique features and if so, what do those features look like?

This idea of the HEI as a community offers the opportunity to employ a framework such as a Community of Practice (CoP) model (Lave & Wenger, 1991) to explore and understand the impacts and responses that pertain to a death by suicide of a HEI student.

Impact

Andriessen, Draper, Dudley, & Mitchell (2016) conducted a systematic review of the impacts on adolescents exposed to or bereaved by suicide; they include grief symptoms such as guilt, blaming, shame and anger; changed perceptions of life, death and relationships; increased likelihood to experience psychiatric problems; greater risk of long-term mental health issues. Their ability to manage these challenges may be inhibited by pre- and post-loss factors like the stability of family networks, strength of friendship networks and previous experience of mental illness. Shneidman (1969) asserted from his professional knowledge of the topic that each death by suicide would affect an average of six people. This figure became embedded in the literature. A small scale survey of 145 members of survivor support groups, from the United States, challenges that figure by suggesting up to 60 people may be affected or bereaved by a suicide (Berman, 2011). Berman (2011) highlights that the suicide deaths of younger people may impact a higher number of people; bereaved parents estimated that up to 80 people may be considered survivors following their child's death by suicide, due to the higher number of people that children and younger adults are in daily or weekly contact with. This raises the question as to whether a high-density population and close proximity of campus based

living increases the felt impacts of a student death by suicide within a HEI community.

HEI staff members are likely to be impacted by a student suicide (Stanley et al, 2007). The sparse literature that pays attention to HEI staff after a student suicide focuses on staff roles in terms of looking after the student population and meeting procedural responsibilities (Stanley et al., 2007), or seeks their thoughts around the contributing factors of a student suicide (Mallon et al., 2009). A qualitative study of teacher's responses to pupil deaths in United States secondary schools set out to fill an identified gap in the literature concerning the kinds of support teachers need following a pupil death (Lazenby, 2006). The findings from 13 interviews identified teachers as the 'forgotten grievers', their responses and needs remained unrecognised by their employers following a pupil death (Lazenby, 2006). Likewise, the experiencing of a student suicide by HEI staff has not yet been explored. A number of studies examine the experiences of different groups of professionals following the death by suicide of a service user. Front line professionals (Gaffney, Russell, Collins, Bergin, Halligan et al., 2009); mental health professionals (Castelli Dransart, Heeb, Gulfi, & Gutjahr, 2015; Takahashi, 1997; Tillman, 2006); counselors (McAdams & Foster, 1999) and GPs (Foggin, McDonnell, Cordingley, Kapur, Shaw et al., 2016) evidence the experience of a personal and professional impact, feelings of guilt and perceptions of blame following the death by suicide of a service user.

A 'continuum of survivorship' model describes the range of impact a suicide death may have; it proposes that impacts of suicide in the United States general population range from 'exposed to', through 'affected by' to 'bereaved by' a suicide death (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014).

It is currently unknown who, amongst HEI staff, perceive themselves to be impacted by a student suicide, how they are impacted and what the impact is like for them. This PhD will enable an exploration of these questions and whether the impact of a student suicide on HEI staff mirrors the experiences of other staff groups, general population groups, or if there are unique, currently unknown, features.

Postvention

Postvention describes the activities that take place after a death by suicide to support the 'survivor-victims' (Shneidman, 1969). Within a HEI this describes any response or actions that aim to meet the needs of students and staff. Good postvention support can be a preventative measure as it provides a protective factor for those who are affected by a suicide, and may be demonstrated to lower risk of further suicide by contagion (Andriessen et al., 2016). Implementation of postvention strategies would be the responsibility of specific staff members within a HEI creating a potential dual experience for some staff members as being both impacted by a student suicide and responsible for meeting the needs of others who are impacted. Postvention literature is described as 'sparse and narrow', focusing on the experiences of family members and friends after a suicide (Andriessen, 2014; Bartik, Maple, Edwards, & Kiernan, 2013). There is a gap in the literature around the postvention experiences of wider networks such as HEI staff. This prompts the question of what the postvention needs within the staff community of a HEI are, and whether current postvention approaches meet those needs.

The research question

This study therefore seeks to ask the following questions:
• How is a student suicide experienced by staff members within a UK HEI and what are the features of that experience?
• Do staff members undertake specific postvention roles following a student suicide, if so, what kinds of roles, and are there any staff needs attached to delivering them?

Study aim and objectives
Aim:
To critically examine the experiences and perceptions of staff working within a UK HEI where a student suicide has been a recent event (between 2 years and 9 months prior to the study), in order to:
a. Identify how a student suicide is experienced by staff members within a UK HEI and highlight the features of that experience
b. Undertake a critical exploration of the experiences of a cross section of UK HEI staff members following a student suicide
c. Explore whether staff members undertake specific postvention roles following a student suicide, if so what kinds of roles, and are there any staff needs attached to delivering them?
d. Understand whether staff members feel they need postvention support, whether support is offered, the nature of support and how the support is experienced, any unmet needs and whether existing postvention models suit the needs of a UK HEI community context.

Objectives:
1. To ascertain the range of staff within UK HEIs who identify themselves as having been impacted by a student suicide, and to explore the range of impacts and needs as identified by these staff.
2. To ascertain the formal roles which are undertaken by staff members following a student suicide. To understand who undertakes these roles, and whether there are any specific needs attached to delivering them.
3. To explore the perceptions and experiences of a cross section of UK HEI staff members following a student suicide.
4. To understand if UK HEI staff members have postvention needs following a student suicide, whether postvention support was offered to them and whether it was suited to their needs. To inform a critical exploration of the application of current postvention models within a HEI community of practice context.

Methods of Data Collection
Due to the sparse research in this area the proposed studies will take a qualitative approach to seek out a detailed understanding of staff experiences and perceptions. The purpose of the research is to look in detail at the phenomenon of a student suicide within a HEI from the perspective of staff members experiencing of the event and of any roles or responsibilities that they undertook associated with the event.

This Application for ethical approval concerns Study 2 and Study 3 of the PhD Research.

Study 2: Scoping Study
This study seeks to ascertain the range of staff within UK HEIs who identify themselves as having been impacted by a student suicide, and to explore the

range of impacts and needs as identified by these staff. In addition it seeks to ascertain the formal roles that are undertaken by staff members following a student suicide. To understand who undertakes these roles, and whether there are any specific needs attached to delivering them.
This will be achieved via a scoping study that takes the form of a survey (Appendix A) consisting of closed questions to identify range of staff and range of impacts (using Cerel's continuum of survivorship to describe types of impact). In addition, open questions will be utilised to identify perception of impacts and needs following suicide; types of roles undertaken and needs attached to roles. A content analysis will identify key themes from the open questions.
Participants of this study will be staff members across purposively identified departments/job-roles within 3 UK HEIs. Please see below for detailed steps regarding participant selection and recruitment.
The survey will be disseminated to staff via heads of departments either electronically or in hard copy dependent upon the format that is most accessible to the staff team/member. A participant information pack and consent form will be integral with the survey (Appendix A). The timeframe of one month will be given for the completion and return of surveys.
A small-scale pilot of the paper version of the survey has been undertaken amongst the researcher's peers at the University of Worcester to test that the survey 'makes sense', is readable and that participants are able to understand what is being asked of them. Two minor amendments were made to wording and a 'Participant Number' box was added in response to feedback. A further pilot of the survey will be undertaken during October 2017 to test the usability of the electronic version.

Study 3: Interviews
This study seeks to explore the perceptions and experiences of a cross section of UK HEI staff members following a student suicide. It also seeks to understand if UK HEI staff members have postvention needs following a student suicide, whether postvention support was offered to them and whether it was suited to their needs. To inform a critical exploration of the application of current postvention models within a HEI community of practice context

This study takes the form of semi-structured interviews. The interview design will be informed by responses/findings from study 2. A guide illustrating the kind of topics that will be asked in the interviews is attached (Appendix B). Interviews will be scheduled at a mutually convenient time and in a private location on the participant's campus. Interviews will be digitally recorded for later transcription by the researcher. A constructivist grounded theory analysis following the protocol described by Charmaz (2014) will be employed.
The proposed process of participant recruitment is detailed below. Participant information packs and consent forms will be used in the recruitment process. (Appendices C & D).
References (Appendix E)

Who are your participants/subjects? (if applicable)

Higher Education Institutions (HEIs)
It is proposed that three HEIs will be invited to act as sites for participant recruitment for studies 2 and 3; this gives scope for heterogeneity in terms of

size, location, academic specialism and age of establishment. The criteria for inclusion is that a full time student at the HEI has died by suicide no longer than two years and no more recently than 9 months prior to the commencement of the first study. The length of the coroner's process following a suicide death in part dictates the rationale for this time-scale. In addition, the researcher has paid attention to the likely processes that staff members impacted by a student death by suicide may have experienced. Theories of grief and bereavement refer to 'stages' (Kubler-Ross, 1975), or phases or tasks (Worden, 2003). Most theorists agree that the process of passing through such stages is an individual one influenced by a range of personalised factors, and as such it is difficult to suggest a 'normal' time frame for the process. However, it is likely that after a period of nine months that the initial stages of Denial/Shock and Anger (Kubler-Ross, 1975), or the phases of Numbness and Yearning (Worden, 2003) will have been completed by those impacted by the death. The end date of the timescale reflects that the death needs to be recent enough to allow recall by the participants.

Staff members within HEIs
From within the HEIs, individual members of staff across a range of job roles and departments will be invited to participate in studies 2 and 3.

Study 2 : The number of participants will be subject to the sizes of and numbers of departments within each HEI site that are meet the criteria to participate (detailed below). The option to participate in the survey will be offered to the whole population of relevant staff groups. This will include staff members from a range of departments and job roles across the HEI, including but not limited to, academic staff; facilities staff; Student Union staff; student wellbeing staff; administrative staff. At the end of the survey participants will be invited to give consent to be contacted to participate in Study 3 (Appendix A).

Study 3: A purposive sample in the region of 20 participants across all three HEIs will be invited to participate in this study. The sample will be selected according to responses and findings of study 2.

How do you intend to recruit your participants? (if applicable)
Recruitment of participants will take three stages
1. the invitation to interested HEIs to participate in the study
2. the recruitment of individual staff members within those HEIs to participate in Study 2.
3. the recruitment of individual staff members from the participants of study 2 to participate in study 3.

Stage 1:
Utilising existing networks a preliminary email has been sent to a small selection of HEIs and HE Organisations for wider dissemination. This email set out the purpose and nature of the study and invited initial expressions of interest by HEIs to act as sites for participant recruitment for studies 2 & 3. The preliminary email has garnered a positive response and firm expressions of interest (Appendix F).
Following ethical approval by the University of Worcester recruitment will follow the steps detailed below:

- A formal invitation to interested HEIs will be made by a letter (Appendix G) from the researcher to the identified point of contact (Appendix F).
- John de Pury, Assistant Director of Policy at Universities UK and Ross Renton, Pro Vice Chancellor for Students at University of Worcester have both offered to give their support to the recruitment process and this will be highlighted in the letter.
- The letter will outline the study details and rationale and will invite the HEI to act as a site for participant recruitment for studies 2 and 3 of the PhD.
- The letter will include an overview of the research proposal and proof of University of Worcester ethical approval.
- When the point of contact at the HEI confirms interest in becoming a recruitment site of participants the researcher will arrange to attend a face to face meeting at which site-specific strategies for recruitment and safeguarding of participants can be discussed and agreed.
- The researcher will provide the HEI with a proposed timeline for the study and a press release (Appendices I & J) that they may publish in internal newsletters and memorandum so as to inform their employees that the HEI is participating in the study.

Stage 2:
- The researcher will identify a key point of contact at the HEI, with whom she will liaise to identify potential participants for Study 2. This will be a purposive selection process guided by a selection framework, identifying potential participants by job role and/or departments within the HEI (Appendix K).
- The study survey, participant information sheet and consent form (Appendix A) together with an introductory email/letter (Appendix L) will be disseminated by the HEI to appropriate heads of department who in turn will disseminate to individual staff members, the survey and associated info will be provided in both electronic and paper copies so as to meet the differing needs of individual job roles.

Stage 3:
- Potential participants for study 3 will be purposively selected via Study 2. This purposive sample will be informed by the findings of study 2 and the responses of individual participants. Only participants who have given permission to be contacted following Study 2 via the tick-box question at the end of the survey will be asked to participate in Study 3.
- The sample size will be in the region of 20 participants (grounded theory requires as many participants as is needed to reach a point of 'data saturation').
- Potential participants will be contacted directly by email or letter with participant information packs and consent forms for the interview study (Appendices M, C & D).

How will you gain informed consent/assent? (if applicable)

Consent will be obtained from both the HEI (Appendix G) and the individual staff members within the HEI who participate in the studies 2 & 3 (Appendices A & D). This will be done by providing participant information packs and a consent form. These documents will be provided in electronic and paper form so as meet the needs of different staff job roles.

Confidentiality, anonymity, data storage and disposal (if applicable)
Participants will be assured anonymity and secure storage of all data collected as detailed in the data management plan below.

Data to be collected Personal experiential responses and accounts of individual participants

How data will be collected Surveys – digital or paper copy as appropriate to participants needs.
Semi structured one-to-one interviews will be digitally audio recorded.

How the data will be stored In line with the University of Worcester Data Protection Policy, digital data will be stored securely on the researcher's password protected computer drive and paper surveys will be stored in a locked filing cabinet both situated in an office accessible by card-pass only.
When paper-based data has been digitised all paper-based surveys will be destroyed by shredding.
Storage spaces are accessible only by the researcher, but will be available for auditing by the supervisory team and relevant ethics committees.

How data will be retained and disposed of In line with recommendations of the University's Policy for the Effective Management for Research Data, digital audio recordings will be retained until the audio has been transcribed by the researcher and will then be destroyed. Anonymised surveys, data processed from surveys and anonymised interview transcripts will be retained for up to 10 years, after which point data will be destroyed.
Participants will be informed of this process in their participant information pack prior to data collection.

How retained data will be accessed Retained data can be accessed by contacting University of Worcester Research School or the researcher directly.
Freedom of Information requests will be referred to the University of Worcester's Head of Information Assurance.
Data that is part of an ongoing research project is not able to be subject to a Freedom of Information request.
Data that pertains to individual participants is protected by UK Data Protection legislation.
Data that pertains to Institutions will be protected by use of a coding system that will be destroyed by the researcher at the end of the research project.

Potential risks to participants/subjects (if applicable)
A risk assessment and management pro-forma (Appendix N) has been undertaken for studies 2 & 3. It details identified risks and associated management/mitigating factors that pertain to:

- The HEI
- The individual participant
- The researcher

Further protective factors for participants are detailed in the Participant Information Sheets (Appendices A & D).

The researcher as a protective factor:

- The researcher is a mature student with comprehensive workplace experience in conducting assessment interviews and support sessions with vulnerable adults and children. The researcher is trained and experienced in using counselling skills, in listening to others talk and in working with individuals in a face to face, one to one setting, and as such is confident in her ability to provide as relaxed, open and supportive environment as possible for these research interviews.
- The researcher has previous experience of undertaking semi-structured research interviews with counselling clients
- The researcher will be engaged in a process of ongoing observational 'risk assessment' throughout all contact with participants; whereby, if the researcher feels concerned about the safety or wellbeing of a participant she will take action to address her concern with the participant and if necessary postpone, cancel or terminate the participant's interview so as to safeguard participants from undue stress or anxiety.
- The researcher has a total of 13 years of professional and academic experience of using supervision as a tool for promoting reflexive practice and as such recognises this as a significant protective factor in terms of safeguarding herself and her participants throughout all stages of the research process.

Evidence from previous or similar studies:
The evidence below highlights that the experience of taking part in research surveys or interviews that request participants to share their personal stories around a sensitive topic such as a suicide death can feel less problematic for the participant than we might anticipate; and that participants have evidenced that the experience can return some positive or helpful outcomes for them.

1. A November 2016 pilot study, undertaken by researchers at Manchester University, exploring what happens to people affected or bereaved by suicide utilised a survey consisting of closed and open questions: N=50. Participants included family members, friends, professional workers and anyone who is impacted by a death by suicide. After completing the survey participants were asked to complete an evaluation (Appendix P) to record their experience of the survey:

- 67% reported that they found it easy to complete
- 75% reported that they were not affected by it
- Many welcomed the opportunity to participate.
- Participants answered the open questions in 'great depth', the responses suggesting that people wanted to share their stories.

2. Hewitt, J. (2007). Ethical Components of Researcher-Researched Relationships in Qualitative Interviewing. Qualitative Health Research, 17(8). 1149-1159.

- provides a guiding framework that promotes consideration of the following aspects of the research relationship when conducting research interviews: Acknowledgement of bias; Rigor; Rapport; Respect for autonomy; avoidance of exploitation; confidentiality.
- The researcher proposes to use this tool both to inform the planning of the interview study and to promote ongoing reflexivity throughout the planning and conducting of the research interviews.

3. Dyregrov, K. M. et al. (2011). Meaning-making through psychological autopsy interviews: The value of participating in qualitative research for those bereaved by suicide. Death Studies, 35. 685-710.
- acknowledges the reticence sometimes displayed by ethical boards with regard to vulnerable populations. Evidences that the experience of participating in qualitative research for people bereaved by suicide can be described as (a) overall positive (62%); (b) unproblematic (10%); and (c) positive and painful (28%). Positive experiences are related to meaning-making, gaining new insight, and a hope to help others. Objective factors concerning the gender of participants, their relationship to the deceased, the method of suicide and the time since loss were largely unrelated to their experience of the interview.

4. Owens, C., Lambert, H., Lloyd, K., & Donovan, J. (2007). Tales of biographical disintegration: how parents make sense of their sons suicides. Sociology of Health and Illness. 30 (2). 237-254.
- ' We show how the parents use the interview to perform a complex reconstructive task, striving to piece together both their son's and their own shattered biographies and repair damage to their moral identities. We argue that their stories represent survival tools, enabling them not only to make sense of the past but also to face their own future.' (pp237).

Other Ethical Issues
Identification of participating Universities from specific details pertaining to a student death by suicide. The researcher will ensure that any such identifying details will not be included or will be anonymised in the write up of the findings of these studies.

Identification of participants from use of participant verbatim quotes. The researcher will be vigilant to ensure that the use of verbatim quotes does not reveal details pertaining to the participants identity.

There is a potential that Freedom of Information requests may arise due to the researcher holding information pertaining to student suicides at three UK HEIs. The strategies for dealing with such requests are detailed in the Data Management Plan, above.

Published ethical guidelines to be followed
The British Psycological Society's (2014) code of human research ethics will be adhered to in all aspects of the research.

Appendix 4.3: Study 2: Responses to the Ethics Committee

Response to Amendments **Hilary Causer**

HSREC CODE: SH17180008

A CRITICAL EXPLORATION OF STAFF EXPERIENCES AND ROLES FOLLOWING A STUDENT DEATH BY SUICIDE WITHIN THREE UNITED KINGDOM HIGHER EDUCATION INSTITUTIONS

The researcher would like to thank the Chair and Members of the Health & Sciences Research Ethics Committee for their constructive feedback and helpful attention to detail.
Please find below a response to the amendments and requests for clarification. Reference to the accompanying documents will provide evidence that these amendments have been actioned as requested.

Required amendments:

a. Revisions to accompanying documents

Participant Information Sheet Study 2

1) Needs a date and version number.

Response: Date and Version number inserted at head of document.

2) Please change wording in first paragraph of "Why have I been invited to take part?" Remove "and feel that they would like to" as you cannot say what a third party feels- suggest you replace with "and agreed to"

Response: The wording has been amended according to the committee's suggestion.

3) Please make it clear that whether you participate or not will be confidential and the department manager will not be informed. This is implied but not clearly stated.

Response: A statement to clarify these aspects of confidentiality has been added to the fourth paragraph under the sub-head 'Why have been invited to take part?' The statement reads:

Whether you participate or not will be confidential. Your department manager will not be informed.

4) Will the university name be included in the researchers written report – can you clarify this in the information?

Response: The name of the university will not be included in the written report. This is clarified under the sub-head 'Will the information I give stay confidential', in the text passage that reads:

'… it will not be possible to identify you or your University from our research report or any other ways in which the research findings are shared or reported.'

5) PIS should not contain specific details naming the HEI and month and year of the student death by suicide.

Response: All references that previously named the University have now been changed to read 'your University'. All references that previously indicated the month and year of the student death by suicide have been removed.

"Do I have to take part?" Section:

6) "...contact the researcher with your participant number..." How will the participants know their participant number? Although there is a number on the paper version of the survey it is not clear how this will appear on the online survey, how will assigning participant IDs be managed if both paper and online version of the survey are being offered?.

Response: The researcher appreciates that this question has been asked, it has presented an opportunity to ensure that the process is water-tight.

The researcher has decided to use a system whereby the participant creates their own number; this process will be identical on the paper- and e- versions of the survey, so there will be just one numbering system with no replications.

A section has been added at the beginning of the survey that asks participants to create their own ID, it reads as follows:
"Please create a six-digit participant ID using the last two letter of your first name, the last two letters of your surname, followed by the last two digits of your phone number. (Example: if your name is John Smith and your phone number ends in 54, your participant ID would be HNTH54). Enter your participant ID in the box below"
*"Please write this down and keep it safe. If you later decide to withdraw your data, please contact the researcher (*email*) and state your participant ID."*
This ID number will allow the retrieval and removal of any data pertaining to a specific participant should they choose to withdraw from the study.

7) "...you will be asked to sign a consent form..." This is not necessary for a survey; completion of the survey provides the assurance that a participant consented to complete it. But you do need to remove this from the information sheet as it is confusing.

Response: The sentence has been removed. The statement of the head of the survey has been changed accordingly so that it no longer explicitly asks for consent, but reads:

'If you complete and return this survey you are giving consent for the researcher to use the information that you share as research data, including anonymised quotations, in publications or reports.'

8) Although not an ethical concern, the information about the study presented to participants is rather long. It would be worth going through to see where information can be given more concisely.

Response: The section, 'What is the purpose of this study' has been edited to a more concise version. It now reads:

'There is very little known about what it is like for people who work in Higher Education Institutions (HEIs) when a student dies by suicide. This study aims to ask staff members' about their own experiences and about the roles that they may have undertaken following a student death by suicide. The things that happen after a suicide are referred to as 'postvention', so this study is looking at postvention in Higher Education Institutions in the UK.

This study will ask how a student death by suicide is experienced by staff members within a UK HEI and what is that experience like. It will also ask whether staff members undertake specific postvention roles following a student suicide, if so, what kind of roles, and are there any staff needs attached to delivering them?:

The study is interested in listening to people who work in a range of roles throughout the University, including:

- *student-facing staff*
- *facilities staff*
- *academic staff*
- *executive staff*
- *administrative staff*

It is hoped that the findings of this research will help to shape future guidance and policies around what should happen in a University after a student dies by suicide.'

Further minor edits have been made to the text throughout the PIS document to make the reading more concise.

Study 2 Survey

Is age relevant? Should length of time in this role be considered rather than age?

Response: The researcher is grateful for this insightful question. Indeed the literature suggests that within some health professions the length of time in role is a factor in terms of perceived impact following a client or patient death by suicide.

The researcher has added this question (Question no ??) to the survey accordingly.

With regard to the participants age, the researcher has decided to retain the question as it may also prove to be a factor in terms of participants' perceived impact or needs.

If participants answered no to question 4 is question 5 relevant? Or should a 4th option be added to question 4 I was not affected?

Response: Please note that due to the inclusion of an extra question in Part 1 of the survey, that subsequent question numbers have changed. Previous Question 4 is now Question 5; previous Question 6 is now Question 7.

The survey has now been amended so that a 'no' response at Question 5 directs participants to Question 7. I do not feel that an additional option 'I was not affected' is needed at Question 5, as this outcome can be expressed by selecting the option 'no'.

Question 6: There is no option for participants to choose if they did not have any needs at all. Option f almost gives this but the following space asks about different needs. Could you add an option g) I had no needs?

Response: Please note this is now Question 7. I have now added an option 'g) I had no needs' as suggested.

At the end of the survey: "If you feel that you would like to..." could be shortened to "If you would like to..."

Response: The wording has been amended as suggested.

Study 3 Information Sheet

1) You don't need to give potential participants at least 14 days to decide; "at least 48 hours" should be plenty, and you can still give individuals longer if they need it. However, if you state that you will give at least 14 days, then you must do this, even if a potential participant did not need this long.

Response: The wording has now been amended to read 'up to 14 days'. The researcher decided in consultation with her supervisory team that a maximum of 14 days allowed potential responses from anyone who may be taking annual leave when the email is sent out.

2) "You can decide not to take part or to withdraw from the study up to 14 days after the interview..." Needs to be reworded to take out "not to take part or" or add a comma after "part". Otherwise it doesn't makes sense that someone can decide not to take part after they have completed the interview already.

Response: A comma has now been added as suggested. The sentence now reads:

"You can decide not to take part, or to withdraw from the study up to 14 days after the interview..."

3) Needs a date and version number.

Response: Date and version number have been added at the head of the document.

4) Best practice would be for consent forms to be completed at the beginning of the interview, after the participant has had time to read the information sheet and can ask any questions, then sign the consent form before the start of the interview. Otherwise it is not clear how participants will sign a consent form electronically to email it to you.

Response: The researcher has amended the process according to the committee's suggestion. The outlined process has been accordingly amended under the sub-heads 'Do I have to take part?' and 'What will happen …'.

Participant Consent Form

1) Needs a date and version number

Response: Date and version number have been added at the head of the document.

2) Should reference the PIS i.e I have read and understood information sheet version x dated xx

Response: The sentence has been reworded as suggested and now reads:

'I have read and understood information sheet version x dated xx '

3) Needs formatting so font is consistent.

Response: The document has been re-formatted so that font and point size are consistent throughout. In addition the researcher has improved the spacing and layout of the document.

4) Needs a statement at the end to say that participants will be given a copy of the consent form to keep

Response: A statement has been added accordingly at the end of the document that reads:

'Participants will be given a copy of this consent form for their records.'

5) Please consider amending to "Person receiving consent" rather than "Person taking consent".

Response: The wording has been amended according to the committee's suggestion and now reads:

'Name of person receiving consent:'

Letter to HEIs

Please change wording "If you feel that you would like..." as this indicates a personal opinion, rather than a consideration on behalf of an organisation.

Response: The words 'If you feel that you would like …' have been removed and the sentence has been re-written to read:

'If consent is given that [name of University] is to become a site for participant recruitment'

Minor error on next paragraph "contact a liaison" needs correction.

Response: The typo has been corrected and the sentence now reads:

'… as points of contact between …'

Consent Form for University

You may need to add in somewhere that it is a consent "On behalf of (University Name)".

Response: The wording has been added to the signature section at the foot of the form. The sentence now reads:

'Name of Person giving Consent on behalf of [University name]:'

Press Release

Word "vital" should be removed from the subject title.

Response: The word 'vital' has been removed from the subject line. The line now reads:

b. Requests for clarification

1. Please could clarification be given as to why the coding system will be destroyed by the researcher at the end of the project and not retained with for the same length of time as the rest of the data i.e 10 years.

   Response: All data that is retained for 10 years in line with the University of Worcester Policy for the Effective Management of Research Data, will be anonymised data. The coding system referred to would provide the key to translating some of that anonymised data into data that recognisably pertains to specific HE Institutions. In line with the Data Protection Act (1998) principles that data should not be retained for longer than necessary and that data should be protected by appropriate security measures, the researcher proposes to destroy the coding system at the point when it is no longer of use. The researcher foresees that point will be at the end of the project.

2. It is a little confusing to have two separate PISs with the same project title and the majority of the same information. Either there should there should be one PIS outlining the 2 phases of one study or the separate PISs should have separate titles and where possible avoid replicating information.

   Response: The researcher would like to retain two PISs as not all participants will be taking part in both phases of the study, and for those who do take part in the second phase, given the sensitivity of the topic it feels helpful to offer a reminder of some of the information. In some cases, the interview might occur some months after the survey was completed.

   To prevent undue duplication the following steps have been taken:

   The project title of the PIS for study 2 now reads:

   'A survey of staff experiences and roles …'

   The project title of the PIS for study 3 remains the same.

   The heading for both PIS sheets now state the phase of the study that they pertain to.

   The opening paragraphs of the PIS sheet for Study 3 have been worded as a 'reminder', and are now more concise.

3. In the event that a department has had involvement with more than one suicide during the timeframe, how will this be managed? Either the wording in the information sheets and survey would need to reflect this, or you would need to exclude the department from the study. In the event that a department experiences a suicide event during the research data gathering phase, how will this be managed?

   Response: This is a helpful question. It is a matter that will be clarified on a site-by-site basis during the first stage of liaison with potential HEI sites. In the event that the department has had involvement with more than one suicide during the time-frame, it is proposed to adjust

the wording on the information sheets in line with other research studies that have asked participants to reflect upon *'the most recent death by suicide'* for the purpose of answering this survey/during this interview. The department would continue to meet the criteria for inclusion. Heterogeneity between sites does not present a methodological dilemma within a grounded theory analysis.

In the instance that a student death by suicide occurs during the course of the data collection period the proposal is to continue with the data collection:

- with an acknowledgment of the event made within the analysis of data and within the thesis as a potential limitation of the study.
- With the pre-agreed options for individuals to choose not to participate and for participants to choose to withdraw during or after data collection.
- In addition, participants may experience another suicide event outside of the university student body during the data collection phase. Once again, in these circumstances they will have the option to withdraw from the study.

An acknowledgement of such a circumstance will be included in the Participant Information Sheets to read:

'In the event that the University experiences a student death by suicide during the course of this research, or if you experience another death by suicide during the course of the research, you will be able to withdraw from participating in the research if you wish. The support resources listed below will continue to be available if this happens.'

4. The HEI consent form point 4 is asking to confirm the researcher "can make direct contact with individual staff members... to provide them with participant information sheets and consent forms thereby offering them the option to take part in the studies". However the PIS for study 2 states completed paper surveys should be returned to the person who gave them the survey who will ensure it is returned to the researcher. It therefore isn't clear exactly who will be approaching potential participants in the first instance. There could be potential issues with the researcher being provided with potential participants' contact details therefore the invitation emails and letters should be sent out on behalf of the researcher by a member of staff within the HEI. It should also be made clear in the application/protocol how many times potential participants will be contacted in connection with the research i.e will reminder invitation emails/letters be sent?

   Response: Thank you for highlighting this discrepancy in process. The HEI consent form has been amended so that point in question becomes two points that read as follows:

   'I confirm that the above named researcher has permission to liaise with leadership staff to identify specific staff groups for recruitment to the above named study
   I confirm that a key staff member will be identified to co-ordinate administrative support to disseminate study information and surveys amongst identified staff groups, and if necessary, collect and return paper-based surveys to the researcher'

As such, the researcher will not be holding any information pertaining individual staff members email addresses or other contact details, except in the case of participants who choose to share such details in the process of consenting to be contacted to partake in study 3.

A reminder email/letter will be sent to participants at the two week mid-point of the data collection for the survey. It will briefly thank participants who have responded already, and offer a reminder to staff who would like to respond but haven't done so already. It will acknowledge that staff are not obliged to respond and as such need to take no further action. The email reminder will include the survey link. The letter reminder will detail where staff can obtain hard copies of the survey.

Appendix 4.4: Study 2: Project Risk Assessment and Management

Research Ethics Risk Assessment and Management

Project: PhD Thesis
Title: A critical exploration of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions
Details: This risk assessment pertains to two studies within the above thesis:
1. A research survey to be completed by adult participants at their place of work
2. A research interview to be conducted with adult participants at their place of work by the researcher.
The topic in both studies is the impact of a student suicide upon Higher Education employees.

Researcher Name: Hilary Causer
Director of Studies: Professor Eleanor Bradley
Key RAG Rating: **Red** = High likelihood
Amber = Medium likelihood
Green = Low likelihood

Identified Risks	**Who is at risk?**	**Potential Impact/Outcomes**	**Risk Management/Mitigating Factors**
What are the risks/hazards present	*Who might be harmed?*	*How might they be harmed?*	*Identify precautions and protective factors that will minimise and address the risks.*
Risk of harm to the organisation's reputation following a student death by suicide	HEI	Reputational harm may be perceived to have a range of impacts such as: • Impact upon potential for professional collaborations with other organisations for employees within the HEI • impact on potential student applications to the HEI • impact upon perceived safety of and duty of care delivered toward the existing student body • raised awareness amongst staff participants of their needs	• HEIs acting as sites for participant recruitment will be offered anonymity at all stages of data collection and write up. • The researcher will strive to work in as discreet a way as possible when visiting sites for data collection by sharing details of whereabouts with only her supervisory team; key point of contact and next of kin. • All respondents will have been consented and the information they share is confidential and not attributable to the individual; as such if a respondent made a claim against the HEI this would not be attributable to the research. • The role of the research is to investigate staff members' experiences of support postvention. The study has no agenda or pre-conceived ideas around the kinds of support that should have been offered and will not be making suggestions or offering

		remaining unmet and subsequent potential for litigation/claims made by staff against the HEI.	feedback to staff members as to the quality and kinds of support that they may or may not have been offered.
Request to answer survey questions around a sensitive topic has potential to cause distress to a participant	Participant	Experience of psychological stress	• Potential participants are provided with project and topic information (Participant Information Sheet) and are invited to give informed consent that they wish to participate • Option to withdraw from survey, or complete survey at a later time is highlighted at the outset of the survey • Question topics are highlighted at the outset and within the survey format; options to withdraw from the survey at any time are highlighted throughout • Signposting for participants to support resources are included in the participant information sheet and at the end of the survey • A quiet and safe environment is provided for participants to undertake the survey.
Discussion of a sensitive topic in an interview has potential to cause distress to a participant	Participant	Experience of psychological stress	• Potential participants are provided a Participant Information Sheet and are invited to give informed consent that they wish to participate • The researcher will make telephone contact with the participant ahead of the interview to discuss the format of and practical arrangements for the interview and to answer any participant queries or worries • The researcher will make an initial and ongoing assessment of the participant's wellbeing ahead of and during the interview with a view to postponing or the participant withdrawing from the interview if the participant presents with anxiety or distress. In such an instant, the researcher would instigate a conversation with the participant to inquire after and acknowledge their feelings and their choices to continue, postpone or withdraw from the interview.

			• The participant has the option to withdraw from or pause the interview at any point; this is highlighted at the outset of the interview and reminders will be offered during the interview if it feels appropriate. • Signposting for participants to support resources are included in the participant information sheet and the participant will be reminded of these at the end of the interview • The researcher will make a final assessment of the participant's wellbeing at the end of the interview and will take time to remind them of support resources and for a brief 'off-topic' conversation as seems necessary. • A private, quiet and safe environment will be pre-booked for the interview in a location that is familiar and convenient for the participant. • The researcher will offer the option of a follow up phone call or email up to two weeks after the interview giving participants an option to discuss any afterthoughts, worries or questions that may arise after the interview. • The researcher has experience of conducting sensitive and challenging one to one conversations with service users including vulnerable adults and young people; of making ongoing risk assessments while working; of responding safely in the moment to risk and challenge; and of noticing and highlighting safeguarding and safety concerns. The researcher also has experience of conducting research interviews with counselling clients as part of her MSc Dissertation study.
Disclosure by participant of unsafe/unethical practice or whistle-blowing.	Participant	Psychological/emotional stress from disclosing the event	• Inform participants to limits of confidentiality in Participant Information Sheet • Remind participants of limits to confidentiality at beginning of interview – check that they understand what that means. • Cease interview at point of disclosure

			• Researcher to discuss next steps with participant – if it feels safe to do so. • Researcher to pass on details of disclosure to identified person according to the nature of the disclosure. • Eg: Disclosure of unsafe practice by a colleague = senior staff member at place of employment Disclosure of criminal activity = appropriate legal authority
Disclosure by participant of risk of harm to self or others by a third party	Particpant / Unknown others	Psychological/emotional stress from disclosing the risk Perceived increased risk of harm due to the disclosure	• Inform participants to limits of confidentiality in Participant Information Sheet • Remind participants of limits to confidentiality at beginning of interview – check that they understand what that means. • Cease interview at point of disclosure • Researcher to discuss next steps with participant – if it feels safe to do so. • Researcher to pass on details of disclosure to identified person according to the nature of the disclosure. • Eg: Disclosure of known risk of harm by a colleague = senior staff member at place of employment • Disclosure of known intent to conduct criminal activity or act of terrorism = appropriate legal authority
Participant at risk of causing harm to self or others	Participant / Unknown others	Psychological/emotional stress from disclosing the risk Perceived or actual increase in risk of harm due to the disclosure	• Inform participants to limits of confidentiality in Participant Information Sheet • Remind participants of limits to confidentiality at beginning of interview – check that they understand what that means. • Cease interview at point of disclosure • Researcher to discuss next steps with participant – if it feels safe to do so. • Researcher to pass on details of disclosure to identified person according to the nature of the disclosure.

			• Eg: Disclosure of intent to harm a colleague = senior staff member at place of employment • Disclosure of intent to harm self = appropriate medical professional or close colleague or family member • Disclosure of intent to conduct criminal activity or act of terrorism = appropriate legal authority
Travel to location of research interviews • Road/rail accident • Physical assault	Researcher	Physical Injury Psychological stress or harm	• Research and plan travel mode options • Awareness of and compliance with University of Worcester Lone Working Guidance for Post Graduate Students, regarding travel, route and accommodation planning, and use of a named point of contact.
Overnight stay at location of research interviews • Environmental hazards/Physical Injury • Physical Assault	Researcher		• Awareness of and compliance with University of Worcester Lone Working Guidance for Post Graduate Students, regarding off-site working, and use of a named point of contact.
Data collection in a location unfamiliar to the researcher with people not previously known by the researcher • Physical Injury • Psychological harm	Researcher		• Awareness of and compliance with University of Worcester Lone Working Guidance for Post Graduate Students, regarding off-site working, and use of a named point of contact.
Conducting research interviews around a sensitive topic under lone-working conditions has potential to cause distress to the researcher	Researcher	Psychological stress	• Use of supervision prior to data collection to discuss and plan a researcher strategy for self-care and safeguarding. • Researcher to identify and pre-arrange times for phone check-in with a member of supervisory team following data collection, if needed.

			• Researcher to employ personal resources such as personal support networks during periods of data collection. • Researcher to utilise professional self-care skills such as use of reflective journal; maintenance of professional/personal boundaries; use of professional networks eg: support from UoW research school; phd peers etc.

Appendix 4.5: Study 2: Participant Information Sheet – Survey

Date:
Version Number: 1.0

Participant Information Sheet
Staff Survey

Title of Project:
A survey of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions

Invitation

We would like to invite you to take part in a research survey. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve. Please take time to read this carefully and ask the researcher if you have any questions. Talk to others about the study if you wish.

What is the purpose of the study?

There is very little known about what it is like for people who work in Higher Education Institutions (HEIs) when a student dies by suicide. This study aims to ask staff members' about their own experiences and about the roles that they may have undertaken following a student death by suicide. The things that happen after a suicide are referred to as 'postvention', so this study is looking at postvention in Higher Education Institutions in the UK.

This study will ask how a student death by suicide is experienced by staff members within a UK HEI and what is that experience like. It will also ask whether staff members undertake specific postvention roles following a student suicide, if so, what kind of roles, and are there any staff needs attached to delivering them?

The study is interested in listening to people who work in a range of roles throughout the University, including:

- student-facing staff
- facilities staff
- academic staff
- executive staff
- administrative staff

It is hoped that the findings of this research will help to shape future guidance and policies around what should happen in a University after a student dies by suicide.

Why have I been invited to take part?

You have received this invitation to take part in the survey because [name of contact & their job role] has expressed an interest in this research **on behalf of your University and agreed to** support it.

They have agreed that I can invite staff members to take part in this survey. I have consulted with [insert key contact name] who has helped me to identify that people who work in [insert name of department] are aware of **a student death by suicide** and that they may have felt impacted by that event.

Some staff members in this department may have undertaken specific roles following the student's suicide and this research is also interested in learning about those roles.

We are asking all of the staff members in [name of department] if they would like to complete this survey. **Whether you participate or not will be confidential. Your department manager will not be informed.**

Do I have to take part?

No. It is up to you to decide whether or not you want to take part in this survey. Please take your time to decide. You can decide not to take part, or to withdraw from the study up to 14 days after the closing date of the survey [insert date]. If you decide to withdraw please contact the researcher with your participant number and your data will be removed from the study and destroyed.

What will happen to me if I agree to take part?

If you agree to take part this is what will happen

- You will be invited to complete a survey that will ask you questions about your experiences and any roles that you undertook following **the student death by suicide at your University**. The survey will not ask you for any details about the student suicide, it will focus on you and your experience after it occurred. Some of the questions will be short tick-box type questions; others will give you more space to write freely.
- [For electronic survey only] The survey is accessible by clicking a link in the email that you have been sent. You can look at the survey before deciding whether to complete it. You may wish to choose a convenient time to complete the survey, when you have a quiet space to work and you will not be disturbed.
- [For paper copy survey only] The survey is attached to this information sheet, and you can take a look at it to help you decide whether you wish to complete it. You may wish to choose a convenient time to complete the survey, when you have a quiet space to work and will not be disturbed.
- The survey will take you roughly between10 – 20 minutes depending on how much you choose to write.
- If you complete the survey on a computer, your answers will be recorded electronically and stored securely on the Bristol Online Survey server until the researcher retrieves it for analysis. If you complete a paper survey you will be recording your answers in writing. To protect your privacy, please seal the survey in the envelope provided and return it to the person who gave it to you, who will ensure that it is returned securely to the researcher.

Are there any disadvantages or risks to taking part?

Some of the questions in the survey will ask you to recall details of your experiences following the student death by suicide that happened **at your University**. These questions will focus on your experiences and will not ask you to share details about the student or about the way that they died. However, you may find that in answering the questions you do remember details about the student, or of the event and about the things that happened at the time of the event. If this causes you to feel distressed or anxious you can choose not to complete the survey, or to come back to it at a later time.

In the event that the University experiences a student death by suicide during the course of this research, or if you experience another death by suicide during the course of the research, you will be able to withdraw from participating in the research if you wish. The support resources listed below will continue to be available if this happens.

If you feel distressed or anxious while completing the survey or at any point after you have completed the survey and would like to talk with someone there are a number of options available:

Support available

- You may seek confidential support within **your University** by contacting [insert details of any confidential staff support service that is available at the HEI].
- If you feel that you would like to seek support outside the University, you can contact [insert details of local/regional support agency inc web/phone/address details]. This support service offers [insert specific details of the kind of support available] and they have agreed to their contact details being shared with participants of this research study.
- You may wish to contact a national support organisation.
    - **SOBS** (Survivors of Bereavement by Suicide) www.uksobs.org offer support resources on their website and have a national helpline that is open between 9.00am – 9.00pm every day 0300 111 5065 (call charges are applicable) or free support via email at sobs.support@hotmail.com .
    - **The Samaritans** are available to listen to anyone who feels they need support regardless of the issue that is causing worry or distress. They can be contacted at any time on 116 123 (calls are free) or by email jo@samaritans.org.uk

Will the information I give stay confidential?

Everything you write is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. The information you give may be used for a research report, but **it will not be possible to identify you or your University from our research report or any other ways in which the research findings are shared or reported**. Personal identifiable information (e.g. name and contact details) will be securely stored until the project ends in September 2019 and will then be securely disposed of. The research data (e.g. surveys) will be securely stored.

What will happen to the results of the research study?

This research is being carried out as part of a PhD study at the University of Worcester. The findings of this study will be reported as part of a thesis and may also be published in academic journals or at conferences.

If you wish to receive a summary of the research findings please contact the researcher on the email address at the end of this letter.

Who is organising the research?

This research has been approved by the University of Worcester Health and Sciences Research Ethics Committee.

What happens next?

Please keep this information sheet. If you do decide to take part, please contact the researcher using the details below.

Thank you for taking the time to read this information

If you have any questions please contact:

PhD Researcher

Hilary Causer h.causer@worc.ac.uk

If you have any concerns or complaints about this study please contact:

Director of Studies

Professor Eleanor Bradley e.bradley@worc.ac.uk

If you would like to speak to an independent person who is not a member of the research team, please contact Dr John-Paul Wilson at the University of Worcester, using the following details:

John-Paul Wilson
Deputy Pro Vice Chancellor Research
Graduate Research School
University of Worcester
Henwick Grove
Worcester WR2 6AJ
01905 542196
j.wilson@worc.ac.uk

Appendix 4.6: Study 2: Participant Information Sheet – Interview

Date:
Version number: 1.0

Participant Information Sheet
Interview Study

Title of Project:
A critical exploration of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions

Invitation

We would like to invite you to take part in a research interview. You are receiving this invitation because you have already completed a research survey and you expressed an interest in taking part in further research and gave your consent to be contacted.

Before you decide whether to take part the researcher would like to remind you why the research is being done. Please take time to read this carefully and ask the researcher if you have any questions. Talk to others about the study if you wish. You will have **up to 14 days** to decide if you want to take part.

What is the purpose of the study?

This study is asking staff members' about their own experiences and about the roles that they may have undertaken following a student death by suicide. This study will ask how a student death by suicide is experienced by staff members within a UK HEI and what is that experience like. It will also ask whether staff members undertake specific roles following a student suicide, if so, what kind of roles, and are there any staff needs attached to delivering them?

The study is interested in listening to people who work in a range of roles throughout the University, including:

- student-facing staff
- facilities staff
- academic staff
- executive staff
- administrative staff

It is hoped that the findings of this research will help to shape future guidance and policies around what should happen in a University after a student dies by suicide.

Why have I been invited to take part?

A selection of around 20 people who have completed the survey are now being invited to take part in the interview study. The selection of participants has been informed by the

information that was shared in the surveys to ensure that a representative range of people is interviewed.

The participants for this interview study are being invited from across three different universities within the UK.

Do I have to take part?

No. It is up to you to decide whether or not you want to take part in this interview. Please take your time to decide; you have **up to 14 days** to make your decision and to let me know whether or not you would like to take part. **You can do this by email or phone, using the contact details for Hilary Causer at the end of this Information Sheet.** You can decide **not to take part, or to withdraw** from the study up to 14 days after the interview has happened. If you decide to withdraw please contact the researcher with your participant number and your data will be withdrawn and destroyed.

What will happen to me if I agree to take part?

If you agree to take part this is what will happen

- **If you have not already done so, you will need to you will need to let the researcher know that you are interested in participating by sending an email or phoning, using the contact details for Hilary Causer at the end of this information sheet.**
- Once you have expressed your interest in participating, the researcher will contact you by email or phone and you will be invited to take part in a research interview. The researcher will arrange a date and time at which the interview can take place. The researcher will come to your place of work and will book a private room or office in which the interview will take place.
- **Before the interviews starts, you will have an opportunity to ask the researcher any questions and you will be asked to read and sign a consent form.**
- The researcher will conduct the interview and will ask you about your experiences and any roles that you undertook following the student death by suicide at your university. The researcher will not ask you for any details about the student suicide, she will focus on you and your experience after it occurred. The researcher is interested in hearing your story in your own words and will give you time to talk freely about the aspects of your experience that feel important to you. She will start by asking you to recall your experience. She then may ask you some further prompting questions to get the conversation started, or to explore in more detail something that you have spoken about.
- The interview may take between 60 - 90 minutes depending on how much you choose to share.
- The interview will be digitally recorded by the researcher so that she can write up a record of everything that you have said. This will be used by the researcher as data for her research analysis. The digital recording will be a password protected file that will be stored on the hard drive of a password protected computer that is only used by the researcher. All of the interview recordings will be destroyed after the analysis process is completed, in the spring of 2019. The written records of the interviews will be destroyed after the completed thesis has been submitted for examination in the autumn of 2019.

- Your name and any personal or identifying details will not be included in the researcher's written report following the interviews. The researcher may include in quote marks some of the words that you have said in her report. This is to illustrate the importance of personal experience in qualitative research. If she does this, your identity will be protected and any identifiable comments or words will be excluded or changed to protect you privacy.

Are there any disadvantages or risks to taking part?

The interview question and prompts used by the researcher will ask you to recall details of your experiences following the student death by suicide that happened at this University. The researcher will focus on your experiences and will not ask you to share details about the student or about the way that they died. However, you may find that during the interview you do recall details about the student, or of the event and about the things that happened at the time of the event. If this causes you to feel distressed or anxious you can choose to stop or pause the interview at any point. If the researcher notices that you appear to be upset or anxious during the interview she will check with you whether you would like to take a break or to stop the interview completely. The researcher will ask you how you are feeling at the end of the interview and will be able to support you to find any follow up help or support that you might feel you need.

In the event that the University experiences a student death by suicide during the course of this research, or if you experience another death by suicide during the course of the research, you will be able to withdraw from participating in the research if you wish. The support resources listed below will continue to be available if this happens.

If you feel distressed or anxious at any point after you have completed the interview and would like to talk with someone there are a number of options available:
Support available

- You may seek confidential support within your University by contacting [insert details of any confidential staff support service that is available at the HEI].
- If you feel that you would like to seek support outside the University, you can contact [insert details of local/regional support agency inc web/phone/address details]. This support service offers [insert specific details of the kind of support available] and they have agreed to their contact details being shared with participants of this research study.
- You may wish to contact a national support organisation.
    - **SOBS** (Survivors of Bereavement by Suicide) www.uksobs.org offer support resources on their website and have a national helpline that is open between 9.00am – 9.00pm every day 0300 111 5065 (call charges are applicable) or free support via email at sobs.support@hotmail.com .
    - **The Samaritans** are available to listen to anyone who feels they need support regardless of the issue that is causing worry or distress. They can be contacted at any time on 116 123 (calls are free) or by email jo@samaritans.org.uk

Will the information I give stay confidential?

Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. The information you give may be used for a research report, but it will not be possible to identify you or your University from our research report or any other ways in which the research findings are shared or reported. Personal identifiable information (e.g. name and contact details) will be securely stored until the project ends in September 2019 and will then be securely disposed of. The research data (e.g. interview transcripts) will be securely stored.

What will happen to the results of the research study?

This research is being carried out as part of my PhD at the University of Worcester. The findings of this study will be reported as part of my thesis and may also be published in academic journals or at conferences.

If you wish to receive a summary of the research findings please contact me on the email address at the end of this letter.

Who is organising the research?

This research has been approved by the University of Worcester Health and Sciences Research Ethics Committee.

What happens next?

Please keep this information sheet. If you do decide to take part, please contact the researcher using the details below.

Thank you for taking the time to read this information

If you have any questions please contact:

PhD Researcher

Hilary Causer h.causer@worc.ac.uk

If you have any concerns or complaints about this study please contact:

Director of Studies

Professor Eleanor Bradley e.bradley@worc.ac.uk

If you would like to speak to an independent person who is not a member of the research team, please contact Dr John-Paul Wilson at the University of Worcester, using the following details:

John-Paul Wilson
Deputy Pro Vice Chancellor Research
Graduate Research School, University of Worcester
Henwick Grove, Worcester WR2 6AJ
01905 542196
j.wilson@worc.ac.uk

Appendix 4.7: Study 2: Participant Consent Form - Interview

Date:
Version number: 01

Participant Consent Form

Title of project: A critical exploration of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions
Participant Identification Number for this study: 01
Name of Researcher: Hilary Causer

Please initial each statement in the box to the right

I confirm that I have read and understood the information sheet dated xxx version number xxx for the above study and have had the opportunity to ask questions.	
I confirm that I have had sufficient time to consider whether I want to take part in this study	
I understand that I do not have to take part in this research and I can change my mind at any time. I understand that I may withdraw my data by contacting the researcher with my participant number up to 14 days after the interview has been conducted	
I agree to the research interview being audio recorded	
I agree to my research data including anonymised quotations being used in publications or reports	
I agree to take part in the study.	
I have been made aware of support services that are available if I need them.	
I know who to contact if I have any concerns about this research	

Name of participant:

_____

Date:

_____

Signature:

_____

Name of person receiving consent:

_____

Date:

_____

Signature:

Participants will be given a copy of this consent form for their records.

Appendix 4.8: Study 2: Introductory Email to Potential HEIs & HE Organisations

Dear
You may recall that I mentioned that I am supervising two PhD studentships who are researching student suicide prevention and postvention to contribute to our knowledge and evidence base. One of the studentships, Hilary Causer, is undertaking a largely qualitative study which seeks to drill down on the impact of a student suicide on university staff and explore staff support needs and postvention roles. There is currently a complete lack of literature exploring this area, although there is some in related fields.
She is seeking a small number of Universities that have experienced a student suicide in the previous academic year (between May 2016 – January 2017) that would be prepared to be study sites. The study would involve the University agreeing to being a participating site and facilitating access to a range of staff within the organisation to participate in two stages of the research. Participants in the first instance would complete a survey, following which they may be invited to participate in an interview, which we hope would last about an hour.
I'm not sure whether you are the correct person to approach but wondered whether you are in a position to explore whether _____ University might be prepared to be a study site to be formally approached by the PhD student with the usual information and consenting processes.
I attach a research summary and a poster outlining the study that we are happy for you to share as appropriate. These do not serve as participant information packs but are an overview of the proposed PhD study that will be followed up if you agree to be a participant site.
I would be grateful if you could email a response to this email either way copying in myself and Hilary so we know where there may be an opportunity to follow up formally or not
Many thanks and best wishes
Jo
Professsor Jo Smith
Suicide safer Project Lead
University of Worcester

Appendix 4.9: Study 2: Letter & Consent form for participant recruitment on the HEI site.

Dear

Re: [Name of University] as a site for participant recruitment for the PhD study: 'A critical exploration of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions'.

I am writing to you as you have expressed an initial interest in the above study following an email correspondence with my PhD Supervisor, Professor Jo Smith. I am now able to offer a formal invitation to [name of university] to become a site for the recruitment of participants to take part in two of the studies within my PhD.

These studies have the support of John de Pury, Assistant Director of Policy at Universities UK and Ross Renton, Pro Vice Chancellor for Students at University of Worcester.

The first study will take the form of a survey of University staff across a range of job-roles and departments with the aim of growing an understanding around if, how and to what extent staff members perceive themselves to be impacted following a students death by suicide. It will also seek to understand the support needs, if any, of these staff members, the kinds of postvention roles, if any, that they undertook and the kinds of support that they may have needed to delivery those roles. The second study takes the form of semi-structured interviews that will seek to gather a richer data set regarding the same topics as the survey. Please find an overview of the research proposal enclosed with this letter that further explains the aim, objectives and methodology of the research.

To become a site for participation there is a necessity to meet the following criteria; that a full-time student at this University died by suicide between the dates of [insert dates].

If consent is given that [name of University] is to become a site for participant recruitment I propose that we move forward by arranging an initial exploratory meeting with yourself and any colleagues that you identify as interested parties, together with my research supervisor, Professor Jo Smith.

The purpose of this meeting will be to formally agree the process of participant recruitment, identifying key individuals as points of **contact** between myself and individual participants and agree a time-scale for the study. Given the sensitive nature of the topic I am keen that we are work together to ensure that the necessary safeguards and protocol are in place before participant recruitment and data collection commences. As such I will seek to gain your formal consent that I may use [insert name of HEI] as a site from which to recruit participants for both studies. A copy of the consent form is attached.

The studies have been awarded full ethical approval by the University of Worcester Health and Sciences Research Ethics Committee. I enclose a copy of the approved ethical application [insert ethical approval ref. no. here]. If [name of university] requires further site-specific ethical processes to be adhered to I am happy to discuss the requirements and how I might best meet them.

Thank you for your interest and your time in considering this invitation.

Kind Regards,

Hilary Causer MSc

PhD Research Student
Institute of Health and Society, University of Worcester

Encs: PhD Research Proposal Overview
Approved Ethical Application
HEI Consent to use [name of university] as a site for participant recruitment.

Consent Form

Consent to use [insert Name of HEI] as a site for the recruitment of research participants.

Title of Project: A critical exploration of staff experiences and roles following a student death by suicide within three United Kingdom Higher Education Institutions
Name of Researcher: Hilary Causer

Please tick

- ○ I confirm that I have read and understood the information provided for the above study and have had the opportunity to ask questions.
- ○ I confirm that I have had sufficient time to consider whether [name of HEI] can be used as a site for the recruitment of research participants
- ○ I confirm that the above named researcher has permission to liaise with leadership staff to identify specific staff groups for recruitment to the above named study
- ○ I confirm that a key staff member will be identified to co-ordinate administrative support to disseminate study information and surveys amongst identified staff groups, and if necessary, collect and return paper-based surveys to the researcher
- ○ I confirm that the above named researcher has permission to liaise with appropriately identified staff members in the course of her research project as needed so as to ease and assist the undertaking of the recruitment of participants and the undertaking of research interviews on the campus site

If I have any concerns about this study I know that I can contact the researcher's Director of Studies, Professor Eleanor Bradley e.bradley@worc.ac.uk

Name of Person giving Consent on behalf of [University name]:

Job Title:

Signature: **Date:**

Name of Person taking consent:

Signature: **Date:**

Appendix 4.10: Study 2: Participant selection framework

Participant Inclusion and Exclusion Criteria

Departmental Inclusion in both studies

Staff Departments will be included if:

- The student who died by suicide was a student within the academic school/institute
- The student who died by suicide was a resident in accommodation serviced by the work team. Eg. Facilities staff.
- The student who died by suicide made use of the facilities/services of the department and/or was known by workers within the department eg: student wellbeing services; student union services; learning support services etc.
- The department undertook specific tasks/roles following the student's death by suicide created by or pertaining to the event of the student's death.

Staff Participation in the Survey Study

Staff within the identified departments will be invited to participate in the survey study if:

- They were in employment within the department at the time of the student's death by suicide
- Their relationship with the student who died by suicide is solely a professional one. That is, the student was only known by them due to their job role at the University and not by any familial or personal relationship outside or beyond their job role with the university.

Staff Participation in the Interview Study

Staff members who complete the survey study may be invited to participate in the Interview study only if:

They ticked the box at the end of the survey expressing their permission for the researcher to invite them to participate in the interview study and provided either an email address or phone number by which such contact be made.

Appendix 4.11: Study 2: Participant invitation email/letter to participate in Survey

An opportunity to take part in a research survey
investigating the impact of a student suicide on Higher Education staff.

Hello.
I am a PhD student with the University of Worcester. I am undertaking a study that aims to understand what the experiences of HEI staff are like after a student has died by suicide. This is a qualitative study, and I am particularly interested in hearing first hand experiences and stories from staff members who work in a range of different job roles across the University. [name of contact & name of university] have expressed an interest in this research and feel that they would like to support it so that more can be learned about how a student death by suicide impacts upon the people who work at the university.
You will find attached to this email/letter an information sheet and a consent form. Please take some time to read these as they outline the research and what will be involved and what will happen next if you choose to take part.
Thank you for your time.
Kind Regards,
Hilary Causer MSc
PhD Research Student
Institute of Health and Society
University of Worcester
Henwick Grove
Worcester
WR2 6AJ

Appendix 4.12: Study 2: Participant invitation email/letter to participate in Interview Study

Dear

Re: Your participation in a Research Study regarding the impact of a student death by suicide on HEI staff members.

I am writing to thank you for completing and returning the survey for the above research study.

You indicated at the end of the survey that I could contact you with regard to the second stage of the research that I will be doing at [name of university].

As such, I am now offering you the opportunity to consider taking part in the second study. This time, the research will take the form of a one to one interview that will be conducted by myself. You will see that I have attached/enclosed an information sheet that gives you more details about this study and what it would be like for you if you chose to take part.

If you feel you might be interested, please take some time to read the information sheet and consider whether this is something you would like to take part in. You might wish to discuss your decision with others or if you have any questions before making a final decision you are welcome to ask me either by email or phone, using the contact details below.

I have also attached/enclosed a consent form. After taking time to consider your decision if you would like to take part in the interview study, please complete the consent form and return it to me by [insert date] by email/using the envelope enclosed.

I will then make contact with you by [insert date] to arrange a time and place at [name of university] that we can meet for the interview. At this stage I will also be able to answer any questions that you may have.

If you feel you do not wish to take part you do not need to do anything further, and it just remains for me to thank you for your contribution and support of my research so far.

Kind Regards,

Hilary Causer
PhD Research Student
Institute of Health and Society
University of Worcester

Appendix 4.13: Study 2: Reminder Participant invitation email/letter to participate in the Interview

Dear

Re: Your participation in a Research Study regarding the impact of a student death by suicide on HEI staff members.

Further to my previous email dated ___, I just wanted to send a gentle reminder as I appreciate that I sent the previous email out at a particularly busy time of the academic year.

If you wish to participate in the interview stage of my research there is still time to respond. Simply complete the attached consent form and return it to me by email. If you have decided that you would rather not participate please accept my apologies for emailing you again, and be assured that this is the only reminder that I will send.

Kind regards,

Hilary Causer
PhD Research Student
Institute of Health and Society
University of Worcester

Appendix 4.14: Study 2: Survey of HEI staff members following a student death by suicide

Participant No: 0001

Survey of staff members following a student death by suicide at [name of HEI]

○ **Before beginning this survey please confirm by ticking the box that you have read the Participant Information Sheet that contains important details about this research and your role in it.**

○ **If you complete and return this survey you are giving consent for the researcher to use the information that you share as research data, including anonymised quotations, in publications or reports. Please confirm by ticking the box that you understand and give consent to this use of the information that you share.**

Part 1: About You.

This section of the survey asks a few questions about you. This is to help us understand whether different kinds of people have different kinds of experiences.

1. Would you describe your job-role as being (please select one):

a. Student-facing staff (eg. Student support services; student counselling & wellbeing; Student Union)

f) Facilities staff (eg. Accommodation; maintenance; domestic; security staff)

g) Administrative staff (eg. Registry)

h) Academic staff

i) Executive staff

j) Other. Please state your job-role here _____

2. What is your age? _____

3. What is your gender? _____

Part 2: About your experience following the student death by suicide at [name of University] during [insert month and year of the student death]

This section of the survey asks you to recall your experiences following the event of a student death by suicide.

If you feel that you would like to talk to someone about your feelings either during the survey or afterwards, please take a look at the suggestions for support in the Participant Information Sheet.

4. Following the event of a student death by suicide at [insert name of University], would you describe yourself as impacted by the event? (please circle the one that best describes your experience)

a) Yes
b) No
c) Unsure

5. This question is about the different kinds of impact that people may experience after a student death by suicide. This kind of event may affect people in three different ways. Those ways are described below:

> **'Exposed to'** describes an impact that involves knowing about the event but does not include a significant emotional effect following the event.
> **'Affected by'** describes an impact that involves feeling significantly upset or distressed by the event and during the period following the event.
> **'Bereaved by'** describes an impact where the loss carries a deep personal meaning and a process of grieving takes place either in the short or longer term following the event. *(Descriptors adapted from Cerel et al. 2014)*

Would you describe the way you have been impacted as being:
(please circle the one that best describes your experience)
a) Exposed to a student suicide death
b) Affected by a student suicide death
c) Bereaved by a student suicide death

6. This question is about your needs following a student death by suicide.
For the purposes of this survey, the word **'needs'** refers to the things that you require in order to be able to come to terms with the event of the student suicide and to feel able to continue doing your job and leading your life to a satisfactory level on a day to day basis.

If you had any needs following a student death by suicide, would you describe them as:
(please circle any that describe your experience)

- **g) emotional needs (This describes needs that relate to an emotional response eg. Sadness, tearfulness, anger, confusion, fear etc.)**
- h) psychological needs (This describes needs that relate to a psychological response such as anxiety, sleeplessness, depression etc.)
- i) practical needs (This describes needs that arise in connection with your practical ability to do the things that you need to do.)
- j) personal needs (This describes needs that arise in your life away from your job-role)
- k) work-related needs (This describes needs that arise in connection with your job-role)
- l) none of the above (please describe your experience below).

Please use the space below if you would like to tell us more about the different kinds of needs that you may have had following a student death by suicide.

7. Please use the space below to describe any support that you sought or received to meet the needs that you identified in question 6.

Part 3: About any role/s, task/s or job/s that you did in connection with the event of the student death by suicide at [name of university].

This section of the survey asks you to recall the things you may have done following the event of a student death by suicide.

8. Following a student death by suicide did you take on any specific role/s, task/s or job/s that arose in connection with the event of the student's suicide?
Yes
No
If yes, please go to question 9.
If no, please go to question 13.

9. Using the space below, can you name or describe the role/s, task/s or job/s that you undertook?

10. Thinking about the role/s, task/s or job/s that you undertook, was the role/s, task/s or job/s: (please circle the answer that best describes your experience).

e) **Given to you by a line/department manager or other colleague?**
f) **Something that you knew you needed to do because it is part of your job description?**
g) **Something that you recognised needed to be done?**
h) **Other**

If you selected d) other can you explain how you came to undertake the role in the space below.

11. If you did undertake any specific role/s, task/s or job/s following the student death by suicide can you tell us about the different kinds of needs that you may have experienced in the process of doing it? (please circle as many as describe your experience)

f) **emotional needs (This describes needs that relate to your emotional wellbeing eg. Sadness, tearfulness, anger, confusion, fear etc.)**
g) psychological needs (This describes needs that relate to your psychological wellbeing such as anxiety, sleeplessness, depression etc.)
h) practical needs (This describes needs that arise in connection with your practical ability to do the things that you need to do.)
i) personal needs (This describes needs that arise in your life away from your job-role)
j) work-related needs (This describes needs that arise in connection with your job-role)
k) None of the above (Please describe your experience below).

Please use the space below if you would like to tell us more about the different kinds of needs that you may have had in connection with the role/s, task/s or job/s that you undertook following a student death by suicide.

12. Please use the space below to describe any support that you sought and/or received to meet the needs that you identified in question 11. Please tell us about the kind of support you received and where it came from and about any other things that you would have found helpful.

13. If there is anything else that you wish to say about any aspect of your experience following the student death by suicide at [name of HEI]; or if there is something that you thought we might ask you about but we haven't, please use the space below:

Thank you for your time in completing this survey.

To our knowledge this is the first time that staff at Universities in the United Kingdom have been asked about their experiences following a student death by suicide. By completing this survey you are helping us to understand what those experiences are like. We hope that this understanding will help the right kinds of support to be provided to people who work in UK Universities.

Would you like to take part in further research?

The researcher will be carrying out another study with University staff members to find out more about the kinds of experiences that they have following a student suicide. This study will involve an interview with the participant conducted by the researcher. This gives an opportunity for participants to share their stories and experiences in their own words in more detail. And it gives the researcher the opportunity to understand at greater depth what people's experiences are like.

Around 20 people who have completed this survey will be selected to take part in the interview study. The selection of participants will be informed by the information that has been shared in these surveys to ensure that a representative range of people is interviewed. Giving your consent to be contacted does not guarantee that you will be invited to participate.

If you are invited to participate in the interview study the researcher will contact you in the first instance by email or phone and if you still wish to take part you will be given an information pack and invited to give your consent to take part in the study.

The research interviews will be held on the site of your University.

If you feel that you would like to give consent for the researcher to make contact with you about the interview study please provide your name and contact details below.

Name: _____

Please provide either your email address or your phone number.

Email: _____

Phone: _____

Appendix 4.15: Study 2: Interview Topic Guide – Study 3

The interviews in this study will be participant led.

The interview topics will be informed in part by the responses and findings of the scoping survey study undertaken as Study 2.

The following guide offers an idea of the kind of topics that the researcher anticipates using.

Topic Guide – Version 1 – Used for Interviews 1 & 2.

Topic	Potential Question
Participant's experiences and perceptions of events following the student death by suicide	I would like to start our interview by asking you if you can tell me about the events that followed the student's death by suicide that happened here in [month and year]? Could you tell me about your thoughts and feelings following the suicide? Tell me about any ways in which it affected you? What kinds of things did you need to help you at that time? What kinds of support were you offered? Can you tell me about something that was particularly helpful at that time? What other things might have been helpful to you?
Participant's experience and perception of taking on any role/s following the student death by suicide	Tell me about any particular tasks or jobs that you took on following the suicide? What was it like for you to undertake that role/task/job? What helped you to manage that role/task/job? What were the difficulties that you encountered in doing that role/task/job?
Participant's experience of helpfulness following the student death by suicide Additional experiences and perceptions not covered within the interview so far	Is there any person or organisation that has been particularly helpful or supportive of you since the student's death? What kind of things have they done? Is there something that you might not have thought about before that has occurred to you during this interview? Is there something else that you think I should know about to understand your experiences better?

Topic Guide – Version 2 – Used for Interviews 3 – 6
Additions made to version 1

Opening Questions

These were added to the topic guide as I found myself asking them from the first interview as a way to settle the participant and help them to feel comfortable in talking with me.

So we are here to talk about your experiences following a student death by suicide here at the University, is it ok if I ask you some questions about that now?

This question was added as I found myself using a similarly phrased opening to check that the participant was ready to move onto talking about the main topic

How did you hear about the student's death?

This question was added in response to my experience of hearing the first two participants tell me their 'stories'. In both instance this was their starting point.

How did you know what to do?

This question was added in response to hearing participants' accounts of feeling unsure about what they should do.

Topic	Potential Question
Opening questions	I would like to start our interview by asking you if you can tell me what your job is and what kinds of things you do How long have you worked here? Have you always done the same job here? What would a typical day look like?
Participant's experiences and perceptions of events following the student death by suicide	So we are here to talk about your experiences following a student death by suicide here at the University, is it ok if I ask you some questions about that now? How did you hear about the student's death? What were the events that followed the student's death by suicide? Could you tell me about your thoughts and feelings following the suicide? Tell me about any ways in which it affected you? What kinds of things did you need to help you at that time? What kinds of support were you offered? Can you tell me about something that was particularly helpful at that time? What other things might have been helpful to you?
Participant's experience and perception of taking on any role/s following the student death by suicide	Tell me about any particular tasks or jobs that you took on following the suicide? How did you know what to do? What was it like for you to undertake that role/task/job? What helped you to manage that role/task/job? What were the difficulties that you encountered in doing that role/task/job?
Participant's experience of helpfulness following the student death by suicide Additional experiences and perceptions not covered within the interview so far	Is there any person or organisation that has been particularly helpful or supportive of you since the student's death? What kind of things have they done? Is there something that you might not have thought about before that has occurred to you during this interview? Is there something else that you think I should know about to understand your experiences better?

Topic Guide – Version 3 – Used for Interviews 7-10
Additions made to version 2

Tell me about any ways in which it continues to affect you.

This question was added in response to hearing participants accounts of ongoing impact

Can you share with me any particular moment or image that has stayed with you?

This question was added after one participant expressed surprise that I hadn't asked about trauma or used the word trauma – she talked vividly of imagery and the impact it had on her. On checking the transcripts of other participants' I found that accounts of imagery and 'flashbacks' were present in most transcripts.

Tell me about any ways in which the experience has changed the way you work now.

This question was added after a participant talked repeatedly about how they had changed their work practice. On checking previous transcripts I found other participants had spoken about doing things differently now.

How do you feel about it all, when you look back now?

This question was added in response to seeing the 'in the moment' emotional responses that participants were displaying during the interviews. It was clear that this event continued to carry emotional resonance. The question provided a way of acknowledging and validating

their in the moment responses, whilst opening an opportunity for clearer articulation of what they were feeling in the moment.

Topic	**Potential Question**
Opening questions	I would like to start our interview by asking you if you can tell me what your job is and what kinds of things you do How long have you worked here? Have you always done the same job here? What would a typical day look like?
Participant's experiences and perceptions of events following the student death by suicide	So we are here to talk about your experiences following a student death by suicide here at the University, is it ok if I ask you some questions about that now? How did you hear about the student's death? What were the events that followed the student's death by suicide? Could you tell me about your thoughts and feelings following the suicide? Tell me about any ways in which it affected you? What kinds of things did you need to help you at that time? What kinds of support were you offered? Can you tell me about something that was particularly helpful at that time? What other things might have been helpful to you? Tell me about any ways in which it continues to affect you. Can you share with me any particular moment or image that has stayed with you?
Participant's experience and perception of taking on any role/s following the student death by suicide	Tell me about any particular tasks or jobs that you took on following the suicide? How did you know what to do? What was it like for you to undertake that role/task/job? What helped you to manage that role/task/job? What were the difficulties that you encountered in doing that role/task/job? Tell me about any ways in which the experience has changed the way you work now.
Participant's experience of helpfulness following the student death by suicide Additional experiences and perceptions not covered within the interview so far	Is there any person or organisation that has been particularly helpful or supportive of you since the student's death? What kind of things have they done? How do you feel about it all, when you look back now? Is there something that you might not have thought about before that has occurred to you during this interview? Is there something else that you think I should know about to understand your experiences better?

Appendix 4.16: Study 2: Sample Interview Transcript: Participant A.

1	A: It took quite a long time, erm, which had been in the kitchen downstairs in the shared house, erm	
2	[long pause] yeah, and then the next day we just followed the checklist of eh the things that we	
3	needed to do which led us to notify [the student's] cohort, I can't remember what course [the	
4	student] was doing, erm, but we done this before where we go in jointly with the academics to, to talk	
5	about what's happened. I mean that, all we are saying is that a student has died, cos with social media	
6	these days they already know –	
7	I: Yeah, yeah.	
8	A: - and we did that with all three years erm, it was quite a small cohort. Erm, offered support to the	
9	staff who know him, offer support to the students we ah, we have a daily drop-in eh, for our wellbeing	
10	services anyway. So actually we don't need to do anything different other than say come to that and	
11	just put more staff on.	
12	I: Mm-hmm	
13	A: At least my experience having dealt with 6 or 7 deaths, people tend not to use them in the day or	
14	two after which is understandable if you are in shock –	

15	I: Yeah	
16	A: Erm, it's very much getting the support there, or letting people know what's what's around, erm, at	
1	this stage there's absolutely nothing mentioned around suicide. And the university held a major	
2	incident response and the, our marketing team would become involved, that's where the	
3	communications team would become involved [unclear] erm, support offered to staff is done through	
4	[name of city] has a city wide major incidence response erm which is fantastic, mainly volunteers and	
5	they would treat a single death like this as a major incidence because of the impact. Erm, I happened	
6	to be working at the time with Samaritans on their postvention in HE project –	
7	I: Ok, yeah,	
8	A: -eh, and so I knew what Samaritans offered, they infact, I spoke to them and went through a like,	
9	almost like a debriefing, eh, what should we do, have you thought about this, that sort of thing –	
10	I: Mm-hmm	
11	A: - eh, and we handled pretty much everything but it's still quite useful to eh to go, cos you've still got	
12	your, your adrenalin is still pumping –	
13	I: Yeah	

Appendix 4.17: Study 2: Example of Memo-Writing
26.02.20

Applying focused codes to survey data:
There is a tension present – between the tasks and the self – between the needs of others and the needs of the self; there is no time to process, to feel, to respond emotionally as all the time is consumed with the doing to things.
One respondent writes that "the university" took care of certain arrangements which "allowed me to concentrate on dealing with it myself" – but of course, 'the university' is in fact other staff members.
Another writes, "my priority is to other staff, I cannot ignore the emotional impact on myself" taking on both responsibility for others and the self"
Another writes, "because I was having to support my staff, no own feelings were put on hold".
The focused code, 'emotions on hold' speaks to a small part of this tension, but does not explore the tension in it's complexity and the self-sacrifice that is being made – the in the moment responding to the needs of others or the needs of a job-role that by necessity excludes attention from the needs of the self.
The focused code, ',managing the emotions' may also speak to part of this process.
28.02.20
There is a lot in the data that is affected by cultures – although the ppts don't name it as such.
There are differences in experience between people in different job roles, different teams and with different job role responsibilities. Work place and team and professional cultures appear to make differences to individuals experiences of support; to the availability of support to them (eg. Professional networks; informal team cultures); their ability to ask for support and their choices around accessing the support that was available and feeling that it met their needs.
The role of the manager appears integral to the individual's experience of support – and of the resources available to that manager – both in terms of availability to staff and ability and knowledge of support resources. Managers themselves however felt unsupported and stressed that their energy was spent supporting others.
18.03.20
Bearing Witness
I realise now that this isn't just a category in it's own right – not just the beginning of everything else that happens – the triggering event. It is present throughout, it isn't so much the triggering event as the defining event.
It is in bearing witness to a student suicide that all following responses and experiences are shaped, and it is through responding and experiencing that people do bear witness.
Responding and ways of responding are shaped and made more awful or urgent or challenging for staff by the fact that a student – a young adult 'in their care' has felt that their only choice was to end their own life – not only that the student felt that awful – but that no one was present to stop them. Doing tasks in this context lends some kind of amplification to the nature and purpose of the task that wouldn't otherwise be felt. There is an urgent desperation present staff accounts of responding and of how they responded that is not about doing the task, but about doing it in the context of a students suicide. There is a sense that if the awfulness, the unsayable is true – that we failed this student – then we must, absolutely must, get this bit right.
As staff see the deceased student, or are present at the place of death, or in the students flat, with the student's housemates, the student starts to become a person, they start to see or witness, or learn about the student – and so the awfulness grows and amplifies the sense of needing to respond now, quickly, professionally, empathically, discreetly and as fully as is

possible. A weight of responsibility is palpable through the accounts – not necessarily for the death, but more, for having to 'get it right', often without knowing really (because of lack of previous experience together with multiple unknowns (like what would the parents want us to do?)) how to get it right. It feels like a tightrope for staff, who try to keep their balance by constantly checking, communicating with each other, meeting with each other, referring to guidelines, seeing what others are doing and taking guidance from the behaviour and responses of others within and beyond the HEI.

In and through these activities and responses staff bear witness not only to a death of a student, but to the beginnings of eth impact of that death. To the involvement of emergency services and maybe other agencies, to the presence of media who want to bear witness on behalf of the public. Also to the reactions of housemates, their shock, astonishment, disbelief, grief, horror, anger, denial. And beyond – to the impact that this death will have on their students as their lives move on, and that of their housemate, their friend, has stopped forever.

Some staff bear witness to the responses and behaviours of parents and family members as the news is broken to them. Witnessing their pain, horror and disbelief – or equally, witnessing their strength, their containment and their ability to face the world. Wider communities throughout the University such as course groups, club mates maybe also learn the news and their reactions are seen by staff members, and they are supported and informed by staff members, guided through the process of learning that their peer, their friend, their team mate has taken their own life.

But bearing witness doesn't just happen in person, in the doing of things and in the seeing of things, it also happens in the being of people, in the processing of things, in the construction of ideas, of perceptions of closeness, in reflecting and in feeling their own personal responses to what has happened, what they had to do, how they did it, what they saw, what they said, what others did, and saw and said. As perceptions and reflections are processed it is all within the context of the students death by suicide.

The bearing witness shapes the sense of fears and the recognition of needs. It is all within the context. Having just experienced it all, the immediate fears of somehow being responsible in some way, of having missed a sign, got something wrong, failed to do their job – to keep a student safe – these are fears that carry the weight of a student's life. The way such fears are experienced is weighted by a student's death – or by the possibility of another student's death.

Appendix 4.18: Study 2: Example of Initial codes with verbatim quotes.

Study 3 – Initial Codes – Hilary Causer

Groups of codes	Initial codes	Verbatim Quotes
A student suicide		
Finding the body	Finding the body	B: 1:12 Ok, so it was, um, one of my team that found the student
	Being first on the scene	B: 29:4 inevitably one of my team will be the first on scene generally it will be security will be first on scene
Seeing the body	Seeing the student's photograph	
	Recalling the student's appearance	
	Seeing the body being taken away	
	Seeing the body has stuck with me	C: 25:16 I think the image of the body being brought out was the thing that most sticks with me and his physical frailty, that has upset me, that did upset me
	Feeling upset at seeing the body	
	Taking the body away	
	Being in the student's room	B: 3:4 I didn't see the student, but obviously, I was in the room after he had been taken away.
Hearing the news	Hearing the news	A: 1:12 I could tell by her face it was bad news erm she said there'd been a death eh in halls and instinctively I knew it was going to be a suicide B: 2:1 we'd been made aware that there was a concern of a student, security had gone up, um and then contacted to say this student had been found C: 3:8 my manager phoned me and said can you come over there's been something happened, so I went over and he told that there had been a suicide
	Being told by phone call	E: 4:1 I'd just come back off me holiday, and the day that I arrived back at home, um, [colleagues name], our head, she actually rung me and told me cos obviously I looked after [the accommodation site] and that's where it happened
	Being filled in on what happened	E: 4:8 I were back at work the next day so obviously I got filled in a bit more, you know, from then, yeah, once I was back, to what had quite happened and what have you
Not knowing/knowing the student	Not knowing the student	A: 9:6 I don't think any of us felt [responsible], cos we didn't know [the student] … I've never met him so there's no personal connection C: 6:9 : It was difficult, because I didn't know this [student]
	Knowing the student	E: 5:5 I knew the [student] as well, cos I used to see him out and about, obviously we're working on there, I used to clean his house, so I used to talk to him in the kitchen, generally, like you do students, and you know, even if I saw him coming out the house I'd always shout across, 'hiya, you alright?' you know we always spoke so … E: 6:3 they all knew each other, and sometimes you clean in the kitchen and they used to come in and you know you'd have a little chat with them and little banter and things like that, so, yes, I did actually know him
	'He was one of my students'	E: 6:8 just because he was there he was one of my students, like I knew quite a lot of the other students that was on there cos there's [a number of] houses down there and there's [a number] students. But you always saw certain ones all the time and he was one of them that … I used to see quite regularly
	Recalling relationship with the student	
	Not knowing anything was wrong/He always seemed fine	E: 5:11 you, you don't actually know, like you say, what a person it going through, so I mean, to look at him, I would've never have guessed that there was anything up with this young boy, you know, whatsoever
	Trying to find out about the student	C: 6:11 because you want to find out about him and his life and pay tribute to it
	Finding out about the student after the event	

Appendix 4.19: Study 2: Example of Focused Codes and Category development.

Working with codes

Categories	Focused Codes
Bearing witness	Finding the body
	Seeing the body
	Hearing the news
Being the responder	Crisis response tasks
	Comms, strategy & Management tasks
	Support tasks
	Practical & Administrative tasks
	Managing student needs
	Supporting other students
	Containing the narrative
	Offering support to staff
	Strategies for support
Ways of responding	Doing the job
	Experiences of responding
	Being directed
	Being a leader
	Process & Procedure
	Working with other agencies
	Information sharing
	Roles & Expectations
	Team working
	Working together
	Building relationships with students
	Experiences of supporting
Cultures of responding	Organisational provision
	Supporting each other
	Creating culture
	Engaging with support
	Cultures of support