Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

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Abstract

Introduction: Thousands die by suicide each year, and many more live with suicidal thoughts, feelings and acts. Suicide and suicidality are often conceptualised as symptoms of pathology, with the focus on treating mental illness and research participants recruited from healthcare settings. Little research has focused on what it is like to live with ongoing suicidality in the community or on how people narrate suicidality. This study aimed to explore how people live with suicidality over time, with the intention of creating collective resources from people's narratives.

Methods: A collective narrative project with contributors recruited via a community group and informal networks. Each contributor had ongoing experience of suicidality. Data was collected in interviews and group workshops. Data was analysed using dialogical narrative analysis. Collective resources are being produced from the shared narratives, in collaboration with contributors.

Findings: Living with suicide was often characterised by experiences of abuse, neglect, rejection and discrimination, across multiple domains in life. People experience suicidality as a response, and sometimes a resistance, to suffering. Shame and stigmatised identities were central to people's narratives of suicidality. Finding ways to be accepted and valued as a 'whole' person counteracted the diminishing effects of shame and stigma. People narrated epistemic injustice as a result of dominant framings of suicide as pathological. Finding value in lived experience and advocating for change were meaningful narratives offering 'reasonable hope' to participants.

Conclusion: Stigma and epistemic injustice were powerful forces in people's narratives of suicidality. A more relational understanding of suicidality as a response to unjust suffering and a resistance to dominant narratives of suicide as pathological are key to creating a more socially just approach to suicidality. Future research should adopt collective and participatory methods to co-create ways of responding to suicidality with people who have lived experience.

1. Introduction

Almost 800,000 people die by suicide yearly (World Health Organisation, 2017). Suicide has an extensive history, with societal and cultural understandings shifting across time and place (Colucci, 2013). People have long sought to understand suicide, reading suicide notes (Leenaars, 1988) or seeking insights from family and professionals connected with the person who died (Cavanagh, Carson, Sharpe, & Lawrie, 2003; Fincham, Langer, Scourfield, & Shiner, 2011). Research has focused on identifying groups at high risk of suicide, theorising that risk factors can inform prevention (Franklin et al., 2017). Alongside research, there is a tradition of understanding suicide through art, essay and literature (e.g., Alvarez, 1973; Berman, 2000).

Living with suicidal thoughts, feelings and acts is a common experience that, despite an interest in understanding suicide, is under-explored (McManus, Bebbington, Jenkins, & Brugha, 2016). Thus, a research gap exists, which this thesis seeks to address by focussing on exploring people’s narratives of living with suicidality and people’s knowledges and resources (Lakeman & Fitzgerald, 2008). In this introduction, theories and ideas about suicide will be summarised, and a rationale provided for research into the knowledges and resources of people experiencing ongoing suicidality.

1.1 My Position

It is important to situate this thesis in my context, namely, why this question and approach were chosen, and my perspectives on the subject. First, I identify as having personal experience of self-harm, suicidal thoughts, feelings, and acts. I understand these experiences as connected to being bullied, rejected and marginalised, and feeling worthless and disconnected from others. For me, these experiences transformed my emotional landscape, leaving me with an ongoing comprehension of the depth and seductiveness of despair. My understanding of myself, my relationship with my work, and my decisions in life and relationships are informed by my sense of how I can feel and act at my lowest point. My feeling is that these experiences will always inform my relationship with myself and the world, and yet they remain almost partitioned from aspects of my life.

Second, I am conscious, as someone who has volunteered and worked in mental health services, of the ways in which suicidality is framed by formal services and the public, and the dilemmas people face around help-seeking and disclosing suicidality. For instance, in my thesis on assessment following self-harm, people spoke of fears they would not be taken seriously or be treated against their will (Hunter, 2011). I have facilitated self-help groups where people talk of responses from others and their fears about others' reactions. My professional and personal reflections leave me with a sense of how we are always in dialogue with the perceived and experienced responses of others when making sense of our lives.

Finally, I have grown more conscious of the socio-political contexts of suicidality, and curious about social justice approaches. Suicide is often situated as an individual problem. Framing suicide as an individual problem can keep people disconnected from each other and knowledges that resist this framing. In doing so, we can neglect the societal forces that create and exacerbate suffering and render suicide a response to said suffering. Taking a collective approach to researching suicide is an act towards connecting people to their histories and each other (Denborough, 2008; Martin-Baro, 1994).

1.2 Definitions

Definitions in suicide research are contested in two ways; first, from the perspective of scientific evidence, wherein the argument is that concise definitions will enable science to delineate and understand the numerous phenomena contained within the auspices of 'suicide'. Variable language use impedes knowledge development by limiting study comparability (Silverman, 2016). Second, definitions are contested from the survivor perspective, who suggest suicide language can be stigmatising (Nielsen, Padmanathan, & Knipe, 2016). This perspective considers how language constitutes social realities (Foucault, 2004), shaping people's responses (Heilbron, Compton, Daniel, & Goldston, 2010). In the survivor literature, there is no one agreed term as each has connotations for different people (Padmanathan et al., 2019), and language choices can be an indicator of the narrative resources available when people re-tell their experiences. Herein, I have chosen to adopt the terms 'suicide' and 'suicidality'.

Suicide is defined internationally as "*the act of deliberately killing oneself*" (World Health Organisation, 2014:12). Suicide is a commonly used term in English language, derived from Latin in the 17th century. This word 'suicide' arguably softened the criminal connotations of 'self-murder' but is associated with taking one's life being re-framed as an act of mental and moral decline (Bähr, 2013; Barraclough & Shepherd, 1994). The phrase 'commit suicide' still references UK legislation from the mid-13th century until the Suicide Act of 1961, which deemed suicidal acts punishable by forfeit of property, fines, and prison (Padmanathan et al., 2019). In many parts of the world, suicide remains a crime (Mishara & Weisstub, 2016). Suicide is prohibited or disapproved of in major world religions, including Christianity and Islam. The associated stigma attached to dominant legal and religious narratives are still important features of society's, and individual, relationships to suicide (e.g., Sheehan et al., 2017). 'Suicide' is used in the thesis due to being common parlance, but it is recognised that it has problematic connotations for some, implying moral personal or communal failure (e.g., J. White, 2007).

'Suicidality' is a research-related term that encompasses a range of suicidal experience, including suicidal thoughts, plans, and attempts (Silverman, 2006). This term enables a consideration of suicidal experience as multi-faceted, operating across cognition, emotion, intent, insight, and behaviour. It is adopted herein as it can include, without delimiting, different aspects of suicide, or positioning someone on a hierarchy of suicidal experience. It is acknowledged that it may carry negative connotations for some. Further, it is recognised that suicidality is not common parlance and may seem less clinically useful due to its inclusiveness (Silverman, 2016).

Where participants or researchers used specific terms, focused on aspects of suicidal experience, or defined qualities of said aspects, this is reflected in the text.

1.3 Context

In the following section, I outline prevalence and trends in suicide and consider how the impact of suicide is understood within the UK and more broadly. I then provide background on dominant and common understandings of suicide and suicidality, and the clinical and societal responses associated with these understandings. These form the background in which people experience suicidality and inform their relationship to living with suicidality.

1.3.1 Prevalence and Trends

Global estimates suggest one person dies by suicide every 40 seconds, with most deaths occurring in low to middle income countries (World Health Organisation, 2017). In the UK, there were over 6,500 suicide deaths in 2018, a significant increase from the previous year and a rise after years of falling rates (Office for National Statistics, 2019). Suicide rates are highest in men, with suicide attempts more common in women (Windfuhr, Steeg, Hunt, & Kapur, 2016). Several explanations have been offered for this discrepancy, such as gendered scripts around suicide methods, help-seeking stigma, and gendered societal roles and pressures (Canetto & Sakinofsky, 1998; Jaworski, 2010).

In the UK, suicides are recorded via medical death certificates. Suicide occurs across the lifespan, with suicide rates increasing with age. In terms of research, most studies tend to focus on suicide in children and young people, despite the rates in working age adults having significantly increased in recent years and suicide rates peaking for both men and women between the ages of 40-49 (Office for National Statistics, 2019). With suicidal thoughts and suicidal acts, working age adults were more likely to report them than older adults, with rates consistently about 20% for suicidal thoughts and 6-7% for lifetime attempts. Women report higher rates of suicidal acts than men across the life course, although men are more likely to die by suicide (McManus et al., 2016). Globally, suicide rates are higher in people over 70 and research has recently explored suicide in older adults in more depth (Conwell, van Orden, & Caine, 2011). There remains a gap in understanding suicidality for working age adults and for people who continue to experience suicidal thoughts, feelings and acts post-transition to adult services.

Trends have varied over time and across countries, although it is notable that suicide is frequently associated with marginalisation, discrimination, structural and interpersonal violence, inequality, poverty, and deprivation (Platt, 2016; World Health Organisation, 2017). In the UK, there have been noted increases in suicide deaths amongst people subject to welfare reforms under austerity (Mills, 2017). Internationally, the 2008 economic recession saw an associated increase in suicide rates, especially within working-age men (Coope et al., 2014). The variability in suicide rates over time and place suggests that suicide rates are sensitive to context and amenable to change.

1.3.2 UK Context

Within The Five Year Forward View, the government committed to reducing suicides by 10% by 2020 (NHS England, 2014). As part of that commitment, the previous government assigned a Minister for Mental Health, Inequalities and Suicide Prevention in 2018, with the role changing hands in 2019. This ministerial post is meant to oversee delivery on the suicide prevention strategy across the NHS and other areas of policy, including education, employment, social security, criminal justice, the media and transport (Mackley, 2019).

The current cross-government priorities are 1) provide services for groups at high risk, 2) address self-harm, 3) support people bereaved by suicide, and 4) investigate the role of the media and internet in suicide and its prevention (Mackley, 2019). This strategy acknowledges that many people do not access mental health services prior to suicide, and advocates training frontline staff at suicide hotspots (e.g., railways) in suicide awareness, and involving voluntary services and employers in reducing stigma (HM Government, 2012). The previous minister committed the government to a zero-suicide approach, pushing mental health trusts to adopt zero-suicide policies and promoting public awareness to prevent every suicide (HM Government, 2019).

Survivor-activists and researchers have cautioned against the zero-suicide movement, citing the potential for staff and patients to feel blamed and unsupported if suicide occurs and suggesting that this aspirational aim may become a barrier to disclosure (Smith et al., 2015). Others have warned of unintended consequences of zero-suicide policies, such as an increase in chemical and physical restrictive practices to prevent suicide (Rothschild, 2015).

1.3.3 Impact

The impact of suicide has historically been understood economically, interpersonally, and socially, reflecting a dominant narrative that situates the individual as "*the author of the [suicidal] act*" who is actively rejecting society's demands and who is therefore responsible for the impact of suicide (Jaworski, 2010:51). Economically, it has been estimated that each suicide costs an average of $2.5million US dollars, through direct costs (e.g., to health and public services), indirect costs (e.g., to society), and intangible costs (e.g., related to stigma and grief experienced by families) (McDaid, 2016). This narrative of the public cost of suicide has been used in UK and international policies to argue for investment in suicide prevention but could be perceived as blaming.

The impact of suicide has been examined interpersonally. Suicide bereavement research has highlighted the complex grief responses and psychological impact of losing a loved one to suicide (McDonnell, 2006; Pitman, Osborn, King, & Erlangsen, 2014). One in ten people report a suicide attempt following a suicide bereavement (Pitman, Osborn, Rantell, & King, 2016). People report stigma, shame, social isolation and difficulties speaking about the suicide death (Pitman, Stevenson, Osborn, & King, 2018). The potentially devastating impact on families and loved ones is an increasingly prevalent narrative in Western society and talking to suicidal people of how their families and loved ones might feel without them is a common feature of risk assessment and crisis plans.

Societal impact has mostly been explored within indigenous populations in Australia, New Zealand, the US and Canada, where high rates of youth suicides have devastated communities (Chandler & Lalonde, 2020; Pollock, Naicker, Loro, Mulay, & Colman, 2018). Studies have highlighted the roots of suicide in historical trauma, post-colonialism, structural inequalities and cultural dislocation, as well as how health services and public health initiatives can replicate social injustices (Wexler & Gone, 2016). Suicide clustering, or multiple suicides occurring in the same community in a short period of time, is considered both a response to collective difficulties and injustices, and an effect of suicide becoming a viable option within one's community of peers (Hunter, Reser, Baird, & Reser, 2001; Kleinman, 2015). Suicide clustering has been observed within schools and psychiatric units, institutions where individuals share an environment and, potentially, characteristics that increase identification with others (Robinson, Pirkis, & O'Connor, 2016).

This literature offers insight into the impact of ongoing suicidality on individuals and their families, due to their embeddedness in these same contexts of how suicide is perceived at a societal, community, and economic level and the narratives about suicide available within society. These narratives focus on the negative impact of suicide on individuals, families, communities and society, but typically do not speak about suicidality as an ongoing lived experience and what that means.

1.3.4 Understandings of, and Responses to, Suicide

Suicide has been investigated through a myriad of epistemological lenses, which influence how society and services respond to suicidality. I will summarise some key theories, focusing on ways of understanding suicide and suicidality which tend to influence clinical practice and policy in the Western hemisphere.

1.3.4.1 Biological/Medical

A primary understanding comes from the medical model. Suicide is often understood as associated with mental disorders, with an implicit inference that mental disorders can lead to suicide. Psychological autopsy studies report high rates of mental disorder (approximately 90%) in people who die by suicide in comparison to matched controls (Cavanagh et al., 2003)[1]. Studies of mental disorders report high rates of suicide compared to the general population (Chesney, Goodwin, & Fazel, 2014). As a result, the identification and treatment of mental disorder is named as a priority in prevention policies worldwide (HM Government, 2012; World Health Organisation, 2014).

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[1] Matched controls are living people, typically matched by age and gender to the deceased

Psychological autopsy studies have been criticised methodologically, for retrospectively applying diagnostic categories based on informant and text analysis (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012). They have been criticised for neglecting social and political contexts, and assuming suicide reflects individual pathology (Marsh, 2010). Regardless of the validity of the 90% statistic, these studies only point to correlative rather than causative patterns (Hjelmeland & Knizek, 2017), and both the variety and variability of associated mental disorders suggest suicide cannot be solely attributed to mental illness (Bertolote, Fleischmann, De Leo, & Wasserman, 2004).

It has been proposed that some suicides have a biochemical component. Certain psychiatric medications, and medication withdrawal, have been connected to akathisia (a state of inner restlessness) and suicide (e.g., Hansen & Kingdom, 2006; Stone et al., 2009). This is a contested area, and the evidence base is difficult to establish given suicide's relative rarity and trial methodology considerations, but some survivors/activists are campaigning to have medication-induced suicidality more widely recognised and medical approaches to suicide challenged.

Under the biological/medical lens of suicide, interventions typically focus on treating mental illness, through medication and/or evidence-based therapies, in line with National Institute for Health and Care Excellence (NICE) guidelines (Zalsman et al., 2016). Due to the risk culture in the Western medical system (manifest in policies such as zero-suicide), it is likely that some staff feel they need to prescribe and keep suicidal people on medication to prevent suicide. Although some medications have been noted to reduce suicide risk in certain sub-groups, there is relatively little evidence to support medication-only strategies for suicidality (Jobes & Chalker, 2019: Zalsman et al., 2016).

There can be unintended consequences to the mental illness approach to suicide prevention. These include over-medicalising suicide, over-valuing medical treatments over psychological suicide-specific ones, a tendency towards a restrictive behavioural strategy for suicide prevention, and a risk of alienating people who fear being hospitalised (Blanchard & Farber, 2018; Jobes & Chalker, 2019). Additionally, people who do not access mental health services are missed entirely under this approach (Andrews, Felton, Wewers, & Heath, 2004).

The mental illness lens operates within the focus on intervening in high-risk groups or at moments of crisis, as there is an assumption that people with mental health problems may need protection from themselves. In terms of high-risk groups, interventions targeting self-harm tend to show little impact on suicide and suicidality. Arguably, if people who self-harm are at high risk of suicide (Cooper et al., 2005), and repeated self-harm associated with greater risk (Riberio & Joiner, 2009), reducing self-harm could impact on suicide. For reducing self-harm and suicidal ideation, cognitive behavioural therapy (CBT) has the most support, but methodological quality tends to be mixed (Saunders & Smith, 2016).

Another approach is to intervene only at the point of suicidal crisis. Crisis support aims to provide containment in acute suicidal crisis and remove access to means. This can sometimes result in coercive and restrictive practices, like constant observation and detention under the Mental Health Act (Cutcliffe & Stevenson, 2008; Riley, Freeman, Laidlaw, & Pugh, 2011). It has become more common for staff to co-create safety or crisis response plans with patients, which is an idea that developed out of no-suicide contracts from DBT (Jobes & Chalker, 2019). These plans aim to capture ways that people can act to stay safe when feeling suicidal (Cole-King, Green, Gask, Hines, & Platt, 2013). Jobes (2016) has argued that a more compassionate and therapeutic approach to suicide risk assessment (such as safety planning) could promote agency and connectedness and reduce stigma and shame. Safety planning can be an effective way to change the dynamic from practitioner-patient to collaborators in future-oriented planning and has been shown to be more effective than no-suicide contracts (Bryan et al., 2017).

Inpatient therapy to address suicidality is uncommon, although research into service-user views suggests a cautious desire for this option (Awenat et al., 2018). What suicidal inpatients seem to want during crisis is a sense of connection, protection, and control over their lives (Berg, Rørtveit, & Aase, 2017).

Some service-users reported attempts to talk about suicidality being met with medication or rebuff; from the staff perspective, risk-aversive ward cultures made it difficult to openly talk with people as staff fear doing harm or overstepping their roles (Awenat et al., 2017). Shame is a common experience for suicidal inpatients and being rebuffed by staff in this way is likely to negatively impact on self-worth and future help-seeking (Peterson & Collings, 2015; Wiklander, Samuelsson, & Asberg, 2003).

Brief contact interventions reach out to people recently at hospital with self-harm or suicidality. It is theorised that brief contact interventions should improve help-seeking, promote connection to others, and perhaps interrupt repetition by providing coping tips (Milner et al., 2016). Evidence of effectiveness is mixed, with some studies decreasing self-harm and others not having an effect (Carter, Clover, Whyte, Dawson, & D'Este, 2013; Kapur, Cooper, Bennewith, Gunnell, & Hawton, 2010). Offering brief psychodynamic interpersonal therapy as part of assertive outreach can be effective in reducing frequency and severity of suicidal ideation (Guthrie et al., 2003). These interventions aim to optimise the opportunity for intervention post-crisis; they do not target people not in contact with services. Interventions which reach out to people post-suicide attempt are likely to reach people who experience ongoing suicidality; however, the focus has typically been on suicide prevention which may influence how people present and talk about suicidality in these studies.

1.3.4.2 Psychological and Psycho-therapeutic

Early psychological explanations often drew on psychodynamic ideas, highlighting the role of internal conflicts in suicidal acts. For instance, Menninger (1938) argued that each person contains the wish to kill, to be killed, and to die, and people who die by suicide turn their wish to kill inwards. He conceptualised suicide as being rooted in the conflict between the life and death instincts, and what may appear to be a logical act (e.g., suicide following financial difficulties so family receive insurance) begins further back in early experiences. He argued that self-injury was a manifestation of the same conflict, with the self-destructive element somehow overwhelmed by the desire to live. Hale (2008) based his suicide theory on people's accounts of suicide attempts. He argued that there were three fantasies (unconsciously) expressed by suicidal people, all underpinned by a desire to escape life, and that people moved into conscious suicide planning when triggered by some perceived slight or rejection. For some, growing conflict and confusion between fantasy and reality pushed them into a suicidal act to resolve conflict. These psychodynamic explanations emphasise the unconscious and internal conflicts and cast suspicion on conscious justifications of behaviour, which can have consequences for how people's stories of suicidality are responded to by therapists, and influence which stories people feel safe to tell in therapy spaces.

Later psychological models focus on internal processes of cognition, attributional biases, and motivation to explain pathways to suicide. Williams' (2001) Cry of Pain model built on the stress-diathesis model to suggest that suicidal acts are behavioural responses to stressors, particularly characterised by defeat or rejection. Cognitive biases (e.g., all-or-nothing thinking) may contribute to people interpreting the stressor as inescapable and themselves as defeated without hope of rescue. Wenzel and Beck (2008) suggest that individuals who attempt suicide do so due to stressors triggering suicide-specific cognitions. Johnson and colleagues' (2008) schematic appraisal model hypothesised the role of negative and positive self-appraisals in modulating suicide risk.

Baumeister (1990) and others have described suicide as an escape from intolerable pain or from self. This idea of escape was linked to personal experiences and influenced by their interpretations of experience. Fear of causing themselves pain was a protector against suicide. In Joiner's interpersonal-psychological model, this fear of pain was built upon, with suicide involving three interacting states: a thwarted sense of belonging, a perceived sense of burdensomeness, and a capability for suicide (Joiner, 2005; van Orden et al., 2010). Without the capability, which has been argued to develop through repeated exposure to pain, people may wish to die but not act upon it. O'Connor's (2011) Integrated Motivational-Volitional Model draws these ideas together into one framework, adding in volitional moderators (such as capability, access to means, and impulsivity) that explain the move from thought to action.

There is evidence to support these models (e.g., Nock & Mendes, 2008; O'Connor, 2003; Williams, Barnhoffer, Crane, & Duggan, 2006). Most evidence stems from cross-sectional studies and cannot speak to causality. Additionally, what is often labelled in these models as 'bias' or 'deficit' (implicitly individualising) needs to be considered in the context of the person. People with childhood experiences of abuse are more likely to engage in suicidal behaviours (Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016), as are people from marginalised or stigmatised groups (e.g., lesbian, gay, bisexual, trans, and queer people (LGBTQ)), and the economically or structurally disadvantaged (e.g., homeless people) (O'Connor & Pirkis, 2016). What is labelled a cognitive bias towards defeat may realistically reflect past experiences and it is likely that understandings that situate suicidality within individuals (as cognitive biases) rather than focusing on past and current marginalisation will be experienced as stigmatising. Capponi (2003:73) suggests that people who learn they will not be heard "*retreat into silence*". However, it is not yet known how people with ongoing suicidality respond to these ideas of cognitive biases and a developed capability to die.

Psychological and psychodynamic understandings tend to suggest psycho-therapeutic responses and yet typically, suicide and self-harm have not been the focus of therapy. People in crisis are usually not considered suitable for therapy until risk to self has abated as they are construed as too unstable to engage in therapeutic work, and treatment usually follows the medical model, targeting underlying pathology instead of suicidality (Jobes & Chalker, 2019). This is likely to have an impact on how people speak of suicidality and in what spaces it feels possible to do. As mentioned above, inpatients sometimes feel silenced by staff who worry about speaking of suicide. It is not known whether this same pattern of silencing around suicide happens in therapy within the community or what it is like for people if it does.

In meta-analyses of randomised controlled trials, CBT and DBT (dialectical behavioural therapy) have been most effective in reducing suicidal ideation, suicidal behaviours and self-harm (Jobes & Chalker, 2019; Zalsman et al. 2016). Congruent with the primacy of cognitive approaches in the UK, these are the most extensively researched models. DBT has two primary aims of increasing emotional regulation and enhancing interpersonal skills (Linehan, 1993). It originated as a treatment for personality disorder and has been extended to treating young people for suicidality (Zalsman et al., 2016). Marsha Linehan has spoken about her personal experiences of suicidality shaped DBT's development (Lezine, 2016). Parts of DBT have proven controversial (e.g., no-suicide contracts), but have widely influenced crisis interventions (Edwards & Sachmann, 2010; Rudd, Mandrusiak, & Joiner, 2006). CBT has demonstrated effectiveness in reducing suicidal ideation and behaviours in a range of groups (Tarrier et al., 2013; Zalsman et al., 2016). CBT typically focuses on addressing suicidality through challenging thoughts and cognitive biases alongside behavioural strategies. Tarrier and colleagues (2013) argue that a theoretical understanding of suicide and the mechanisms underlying distressing thoughts and behaviours is needed for effective therapy. Their approach draws on cognitive theories of suicide and psychosis and has demonstrated effectiveness in adults. Both CBT and DBT focus most on the here-and-now and how the individual can change their own behaviour, teaching emotion regulation and coping strategies and addressing cognitive biases in how individuals process information. They rarely focus on the circumstances that lead to suicidality. Both models closely align to the medical system of diagnosis, which means that suicidality is often construed within these therapies as a symptom of mental disorders, with all the same connotations for service users as described in section 1.3.4.1.

1.3.4.3 Sociological and Socio-Political

Another way to conceptualise suicide is to consider it an indicator of society's functioning (Baudelot & Establet, 2009). Durkheim's (1951) study argued that suicide arose from social circumstances. He named four kinds of suicide, associated with extremes of social integration/disintegration and moral regulation/dysregulation. The implication was that suicide cannot be understood outside of social context, being intimately bound up with a person's positioning in society.

Sociological research has often focused on large-scale quantitative studies, identifying and theorising trends in social and cultural factors (Wray, Colen, &

Pescosolido, 2011). Socioeconomic disadvantage and inequality – e.g., poverty, unemployment, financial and housing instability – have been identified as important factors in suicide (Ferlatte et al., 2019; Platt, Stace & Morrissey, 2017). Experiences of detention – in prisons, in immigration detention centres – and victimisation are also linked to suicide (Fazel, Ramesh, & Hawton, 2017; Mills, 2020; Rivlin, Fazel, Marzano, & Hawton, 2013).

Sociological autopsy research has highlighted how suicide relates to changes and breakdowns in social ties and connections across the life-course and understands suicide as primarily relational (Fincham et al., 2011). For instance, in analysing suicide notes, they found expressions of care for others, such as apologies and notes on the emotional and practical details that follow death, suggesting people reflected on others before death (ibid).

Mills (2017) undertook a psycho-political analysis of media reports of suicide deaths in the context of welfare cuts. This analysis demonstrated the interplay between the structural and psychic, whereby people live and die by the psychological realities of social policies. Approaching suicide via a psycho-political lens situates individual experiences (such as shame and burdensomeness) within a socio-political context that creates and validates these experiences. Scherer (2020:147) contextualises these ideas within Scherer's own experience, querying the utility of the term 'suicide', when "*systemic injustice has translated into sustained trauma*". Scherer argues that "*delayed, self-completed murder*" more aptly captures how "*systemic, intersectional social injustices create sustained wounding*" (ibid). These studies focus on the ethical dimension of suicide, emphasising our complicity as social agents in structures and processes that generate suffering and removing the focus on the individual's failings that is implicit in some psycho-therapeutic approaches (White, 2020).

Taking a sociological lens presupposes that responses should be aimed at the socio-political conditions under which people live, for instance, via public policy and public health that addresses inequality. Whilst many countries have signed up to suicide prevention strategies as public policy (e.g., Health Service Executive, 2015; HM Government, 2012), it is rare for suicide to be tackled at a public health level via tackling inequality and discrimination on a large scale. Public health initiatives tend to focus on reducing suicide via policy that curtails individual behaviour, e.g., restricting sale of over-the-counter analgesics and access to sites where people seek to end their lives (Mohatt et al., 2013; Pirkis et al., 2015; Zalsman et al., 2016).

Public health interventions have focused on raising public awareness and reducing stigma to promote help-seeking, with variable effectiveness (Zalsman et al., 2016). Stigma, discrimination and shame have been highlighted as factors in suicidality and media campaigns often seek to normalise help-seeking in order to combat stigma (Azizpour, Taghizadeh, Mohammadi, & Vedadhir, 2018; Niederkrotenthaler, Riedenberg, Till, & Gould, 2014). On social media, survivors and activists have been vocal in problematising these ‘reach out’ campaigns, pointing out that they place the onus on individuals to seek help without considering structural (e.g., cuts to crisis services) and relational (e.g., unhelpful attitudes of others) barriers (Maopolski, 2018). No research to date has looked at how people experiencing ongoing suicidality respond to these messages and how it influences the ways in which they narrate suicidality.

Recent anti-stigma campaigns have focused on encouraging the public to intervene if someone is in distress and on providing training to public workers in suicide hotspots (e.g., train stations) (Isaac et al., 2009; Public Health England, 2015). These interventions operate on the principle that interrupting a moment of crisis can prevent suicide, as in Jonny Benjamin’s story (Benjamin & Pfluger, 2018). Similar stories worldwide support this idea (Simon, 2007). In these stories, less attention is paid to what happens next, and whether suicidality continues for those people. In addition, public awareness campaigns can have been unintended consequences which may exacerbate shame and discrimination, e.g., such as people being arrested and charged for suicide attempts (under public nuisance laws) (e.g., Gordon, 2019), and experiencing distress and terror when forcibly detained during crisis, suggesting that not all interventions to prevent suicide are experienced or delivered benignly (Riley et al., 2011).

1.3.4.4 Cultural and Community

White and colleagues (2016:1) argue that standardised or individualised ways of understanding suicide are of little value, as suicide is "*deeply embedded in particular social, political, ethical and historical contexts*". These contexts include societal attitudes towards death and suicide, attitudes towards help-seeking, perceptions of need and of the value of available interventions (Pitman & Osborn, 2011). They include wider political and historical forces which create the conditions that impel certain groups into unliveable lives and towards death by suicide or circumstance (Mills, 2020).

The cultural model of suicide proposed by Chu and colleagues (2010) identifies three areas in which culture intersects with suicide: 1) culture influences the stressors people experience; 2) suicide and life stressors have cultural meanings attached, which influence a person's tolerance of suffering and suicidal acts; and 3) culture affects the expression of suicidality. In a study comparing attitudes towards suicide in Australian, Indian and Italian youths, differences were found in associated meanings of and reasons for suicide and protective factors against suicidal acts (Colucci, 2013). Choice of method to hurt oneself or take one's life is another area in which cultural meanings and values come into play (Canetto & Sakinofsky, 1998; Lester, 2008). Even ideas of selfhood differ across cultures, influencing suicidality and what it means to be suicidal (Tzeng, 2001).

In the West, attitudes towards suicide are historically related to religious and moral indictments of suicide and are more recently embedded in a risk culture that continues to view suicide as a failing (Douglas, 1992; Rose, 1998). How suicide and suicidal behaviour are perceived and positioned as a mental health problem for professionals to prevent is guided by overarching cultural notions of risk, rationality, and responsibility (Marsh, 2010). Some argue that death itself has been sanitised and rejected in the West, with death mostly moving out of the home into medical settings and needing to be accounted for by medical professionals (e.g., coroner's inquests, death certificates) (Ariès,1974). Minois (1999) points out how attitudes towards suicide reflect a culture's broader beliefs and expectations of its inhabitants, for instance, suicide in antiquity was honourable under certain circumstances (e.g., as a matter of conscience following public failure) but dishonourable in others (e.g., a soldier's suicide robbing the state of its property). This theme of the relationship between government and individual, in which the individual's life is not solely their own or where different lives are valued differently by governments, recurs in socio-historical understandings of suicide and challenges notions of it being an individual act of agency and personal tragedy, as our understandings of life, death, and our right to exist are always framed by our specific contexts.

Culturally informed responses to suicide have aimed to intervene within communities where suicide rates are high to address cultural and social factors creating suicidal conditions. For instance, in Philadelphia, Mohatt and colleagues (2013) created a storytelling website, storytelling community groups and a public mural representing life preservation in crisis; participants described the project as healing and humanising, fostering a sense of community cohesion. Malone and colleagues (2017) blended psychobiography with visual arts to assist an Irish Traveller community in remembering the lives of lost loved ones. Creating this space collaboratively seemed to foster communication about suicide, loss and communal challenges and improve wellbeing within the community. These interventions move away from individualising suicide towards a broader understanding of the social and cultural contexts in which suicide becomes a response.

The media is another source of narratives around suicide, and there has been a recognition of how media reporting can and contribute to suicide clustering within communities. Media guidelines for suicide reporting are recommended, due to the negative impact of graphic media reports on suicide rates (Pirkis, Mok, Robinson, & Nordenstoft, 2016). Media reports are thought to influence suicidality through identification, i.e., a person sees themselves in the individual who has died by suicide and decides to copy their actions (ibid). This theory of identification relies on ideas that stories can influence others, and a paternalistic attitude that individuals who are susceptible to suicidality need to be protected from stories of suicide for their own good.

Online communities have attracted research attention, finding a nuanced perspective on the values and dangers of social media in relation to suicide (Krysinska et al., 2017). Biddle and colleagues (2018) found that suicidal young people tend to use the internet purposefully, and people with more intense suicidality are more likely to look at method-specific and factual material about suicide. Daine et al. (2013) reviewed pro-suicide websites and forums and outlined several concerning features, including normalisation of suicide, advice on methods, and discouragement of help-seeking. Colombo and colleagues (2015) analysed suicide-related twitter content and described a networked community posting and sharing suicidal feelings with each other. They raised concerns around how this network might normalise suicide or lead to suicide contagion, but it was unclear that twitter communications did either of these things. It is worth noting that one individual could use the internet in multiple ways; Harris, McLean and Sheffield (2009) found that suicidal individuals used the internet for life-affirming and suicide-related content. Given the social isolation and shame people may experience, the internet's anonymity could be attractive and enable openness in ways that offline communication may not.

The UK government has highlighted the importance of community-based interventions, as it recognises that some people may be more likely to engage with non-clinical settings due to stigma and attitudes towards, and experiences of, help-seeking (National Institute for Health and Care Excellence, 2018). For instance, it is argued that men may require alternative service models due to a tendency to reject or fail to access more formal medicalised services (River, 2018). Discourses of masculinity and their influence on choice of means, the acceptability of emotions, struggle, and help-seeking are often noted as part of male suicidal behaviour (e.g., Canetto & Sakinofsky, 1998).

In contrast to more medicalised versions of crisis support, there are community crisis houses around the UK that aim to reduce stigma around help-seeking and reach people who are currently suicidal, e.g., Maytree respite centre in London, Suicide Crisis Centre in Cheltenham, and James' Place, a non-clinical centre for men in Liverpool. Suicide crises present a crucial opportunity for intervention and connectedness, compassion, and relational safety are essential components

(Beaton, 2012). Being able to sit with and hear suicidal people, compassionately and non-judgementally, seemed able to reduce people's despair (Beaton, 2012). These houses tend to offer brief respite stays, offering a non-medicalised, non-judgemental space for people in acute crisis. A service evaluation of the Maytree highlighted that people appreciated the service and that the informal befriending approach generated opportunities to break out of the suicidal process and feel hopeful (Briggs, Webb, Buhagiar, & Brown, 2007). Briggs et al. (2007) noted that Maytree's position outside statutory organisations may have enabled it to separate different responsibilities around care and risk in a helpful way.

One pertinent cultural context for people living with suicidality are communities of peer support. Morse and colleagues (2020) argue that marginalised groups may feel unable to access mental health services, both as recipients and providers. Anxiety arising from being seen by someone from a more privileged socio-economic group can interfere with relationship formation. Peer support limits, if not eliminates, difference anxiety that can negatively impact on help-seeking (Andrews et al., 2004). Peer support groups exist in several countries, with evidence that they increase hope and reduce repetition of suicidal acts (Bergmans & Links, 2009). Whilst suicide-specific peer support groups are relatively limited in number, the evidence base for peer support in mental health generally is mostly positive (Lezine, 2016). Theoretically, it makes sense that an experience often characterised by shame would benefit from a peer support approach.

Cultural understandings of suicidality draw attention to some of the sources of narratives for suicidality, including the media, public policy and the internet. Culturally-informed responses typically seek to reduce stigma and understand suicidality as arising from cultural contexts and imbued with meaning from those contexts. It is likely that people who live with ongoing suicidality will be drawing on narrative resources within their own contexts to narrate their stories.

1.4 Summary of Context

Suicide has been theorised through multiple lens, often reflecting the social and historical context of the time. There is a predominant assumption that suicide is an individual act; whilst challenged by some, it is mostly assumed that suicide is a response of an individual to (internal and/or external) circumstances. A second thread is that suicide is seen as intentional and meaningful; that suicide stems from mental illness attributes intention and meaning to the connection, even if that meaning is considered illogical due to the purported nature of mental illness. The frame for how suicide is understood has led to certain responses or interventions, which are not always experienced as helpful by service users. Some responses have been considered actively harmful and may lower the likelihood that someone will seek help in the future.

These dominant ways of understanding and responding to suicide have typically not been created by or in collaboration with service users (with some exceptions) and have tended to focus on suicide as a prevention target, whether this is to be achieved via the treatment of illness, detention during crisis or reducing access to means, or increasing help-seeking within communities. It is rare for studies to consider suicide as a feature of people's lives, despite my awareness of people within the community who live with suicidality over time. It is of interest to consider how people who experience suicidal thoughts, feelings and acts may view suicide and the narratives they use to understand ongoing suicidality, as this will have an impact on help-seeking and how people relate to others.

1.5 Literature Review

From the literature on the broader context, I recognised that there was a gap around understandings of suicidality as an ongoing experience, and an understanding of ongoing suicidality from the perspective of people who live with it. I wondered about the impact of the various dominant narratives of suicide on people who live with ongoing suicidality but did not have a clear sense of whether this had already been investigated. I conducted a scoping review on people's experiences of suicidality, to gain an understanding of how people narrate suicidal thoughts, feelings and acts and to check what was already known about living with ongoing suicidality. I searched relevant databases, using search terms related to experiences of suicidality (Appendix 1). I conducted a broad search on experiences of suicidality as I was aware that research typically did not refer to "ongoing suicidality", so I examined all relevant literature for references to suicidality as an ongoing experience. Key papers were identified, and citation searches carried out. Reference lists were also hand-searched. Suicide-related journals were checked for articles that focused on suicidal experience. Additional sources for grey literature included search engines, social media, and project participants and gatekeepers.

Suicidal experiences are an important source of knowledge for clinical practice (Leenaars, 2002). Research into suicidal experiences can aid understanding suicidality in context (Hjelmeland & Knizek, 2017). Experiential research may also capture and contextualise complexities relating to changes in suicidality over time (Hjelmeland & Knizek, 2010). Below, I consider research into different aspects of suicidal experiences. These sections report on 44 papers, using the language, focus, and findings of those papers to categorise them. Only a small number of papers considered suicidality as an ongoing experience and these are discussed.

1.5.1 Suicidal Thoughts and Feelings

Suicidal thoughts, or ideation, are often examined as precursors to suicidal actions (Klonsky & May, 2014). Suicidal thoughts are common, with one in five people experiencing them (McManus, et al., 2016) and most people will not die by suicide (Kessler, Borges, & Walters, 1999). Some argue there is a spectrum of ideation (transient/persistent, passive/active), with varying suicidal intent and implications for risk, but this idea has not really been explored from the perspective of people who live with suicidal thoughts (Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007). Research has focused on the relationship between suicidal thoughts and suicide, to predict people most at risk (Dhingra, Boduszek & O’Connor, 2015). Dhingra et al. (2015) found differences in the motivations and social contexts of people who acted upon suicidal thoughts versus people with suicidal thoughts only. They suggested the experience and meaning of suicidal thoughts and attempts needs further exploration.

Mahmood (2019) conducted an interpretative phenomenological analysis (IPA) of people experiencing suicidal thoughts but not acting on them. Mahmood described participants moving between ‘wanting to live’ and ‘wanting to die’, feeling stuck and despairing with ongoing thoughts. Feeling connected with others and some purpose to suffering seemed to help people into the ‘wanting to live’ position (ibid). Suicidal thoughts were sometimes triggered by painful memories and feeling isolated and rejected (Huang, Tsai, Liu, & Chen, 2017). Another study of suicidal thoughts highlighted how feeling isolated was part of the experience (Dodemaide & Crisp, 2013). Acceptance – by self and others – was mentioned as restorative, whilst fearing rejection maintained people’s hopelessness and reticence (ibid).

Suicidal feelings are relatively neglected, although feelings like despair, hopelessness, burdensomeness, anger, and loss are mentioned in suicidal thoughts research (Dodemaide & Crisp, 2013; Mahmood, 2019; Wu, Tsao, & Huang, 2012). Many who are suicidal speak of feeling unbearable emotional pain; which Shneidman (1993:145) named “*psychache*”. Benson, Gibson, and Brand (2013) conducted a qualitative study on 124 participants to explore what feeling suicidal means. Feeling suicidal was described as an existential feeling, connected to experiences of loss or disruption of the agentic self. They argued that this is a qualitatively different experience to suicidal thoughts, not necessarily connected to suicidal intent but reflecting an orientation towards ending an intolerable existence. They outlined four elements: loss of core assumption of an integrated self; disruption of reciprocity with the world; feeling they lack mental resources to cope; and bodily sense of suicidality via feeling extreme strain and tension or feeling empty and numb.

These studies offer a complex picture of suicidal thoughts and feelings and highlight the emotional and relational content of these experiences.

1.5.2 Self-Harm

Self-harm is a major predictor of suicide risk (Cooper et al., 2005), although many who self-harm do not die by suicide, and not all people who die by suicide have a history of self-harm (HM Government, 2012; Royal College of Psychiatrists, 2010). Some characteristics and experiences of people who self-harm overlap with people who take their lives (e.g., histories of abuse, mental health problems and/or substance misuse, social isolation, financial difficulties) (Johnston, Cooper, Webb, & Kapur, 2006; Skegg, 2005). However, there are differences, e.g., self-harm rates being higher in women and younger people (Arensman, Griffin, & Corcoran, 2016). What emerges is that both phenomena occur across the life-course, and whilst they overlap, there are differences in trends and prevalence.

Self-harm is commonly understood as a response to emotional distress, but the behaviour can serve numerous functions, such as self-punishment, releasing emotional pain through physical pain, ending dissociative states, communicating when unable to communicate in other ways, desire to escape, cutting something intolerable from the body, self-directed anger, and creating an opportunity to self-soothe or master oneself (Edmondson, House, & Brennan, 2016; Klonsky, 2007). For some people who self-harm, self-harm can be anti-suicide, a strategy that sustains life (Harris, 2000; Nathan, 2006). Researchers have pointed to parallels between self-harm functions and functions of other behaviours, including eating behaviours, exercise, smoking and drug and alcohol use (e.g., Babiker & Arnold, 1997; Hufford, 2001). Self-harm can be viewed as part of a spectrum of behaviours – some more socially acceptable than others – that can cause self-injury (Babiker & Arnold, 1997; Turp, 2003). Likewise, functions of suicide, such as escape from intolerable pain, may overlap with self-harm functions (Baumeister, 1990).

The relationship between suicide and self-harm is complicated by the issue of method. People who take overdoses often disclose non-suicidal reasons or ambivalence of intent (Rodham, Hawton, & Evans, 2004; Salter & Platt, 1990). A pesticide self-poisoning study in Sri Lanka described people’s motivations as mostly related to stress rather than suicidal intent; yet, pesticide injestion often causes serious damage or death (Konradsen, van der Hoek, & Peiris, 2006)[2]. Both choice and availability of means to self-injure, as well as awareness of the damage that can be done, are factors to consider when differentiating between suicidal and non-suicidal intent.

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[2] Pesticides were a common, cheap household item; they have since been banned or restricted and suicide rates have fallen (Knipe et al., 2017)

Some self-harm accounts blur the boundaries of intent, with people's motivation shifting during a self-harm act (Solomon & Farrand, 1996). In a study of young people, some felt pushed towards suicide when self-harm did not grant the intended relief (Spandler, 1996). Additionally, people can have concerns and worries around declaring suicidal intent after an act of self-harm (Wiklander, et al., 2003). This all contributes to the difficulty of exploring intent in formal settings; people may worry about the consequences of disclosure and deny suicidality (National Institute for Health and Clinical Excellence, 2004).

1.5.3 Suicide Attempts

It is estimated that there are more than twenty attempts for every person who dies by suicide (World Health Organisation, 2017). Suicide attempts include any action taken by a person with suicidal intent. Behaviourally, this may look the same as an act of self-harm, only differing in expressed intent.

Near-lethal suicide attempts have been suggested as a useful proxy for suicide (Biddle et al., 2010; Borrill, Snow, Medlicott, Teers, & Paton, 2005; Rivlin, Fazel, Marzano, & Hawton, 2012; Rosen, 1975). Near-lethal attempts involve a method associated with high fatality rates or that would result in death without medical intervention (Biddle et al., 2010). Whilst we cannot assume lethality and suicidal intent are related (e.g., Gjelsvik, Heyerdahl, Holmes, Lunn, & Hawton, 2017; Vlad et al., 2011), it is likely there is overlap between the experience of survivors of near-lethal attempts and people who die by suicide.

Some survivors speak of their relief at surviving or beliefs that they survived for a reason (e.g., Berglund, Åström, & Lindgren, 2016; Rosen, 1975). Others speak of disappointment to be alive and experiencing the same struggle (Crocker, Clare, & Evans, 2006; Hunter, 2011). Following a suicide attempt, people sometimes re-appraise the meaning of what happened (Tzeng, 2001), and move away from the suicidal state, especially when feeling connected to others (Hunter, 2011; Lakeman & Fitzgerald, 2008). Lakeman and Fitzgerald (2008) highlighted the existential nature of people's struggles prior to and as a result of their suicide attempt. For some people who have been suicidal, suicide remains a "*continued psychological presence*" in their lives after an attempt (Roberts, 2016:62)

The meaning of suicide can be complex, representing a means of coping and a failure to cope simultaneously (Lakeman & Fitzgerald, 2008). For some, suicide attempts are part of a struggle for control, a desire to exert control, or feeling out of control (Brand, Gibson & Benson, 2015; Pavulans, Bolmsjö, Edberg, & Ojehagen, 2012). For others, being unable to resolve past difficulties make life feel unliveable (Holm, Lyberg, Berggren, Cutcliffe, & Severinsson, 2014). Some have argued that feeling burdensome is central to suicide (Joiner, 2005); this centrality was queried in a study of Muslim women's suicides, wherein suicides protested the societal injustices and burdensomeness of others upon women (Canetto & Rezaeian, 2020). Likewise, prisoners engaged in suicidal acts for numerous reasons; e.g., as a response to feeling unexpectedly overwhelmed; a response to drugs withdrawal or psychotic symptoms; or an instrumental act to achieve something (e.g., environment change or anger expression) (Rivlin et al., 2013).

Resisting suicidal impulses can also be a protest in the context of ongoing suicidality (Sen, 2013). For some, making suicidal plans protects against suicide; reassuring them that there is an escape route, which allows re-engagement with life's tasks (Brand et al., 2015). Articulating these multiple and complex experiences when accessing care might be challenging. People can experience the language of 'suicide attempts' or 'failed suicide' as problematic, due to connotations of failure (Pembroke, 1994; Spandler, 1996). People can feel shame about suicidality (Wiklander et al., 2003), worry about being stigmatised (Azizpour, et al., 2018), and feel ambivalent about wanting others to intervene (Krychiw & Ward-Ciesielski, 2019). The reasons and meanings of suicide are multifarious, and the socio-cultural context plays a significant role.

1.5.4 Reasons for Living

Protective factors studies focus on establishing constructs associated with lowering risk or preventing suicidal behaviour (McLean, Maxwell, Platt, Harris, & Jepson, 2008). Factors can be psychological, social or cultural, and include constructs such as religion, resilience, hope, purpose in life, and social networks. Studies are largely cross-sectional and quantitative. Whilst protective factors offer important intervention targets, research often implies that factors are either present or absent, rather than fluctuating and intersecting.

Questionnaires have been designed to capture common reasons for living; these were initially developed to differentiate between general population and clinical samples (people with suicidal ideation/acts) (Linehan, Goodstein, Nielsen, & Chiles, 1983). Constructs include survival and coping beliefs, child-related concerns, responsibility to family, fear of suicide, moral objections, and fear of social disapproval. Whilst described as reasons for living, most constructs are negatively loaded, invoking fear and moral disapproval. They highlight another dimension of suicidal experience relevant to assessment and therapy, but they do not capture what might sustain someone in a life-affirming way.

Survivor websites share stories of people who have survived suicidal acts (e.g., NowMattersNow.org; LiveThroughThis.org). These resources aim to help people find ways to continue living when suicidal. Story themes include the notion of turning points/moments where they moved away from suicide, living through this (people persist and demonstrate survival as possible), and things change (suicide in past and present does not mean future suicide).

1.5.5 Ongoing Suicidality

Few studies explore suicidality as an ongoing experience. This may be partly attributable to the tendency for suicidality to be understood through a psychiatric lens, rather than as an experience on its own (Marsh, 2010). It may reflect societal taboos around suicide (Azizpour et al., 2018), or be an artefact of research methodology, as research is often retrospective (examining moments of crisis or death), or cross-sectional (e.g., presence or absence of risk factors).

Bergmans, Gordon, and Eynan (2017) highlighted how people who attempt suicide multiple times can feel precariously balanced between life and death, unsure of which to lean towards. People describe various practical, cognitive, cultural and social resources to manage suicidal thoughts and feelings in the community (Han & Oliffe, 2015; Peterson & Collings, 2015). They may manage alone to protect loved ones from stigma (Han & Oliffe, 2015). The idea of suicide can provide some with consolation (Vatne & Naden, 2012) and may motivate people to self-manage ("*it's either do it or die*"; Peterson & Collings, 2015:173). Roberts (2016) investigated life after a suicide attempt. He used a spatial metaphor to capture people's experience of suicide as something they moved away from or closer to, or remained in the shadow of, post-attempt.

Across different studies, people seem to carefully choose where and who to speak to about suicidality, with conversations often taking place outside formal services (Blanchard & Farber, 2018; Peterson & Collings, 2015).

1.6 Summary of Literature Review

There is a wide range of papers that explore aspects of suicidality, yet the focus is typically on what leads to suicidality, how people recover from suicidality after an episode of crisis, or what prevents suicide (with less attention paid to what suicidality is like when suicide is prevented). Despite community studies demonstrating that suicidal thoughts, feelings and acts are common, and knowledge from survivor spaces (online and face-to-face) that people live with ongoing suicidality, few studies have examined ongoing suicidality as a phenomenon. The few studies that made that examination highlighted that people draw on a variety of resources to live with suicidality and often carefully negotiate how to speak of suicidality and to whom, but this relational aspect of living with suicidality is under-explored. There are hints that living with ongoing suicidality may be qualitatively different to existing suicide recovery narratives and may present different challenges for people.

Given the lack of literature on how people live with ongoing suicidality and the indications that living with suicidality is relationally situated, I chose to investigate how people live with ongoing suicidality and how they narrate suicidality. In light of literature suggesting that a substantial proportion of people do not come into contact with formal services or discuss their suicidality with others, I was interested to explore both the stories and the audiences (real and imagined) to which people with ongoing suicidality address their stories, as this has implications for how suicide prevention endeavours should be constructed.

1.7 Relevance to Clinical Psychology

In line with feminist and critical perspectives, I view clinical psychology as a profession with epistemic and moral authority within western society, which contributes to the socio-political landscape (Parker, 2007; Rose, 1999). Psychology as a profession and set of practices is involved in defining experiences, creating knowledges, and legitimating narratives. Because of its epistemic and moral privilege, it can be a tool for bolstering oppressive structures or employed to promote social justice (Patel, 2003; Prilleltensky, 2003).

Clinical psychologists are part of the health-system culture of risk assessment and management. In mental health services, zero-suicide policies have been recently foregrounded, and it is likely that clinical psychology is involved in designing and delivering interventions in line with these policies, in managing the emotional consequences of suicides in services and in working with suicidal individuals and their families. Clinical psychologists are well placed to formulate around suicide prevention in services and to challenge harmful practices. Clinical psychologists should be willing to appraise policies and practices from multiple perspectives and consider ways forward. For instance, we have the power to gate-keep services and determine who receives which intervention, or advocate for change to meet service gaps. Taking our epistemic and moral privilege seriously, clinical psychologists have a significant role in shaping suicide discourse and practices. Alleviating distress is often our focus, but it is not our only skill, nor does distress need to be understood as an individual problem (Smail, 2005).

The value of a collective resource for clinical psychology could be several-fold. It could inform empathetically exploring, formulating and working with suicidal experiences (Wang, Lightsey, Pietruszka, Uruk, & Wells, 2007), and inform policy and service development. It could also be useful as a political tool for re-framing discourses around funding and intervention.

1.8 Research Aims and Questions

This project aimed to explore how people live with ongoing suicidal thoughts, feelings, and acts, and to collectively create a resource to share with others. By examining the ongoing experience of suicidality, it sought to contribute to a growing understanding of suicide and suicidality as relational and embedded in the (past, present and future) context/s of people's lives. By working collectively, this project hoped to re-connect people with their knowledges, skills, and resources and somewhat redress the tendency of traditional research to isolate individuals and de-contextualise experience (Chandler, 2020).

The research questions are articulated and contextualised thusly:

- ***How do people live with suicidal thoughts, feelings and acts?***

Given the pre-dominance of narratives around suicide that emphasise its irrationality and how it can negatively impact on society, it is pertinent to ask how people who experience ongoing suicidality respond to and narrate their experience in this context. The major Western responses to suicidality (especially the medical and psychological approaches) situate suicidality as an individual problem and respond to it at that level. Responses that situate suicide as a reflection of society are lesser known, and thus less likely to impact on the care that people experiencing ongoing suicidality receive.

Research into lived experience of suicide has mostly focused on the experience of, or recovery from, suicidal thoughts, feelings and attempts, neglecting narratives of ongoing suicidality. There is a gap in our understanding around how people live with suicidality over time, particularly in what resources they draw on to live in this way, and how and if they understand the experience of suicidality as an ongoing presence or as moments of crisis from which to move on from, as dominant research and societal narratives suggest.

- ***How do people want to share their narratives, and to whom do they wish to speak?***

Major themes throughout the literature are the negative impact of suicide and the view of suicidality as a sign of mental ill-health, with associated stigma. Within the literature on lived experiences, shame, stigma, and worry are common emotional experiences attached to the idea of speaking of suicide to others. Few studies have examined the concept of ongoing suicidality, and it is likely that, in the context of suicide-related stigma, narratives of recovering from suicide are safer to tell. There is a gap in the literature around how people who live with suicidality over time would narrate suicidality.

In addition, given that people carefully choose their audiences for disclosure, specifically exploring the idea of speaking of suicidality as a directed action with an audience in mind is of interest. The relationality of narrating suicidality (what people wish to share, to whom) is an under-explored area that is relevant to a variety of audiences, including formal services, policy and the public, as it can inform how to support people who experience suicidality.

2. Methods

This chapter will outline the research epistemology and methodology, describe and justify data collection and analysis methods, and reflect on practical and ethical aspects of the research.

2.1 Epistemology and Ontology

The term "*epistemology*" refers to theory of knowledge (or knowledges) (Willig, 2008). Throughout this thesis, I take the social constructionist position that the social world is constituted by people, and "*society is a human product*" (Berger & Luckmann, 1966:61). I argue that our concern as researchers lies with "*the human face*" of reality, namely the reality that is socially created (Putnam, 1990:3). My focus is therefore how social meaning is constructed by people and how people are shaped by the meanings available to them (Martin & Thompson, 1997). People and society are mutually constituted; we create the social world, and the social world shapes our subjective realities.

Knowledge is subjectivist and contextualist, linked to our subjectivity and situated in our contexts (Guba & Lincoln, 1994; Madill, Jordan, & Shirley, 2000). It is posited that we are continuously (re-)making and co-constructing our reality interactionally (Bruner, 1990; Smedslund, 2009). When we interact, we draw on available stories to create shared meaning (Frank, 2012). Because knowledge is interactionally constructed, there is no one 'final' knowledge. Knowledge is instead knowledges, partial, situated and revisable.

Ontologically, I adopt a position that views reality as a socially constructed concern, created from our subjectivities. I make no assumption of an external reality that exists separately from human experience nor do I deny the possibility of one. I acknowledge that there are debates around the definitions and shades of different ontological positions (e.g., Bryman, 2008) and acknowledge Willig's (2016) challenge that research which seeks to create change within a social system cannot be completely committed to hard relativism, as research assumes the possibility of changing a co-experienced reality. Even with this caveat, the research fits closest with a relativist ontological position, as reality is viewed as subjective and socially constructed (Denzin & Lincoln, 2005).

This study is interested in how people narrate ongoing suicidality. In the context of the above epistemological and ontological positions, a focus on narratives of ongoing suicidality acknowledges how people construct social reality via language, especially story-telling. Investigating narratives is a way of exploring the construction of reality via story-telling acts. Adopting a relativist ontological position acknowledges that there may be multiple versions of ongoing suicidality, arising from different subjective experiences, and that I make no claims to discovering one 'truth' shared by all. Epistemologically, viewing knowledge as co-constructed connects to the research aim of connecting people to each other's knowledges as an act of social justice, as it acknowledges how interaction actively transforms knowledges and thereby people's realities.

2.2 Social Justice and Epistemic Injustice

As knowledge is not neutral and (human) reality socially constructed, it follows that research be considered a constitutive site of knowledge production. Research actively creates knowledge/s and legitimates knowledge/s and knowledge-creators. It can maintain or challenge oppressive social structures (Martin-Baro,1994). Via the privileging of evidence-based knowledge in medicine and policy, research has political force in Western society (Haraway, 1988; Mather Saul, 2003). How people are positioned and whose voices are privileged in research are social justice issues, with researchers bearing an ethical responsibility to conduct research that promotes justice (Denzin, 2010; Fine, Weiss, Weseen, & Wong, 1994; LeBlanc & Kinsella, 2016).

Traditionally, research has not privileged the knowledge/s of people experiencing ongoing suicidality (Lezine, 2016). People often feel unheard or not taken seriously by healthcare staff when seeking help in crisis (e.g., Sheehan et al., 2019; Vatne & Naden, 2014). Being considered less credible due to a feature of one's experience or identity and having limited available understandings of one's experience are forms of epistemic injustice (Fricker, 2007). Research which seeks to privilege, and attend to injustices in, the stories of marginalised groups can be considered actions toward more just epistemic practices (Chandler, 2020; Tuana, 2017).

2.3 Methodology

This is a qualitative study which takes an ethical stance; it views research as an active political endeavour (Denzin, 2010). Given research's epistemic power, I have chosen to adopt a collective narrative approach to work alongside people to create collective resources (Denborough, 2008). This approach views people's knowledges as unique, invaluable resources, and considers research process and product/s as equally important (Parker, 2004). There is a methodological commitment to honour the knowledges of people experiencing suicidality whilst using the research paradigm to actively connect marginalised people with each other (White, 2020).

2.4 Recruitment

Where and how to recruit people required careful consideration. In recruitment, power traditionally lies with the researcher, who delineates the study population and thereby influences who can contribute to knowledge construction (Karnieli-Miller, Strier, & Pessach, 2009). I was mindful that much research takes place via formal services, and yet people do not always access these services (National Confidential Inquiry, 2018). Research has also demonstrated that different settings and professional roles influence interactions, as participants shape their responses based on assumptions about the researcher (Oakley, 1981; Richards & Emslie, 2000). I concluded that recruiting via informal networks was more in line with the project's ethical commitment and may help reach people who eschew formal services.

2.4.1 Sites and Gatekeeping

I developed relationships with two existing community groups who acted as study gatekeepers. Accessing existing groups meant that potential participants were already connected to peer support networks. The first site, located in the south of England, was a mental health arts charity which provided a regular drop-in space for anyone with mental health problems. This space was hosted by volunteers, some of whom have lived experience. The second site, located in the North of England, is a self-help group for self-harm. This group also operated as a drop-in space, with a focus on providing peer support. It is hosted by one facilitator with lived experience and another with a professional background. Neither group specifically focuses on support around suicide or suicide prevention, although informal discussions with facilitators revealed that it was a topic of interest. I had a prior relationship with the self-help group, as I had previously facilitated it with one of the current facilitators. The connection with the mental health arts charity was established through informal networks.

2.4.2 Sampling

The sampling approach combined convenience and snowballing strategies, with the community group facilitators approaching people about the study on my behalf (Robson, 2002). Snowballing entailed asking participants to pass on project details to others who may be interested. This approach can increase the diversity of the sample derived from convenience sampling, but comes with its own risks (e.g., no direct contact with people; it takes time to build relationships). Both strategies are typically recommended for ‘hard to reach’ groups, due to the approach via informal networks (Valerio et al., 2016).

2.4.3 Inclusion and Exclusion Criteria

The inclusion criteria were as follows:

- Adults aged 25 and over
- People who identify as experiencing suicidality for at least a year during their lifetime
- People who currently feel able and safe to participate
- People who speak English sufficiently well to participate

The exclusion criteria were:

- People who currently identify or present as in crisis (suicidal or otherwise)
- Anyone lacking capacity to participate

On first contact, I screened potential participants, to check they meet inclusion criteria.

Whilst suicide occurs across the lifespan, most deaths occur in adults aged 25-49 (Office for National Statistics, 2017). Research often focuses on younger people or certain groups (such as LGBTQ+) or diagnoses (e.g., emotionally unstable personality disorder or depression). Despite their presence in suicide statistics, adults of working age are a relatively neglected group (Fincham et al., 2011). I chose not to limit my sample by characteristics other than age for two reasons. First, I hoped to recruit people from the community with a range of resources to live with suicidality. Second, people living with suicidality might be difficult to recruit, due to their geographical dispersal and stigma around suicide. Having open inclusion criteria could enable recruitment. However, there are drawbacks to this approach. For instance, specific marginalised groups may not identify with a generic advert or approach a researcher from a different background (e.g., white, female, visibly able-bodied, professional). Also, people who struggle with heterogeneous groups (for any reason) may be less likely to take part.

The rationale for focusing on people with suicidality for at least a year was to involve people who can speak about, and draw on, experience over time. It was theorised that people who live with suicidality over time develop their own resources, knowledges and meanings.

Only including people who feel able and safe to participate was designed to foreground a consideration of people's needs during recruitment (and signpost/refer accordingly) and ensure participants were not currently in crisis. If someone presented in crisis or significant distress at any point, there was a distress protocol to sensitively explore this, discuss concerns, and act accordingly, taking a collaborative approach which balanced the person's rights to self-determine alongside their needs and my clinical judgement.

Owing to the project's financial and time constraints, and the need to form groups who can interact with each other, only people who speak English were invited to participate. Likewise, if people did not have capacity to take part, they were excluded as the research question could be explored without their inclusion.

Following the Mental Capacity Act (2005), capacity was assumed unless there was reason to doubt it by virtue of their presentation, in which case I would introduce and apply the two-stage capacity test with the person. The issue of capacity in people who are suicidal is a contested area that warrants its own exploration, as dilemmas around the balance between autonomy, the role of services, and the interpretation of capacity law are complex (e.g., Richardson, 2013). Here, capacity considerations focused on the specific decision to participate in the study. As standard practice, I checked people understood the project and its requirements and had considered the implications of participation at each contact.

2.5 Ethical Issues

2.5.1 Ethical Approval

This study received ethical approval via the University School of Psychology Ethics board (Appendix 2).

2.5.2 Informed Consent

Potential participants were provided with an information sheet and given at least 24 hours to consider participation before I obtained written consent (Appendix 3). People were given time to ask questions by telephone or email before agreeing to participate and in person prior to a workshop/interview. Written consent was taken before data collection and checked at the end, as topics can arise in conversation that people do not anticipate. Consent was verbally re-checked at all contacts, respecting the dynamic nature of consent (Cutcliffe & Ramcharan, 2002). The information sheet and consent forms outlined the right to withdraw participation.

2.5.3 Collective Resource Creation

This aspect of the project could not be pre-defined, as I planned to collaborate with participants around what to create, what to include, and how and who to share it with. People were given information about likely timelines and possibilities of involvement and given time to consider their participation. People were offered multiple options around involvement in collective document creation on the follow up sheet (Appendix 4). Participants were offered the choice to edit their own transcripts, participate in creating resources, and attend further workshops.

Any collectively created documents will be licenced under a Creative Commons license that permits joint authorship and non-commercial sharing and editing (Creative Commons, 2018). Audiences and sharing methods were considered with participants, to make collaborative decisions.

2.5.4 Data Issues

Study documentation outlined how and for what purposes data will be used. Each participant was advised that they would be given a pseudonym for the thesis to protect their identity. Participants were offered the option to choose a pseudonym if desired. Confidentiality, especially confidentiality limits in group settings and the legal obligations around serious risk of harm, was explicitly addressed in the information sheet and as part of the group agreement for workshops.

Any personal data (e.g., names, email address, phone number) was stored securely on UEL onedrive, accessible only to me. Personal data would be deleted at the project end or if someone withdrew from the study. Consent forms were scanned into the UEL onedrive with hard copies disposed of in confidential waste. Audio-recordings were stored securely on the UEL onedrive to be securely deleted after thesis examination. Whilst images could be included in the study if participants desire, no identifiable images would be taken. Anonymised transcripts and images will be retained for two years post-project completion, to enable publications, collective documents completion, and as part of quality assurance practices.

2.5.5 Protection of Participants

Potential participants were approached through trusted organisations who already provided support to participants. This approach conferred legitimacy to the research request and provided distance and protection for potential participants, who could consider participation without obligation (Miller & Bell, 2012).

As suicide is a sensitive topic, I developed a protocol for screening and supporting participants (Appendix 2). At each contact, I explored the preferences and emotional state of the participant, taking a sensitive, non-judgemental stance. Participation was followed by a debriefing conversation and reflection. A resources list was available if people chose (Appendix 5). I respected choice around help-seeking preferences, in keeping with research (Peterson & Collings, 2015). Participants were offered follow-up contact via their preferred communication method.

Emotional responses to participation were not assumed to be harmful (Faulkner, 2004). It felt important to offer people space in which they could experience distress without judgement, if this was part of telling their story. Previous studies have demonstrated that participants value being able to express distress (Blades, Stritzke, Page, & Brown, 2018; Biddle et al., 2013; Faulkner, 2004). During participation, I reiterated that people could take breaks, re-schedule/cancel or undertake self-care, if appropriate and necessary. People’s right to choose was respected (Kennedy, 2005). To ensure a timely and sensitive response to distress, each workshop was facilitated with a co-facilitator from a community group.

2.5.6 Relational Aspects

I chose to openly identify as having lived experience of suicide and self-harm. This was a difficult decision, as it was hard to anticipate the impact of this openness on myself, my relationships with participants and colleagues, and my career prospects (Rhinehart, Johnson & Killick, 2020). However, it felt important to approach the project from an authentic position, due to the marginalised nature of ongoing suicidality. It also felt to me that this shared identification may help create relational safety (Oakley, 1981). I adopted a both/and position, recognising the likely connections between myself and participants which may deepen data collection and analysis, and yet staying curious, recognising the importance of holding space for difference (Hunter, 2010; Hurd & MacIntyre, 1996).

The project was designed to privilege people’s knowledges, re-connect people with their histories and others’ stories, and promote their agency in producing collective resources (Denborough, 2008: Stout, 2010). This inevitably entailed developing relationships with participants that were flexible and responsive, meaning reflexivity and ongoing consent processes were crucial (Cutcliffe &

Ramcharan, 2002; Guillemin & Gillam, 2004). I took the position that research is inter-subjective, involving each contributor in relation with self and other (Rose, 1997). My reflections on these dynamics and relations informed analysis.

2.5.7 Protection of Researcher

I put self-care and safety measures in place, acknowledging the likely emotional and personal impact of this project (Boden, Gibson, Owen, & Benson, 2015). Conducting research in a topic that is a passion and a personal experience acts as a counter-practice against the despair that working in services can sometimes elicit (Morgan et al., 2019), but also requires a level of embodied engagement that can drain one's resources (Hunter, 2010). I set clear boundaries around my availability, both when speaking with participants and by using automated messages on email and phone to manage expectations. Using the follow up sheet enabled me and participants to agree when and how to keep in contact post-data collection.

Thesis supervision was available throughout the project and the emotional impact was an explicit item for discussion. I also had other support structures, including a co-facilitator for mutual support during and after workshops, a personal and professional development group, a trainee support group, my personal tutor, and friends and family. More formally, therapy was available as a space to explore the emotional impact and issues arising for me, bearing in mind participant confidentiality. I also used reflexive journaling to process emotional responses to the material (Appendix, 6; Burns, 2003).

For personal safety, locations for data collection were risk assessed. Both community spaces and the university had reception desks and sign in procedures. In line with lone working policies, I adopted a buddy system for interviews.

2.6 Data Collection

People were initially invited to participate in a workshop or interview to explore their relationship with suicidality, consider what they wish to share with others, and collaborate on developing collective resources. It was hypothesised that some people may prefer not to participate in a group context, so flexibility and choice was offered.

2.6.1 Collective Narrative Practice

The project sought to create a dialogue between participants and interested parties in line with the ethics of collective narrative practice (Denborough, 2008). The project process and outputs were negotiated with participants and gatekeepers to ensure that it included and connected people in ways that felt respectful. The underlying ethos was to create a shared context for people’s stories, enabling a double-storied perspective where knowledges/resources and suffering are upheld (White, 2004). It was felt that to create safer spaces for people to connect, the work should take place through community groups. It also felt important that this ethos and its root in my lived experience was shared with participants. First, being open and vulnerable with people is an embodied practice which can open dialogue through mutual recognition and respect. It challenges artificial divides between researcher and researched and opens space to be alongside each other (Gaventa, 1993, Martín-Baró, 1994). Second, people may not be used to having their knowledges valued and centred and therefore explicitly sharing this ethos is an act towards redressing this injustice.

In acknowledging shared dimensions of experience, it was also important to recognise difference and own my positions within clinical psychology and research which afford me power (Arber, 2000; Song & Parker, 1996). Owning my positions and honouring the knowledges of others is an ethical stance I have adopted throughout.

2.6.2 Project Contributors

I use the terms ‘contributor’ and ‘participant’ to foreground the project’s collaborative and performative ethos. Choosing these terms also acknowledges that this situated telling (a thesis) is not co-authored in the way that collective resources will be.

Pseudonyms were assigned by me for the thesis (Table 1) and reflect participant preferred gender pronouns but no other demographic characteristics. Participants have been offered the opportunity to re-name themselves for collective outputs. Participants were aged between mid-20s and mid-70s. People were not asked to categorise themselves by demographics such as gender, ethnicity, health status, and sexuality; these details are only presented where participants narrated them.

Table 1: Contributors

Pseudonym	Recruitment via	Contribution Site/s
Adele	Informal networks	Interview
Willow	Southern charity	Interview; Creative Workshop
Leonard	Southern charity	Interview
Billie	Southern charity	Group and Creative Workshops
Barbra	Southern charity	Group Workshop
Celine	Southern charity	Group Workshop
Whitney	Southern charity	Group Workshop
Cristina	Southern charity	Group and Creative Workshops
Paul	Southern charity	Creative Workshop
Katy	Southern charity	Creative Workshop
Kelly	Southern charity	Creative Workshop
Shirley	Southern charity	Creative Workshop
Jennifer Co-facilitator	Southern charity	Group and Creative Workshops
Tom Film-maker Co-facilitator	Southern charity	Creative Workshop

2.6.2 Workshops

I planned to host a workshop in both locations, drawing on narrative practices and ideas (Denborough, 2008; Ncube, 2006; M. White, 2007). I planned to involve three-four people in order to support in-depth conversation and relational safety (Appendix 7). Initially it was designed so that participants would have the opportunity to tell their own story and have it witnessed by other participants, using witnessing questions to aid responses (M. White, 2007). The storyteller would then have space to reflect on the responses, and the workshop would end with a discussion around collective resources, further involvement, and emotional debrief.

Due to changes in facilitator circumstance (which meant the workshop planned in the North of England could not take place), greater demand for places in the

South of England location, participant preferences, and time constraints, the workshop plan was amended. In consultation with Jennifer and participants, we simplified the workshop format so that one participant’s story (with permission) was read out to a group of five participants (Appendix 8). Participants then responded to the reading, guided by witnessing questions, where they were asked to reflect on key images, words and phrases that struck them, as well as on ways in which they were changed by the telling[3]. The workshop ended with discussion around audiences, collective creation, and debrief.

Jennifer co-facilitated the workshop. Jennifer identified as having experience of suicidality and was employed by the mental health arts charity. The workshop was two hours long.

2.6.3 Interviews

Interviews were conducted with three people who chose this method of participation. Interviews were semi-structured, employing open questions to guide conversation around experiences of suicidality over time (Appendix 9). Interviews were considered appropriate as participants have found them acceptable for similar studies on suicide and self-harm (Biddle et al., 2013). Each interview also explored ways of connecting and collaborating on collective resources, and participants were invited to the creative workshop. The interviews were between 97 and 130 minutes in length.

2.6.4 Creative Workshop and Collective Resources

Each contributor agreed to continued contact to create collective documents. The first agreed output of an animated film emerged from the group workshop and was proposed by Jennifer as an activity funded by the charity. To continue the conversation from the workshop, Jennifer and I hosted a creative workshop with Tom, a filmmaker with lived experience of suicidality. Tom was paid by the mental health arts charity for his work. The creative workshop brought people together to discuss and suggest film content (Appendix 10). Images and ideas drawn from

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[3] Adele was offered these responses and accepted them; however, due to time constraints, it was not possible to gather Adele’s response prior to thesis deadline

the interviews and workshop, and images commonly used to represent suicide, were offered to stimulate conversation. A script is being created in collaboration with the contributors and Tom will then illustrate the film, which is due for completion in July 2020. The creative workshop was two and a half hours long.

Other avenues have been suggested by contributors (e.g., a theatre performance; hosting a death café, sharing stories online) and will be further explored post-thesis submission.

2.6.5 Transcription

The interviews and workshop were audio-recorded and transcribed, with participant consent. For the creative workshop, it was a group decision to audio-record discussion to aid film-making but not transcribe for research purposes.

2.7 Narrative Analytic Approach

Narrative analysis was chosen as an appropriate approach because I was interested in ongoing suicidality as a construct and how people are narrate their relationship to it ("*how to live with it*" rather than "*what it is as an experience/phenomenon*"). It felt valuable to explore both the content and the form of stories around ongoing suicidality, to establish an understanding of the different ways people relate to an idea of "ongoing suicidality", assuming that each person would have unique knowledges and that there would not be one shared 'truth' or 'essence' to access. As living with ongoing suicidality is under-explored construct in research, it felt important to explore how people narrate this construct in their contexts and what narrative resources they utilise to do so, recognising that these narrations are creating knowledges interactionally. Whilst other qualitative methodologies may have been appropriate (e.g., interpretative phenomenological analysis to explore the phenomenon of ongoing suicidality), the narrative analytic approach fitted with the ethical and epistemological stance of the research questions most closely, as narrative analysis can be concerned with story-telling in the research context as an epistemic action (a co-creation of knowledges). In line with viewing reality as socially constructed, the second research question on audiences and methods of sharing was suitable to a narrative analytic approach as narrative analysis presumes story-telling is a social endeavour, always involving audiences (present or imagined at the time of speaking).

2.7.1 Narrative Definition

Narratives are understood as dialogical, as responses to others which anticipate others' responses (Bakhtin, 1984; Frank, 2012). When anyone speaks, they speak in multiple voices, and each story builds upon and draws from previous stories told (Frank, 2012). Narratives presume an audience and both (re)construct and (re)position the self in relation to others. In their creative capacity, narratives remain open to revision, encapsulating what Bakhtin (1984:59) called the *"inner unfinalizability"* of people.

Dialogue can be understood in relation to how people speak to imagined audiences as well as with the stories of others, which Bakhtin (1984) called polyphony. It also reflects the interaction between storytellers and available storytelling resources, which Bakhtin called heteroglossia (ibid). Finally, dialogue occurs between storyteller/s and listener/s throughout the research, and between this written account and the reader/s of said account.

2.7.2 Narrative Analysis

I have taken a pragmatic approach to narrative analysis, drawing on more than one theoretical resource as suits the research's methodological aims (Squire et al., 2014). This thesis primarily draws on Frank's (2012) dialogical narrative analytic approach, but also brings in a concept of emotional narratives (Kleres, 2010). Frank (2012:33) suggests that stories are "*artful representations of lives […which] reshape the past and imaginatively project the future*". Following this notion of narratives as creative and intentional, different questions can be brought to bear in analysis, such as what work they are doing to shape identity and locate people in groups, how they address particular audiences and to what ends, what resources they draw on, and what voices can be heard in them (Frank, 2012).

The concept of emotional narratives is incorporated to honour human suffering in suicidality. It is argued that storytellers narrate in part to make meaning of social life, and that emotions are a fundamental part of social life, accounted for and constructed within narrative plots (Kleres, 2010; Sarbin, 1989). I will attend to emotion and emotional talk in people’s narratives and consider the identities, voices, and plots being taken up or constructed within these narratives in words and in emotional content.

2.7.3 Analytic Steps

For interview data, the first analytic step is to read each transcript individually, taking time to identify the stories created in dialogue between participant and researcher (Riessman, 2008). With group data, the same step was taken, engaging with each narrator’s contribution separately, and then moving into analysis of dialogue between contributors.

Every voice resonates with other voices and every story is constructed from the stories available (Bakhtin, 1984). Stories are social acts; they always speak to audiences (Squire, Andrews, & Tamboukou, 2013). Each transcript was read for the multiplicity of voices that the narrator brings into their story, for the audiences the narrator addresses (explicitly and implicitly), and for the narrative resources they draw on (and limitations of available resources).

Transcripts were also read for what stories achieve for participants and the effects of their telling. I incorporated consideration of identity positions made available through tellings and responses. I also considered what is at stake for the person in telling their story, and how the story as told creates or shuts down possibilities of being (Frank, 2012).

To honour the dialogical nature of this process, my responses and contributions to narrative creation also form part of the analysis. These are interwoven with the participants’ stories, to explore the possibilities opened by this dialogue.

Table 2 presents a breakdown of the analytic questions and research questions, bearing in mind that the analysis process will inevitably be more fluid. I have drawn on Squire et al.’s (2014) definitions of narrative approaches to outline the focus of different analytic tasks. I attend most to narrative content, exploring meanings and voices within and across stories, and context, including ideas of how narratives work and what they do.

Table 2: Analytic Questions and Focus

Analytic Questions	Focus	Link to Research Questions
Whose voices can be heard?	Content	Q1 - Pertains to how people live with suicidal thoughts, feelings and acts; attends to relational nature of suicidality
What emotional narratives are told, and what plots do these entail?	Content/ context	Q1 - Pertains to how people live with suicidal thoughts, feelings and acts; attends to emotional nature of suicidality
Which audiences are being addressed, and to what end?	Content/ context	Q2 - Pertains to audiences for narratives
What narrative resources are being drawn on, and what are the possibilities and limitations of these resources?	Context	Q1 - Pertains to how people live with suicidal thoughts, feelings and acts; attends to context of experiences and meaning-making resources available
What identity positions are made available through story-tellings and responses?	Context	Q2 - Pertains to how people want to share their narratives
What is at stake in storyteller's tellings? What possibilities are opened and closed?	Context	Q1 - Pertains to how people live with suicidal thoughts, feelings and acts; how do they perform possibilities and identities through narratives
What possibilities are opened and closed in researcher-participant dialogue? How is dialogue created?	Context	Q2 - Pertains to how people want to share narratives

2.8 Presentation

To honour the tension between dialogue and analysis, which Frank (2012) described as speaking with or about people, I encourage the reader to consider the analysis as one possible reading of the participant's contributions, and to enter their own dialogue with the presented analysis. As researcher, I have been involved in co-creating stories with participants, both through opening spaces for situated tellings and through reading and responding to these tellings within the context of my engagement with the topic. This reading is mutable and revisable, shaped by its intended audiences. I have aimed to honour each person's stories in my response, but hold to the unfinalizability of the people at their centre:

> "*As long as a person is alive, he lives by the fact that he is not yet finalized, that he has not yet uttered his ultimate word*" (Bakhtin, 1984:59)

2.9 Reflexivity

Reflexivity can be defined as a process of "*critical self-reflection*" (Finlay & Gough, 2003: xi), a "*way of working with subjectivity*" across contexts (Parker, 2004:25). Reflexivity involves engaging with and reflecting on our (inter-) subjective positioning, how our identities are brought into interaction and influence dialogic co-creation. Reflexivity was, therefore, built into the research, to serve several functions. Primarily, it was part of the dialogical approach to analysis. My responses to participants' narratives and their effects on me were interwoven into this telling. Secondly, it was a form of emotional de-brief (Jaggar, 1989). Finally, it acts as an audit trail, keeping an account of the research process to capture relationship building and reflection over time (Koch & Harrington, 1998; Yardley, 2000).

2.10 Evaluation

This study undertook Denzin's (2010) commitment to a politically impassioned qualitative research and Jennifer White's (2020) notion of relational responsibility. In evaluating this research, I urge the reader to consider whether these ethical principles have been upheld, rather than considering concepts such as validity and reliability which relate to a realist approach to research (Porter, 2007). It is more in keeping with the study's epistemological and ontological commitments to consider "*a process of consensual validation*" (Lieblich, Tuval-Maschiach, & Zilber, 1998:173), whereby the presented research is offered for consideration by the research community. This community can judge whether the thesis offers a comprehensive picture of the participants' stories and presents a reading of these stories that is coherent, parsimonious, and contributes to the readers' comprehension of their own lives (ibid). Ultimately, I hope that the thesis will make a difference to the storytellers and responders, and that this difference will extend beyond the thesis.

3. Analysis

This chapter presents a dialogical narrative analysis. Each interview participant has a section devoted to their narratives. Analysis focused on their stories of suicidality, how they narrated living with suicidality, and what adopted narrative resources and positions afforded them. There follows a section dedicated to collective narratives, focusing on audiences and stories across participants, attending to polyphony.

I have sought to respect and reflect nuances and complexities of the narratives in this situated (re-)telling and attend to the productive nature of dialogue between contributors.

3.1 Text Conventions

Italicised text in quotation marks are direct quotes. Where text is italicised but not quoted, it comes from my notes which recorded specific phrases and images used by contributors. Line numbers follow quotes in brackets. Where text is in square brackets, it has been added to clarify meaning. Ellipses indicate text has been truncated for brevity.

3.2 Analytic Process

The analytic process was informed by the analytic questions as outlined in section 2.7.3. I started by analysing the individual interview transcripts one at a time, reading for the stories and voices in each interview in-depth. Transcripts were annotated with the ideas I developed in dialogue with the individual interview, and preferred narratives were identified through a process of iterative engagement with the text and reflection on my own dialogue with the text. Throughout, I was guided by the research questions, making sure to attend to stories of how people live with suicidality and both how they want to share their stories and how they were actively sharing with me during the interview. However, I also took a both/and position in the reading of the texts, in line with narrative practice, listening for stories that addressed the research questions and reflecting on what the person brought to the interview in terms of stories outside of the research questions, as I was conscious that stories that seem like digressions from the study focus will be meaningful for the participants and will be narrated with purpose (Riessman, 2008). This process involved multiple readings of each interview, and I reflected on this engagement over time in my reflexive journal, attending to what arose for me during this process and what struck me most whilst in dialogue with the texts. Initially, I aimed to hold any ideas of narratives that crossed the transcripts in mind without focusing too closely or quickly on the commonalities, and the process of noting these down helped me leave them aside and try and focus on the unique stories of each person.

When I had read, re-read and reflected on the individual interviews, I moved onto analyse the group workshop first. The process was similar, reading and re-reading with the research questions held in mind and attentive to what the participants chose to tell each other and how they chose to respond to Adele's story. Each participant's stories within the group workshop transcript were analysed separately initially, noting ideas and stories in a similar manner to the individual interviews. I also considered the dialogue between individuals who were present in the group workshop, as well as any dialogue with Adele (who was not present) and others who were not present. Once this had been thoroughly analysed and reflected on separately to the individual interviews, I moved onto the film workshop notes, and carried out a similar thorough reading and analytic process initially focusing on individual participant's stories and then moving onto considering the dialogue between participants. In this case, the data was often in the form of images and the articulation of what the image meant for the participant and how it connected to their experience of suicidality, due to the film workshop being conducted to elicit stories in this way (as opposed to eliciting chronological or biographical stories).

Inevitably, due to the group workshop being a response to Adele's story and the research topic, and the film workshop eliciting responses to images that arose from both the individual interviews and from a general search for suicide-themed imagery, the data from the two workshops were informed by the prior dialogue with the interviews. This informed my decision to structure the analysis by foregrounding the individual narratives of the three interviewees, and then dedicating a section to collective narratives that sought to speak to the dialogue between the contributors. The individual narratives therefore were envisaged as more biographical stories, where the contributors narrated their relationships with suicidality and spoke to both real and imagined audiences. The collective narratives were envisaged as responses to the contributions of the individual interviewees, and both deepened and expanded the range of narratives of suicidality through the dialogue between contributors and contributions. Similar to the process of establishing preferred narratives in the interviews, I sought to hold a both/and position in developing the collective narratives, choosing to focus on some core narratives that allowed both the unique and shared stories of the contributors to be re-presented. For instance, the metaphor of a "*caged bird*" was developed as a core collective narrative because it was chosen by one of the contributors at the film workshop as a message they wanted to convey to their imagined audiences and spoke of their relationship to living with suicidality, and it also created a rich dialogue between contributors on how the metaphor could be read by audiences and their own relationships to suicidality.

The division of 'individual' and 'collective' narratives is somewhat artificial and should also be held loosely, as the narratives that were identified via my engagement with the individual interviews are not necessarily unique to those individuals, and the collective narratives are not necessarily shared narratives for each contributor. For instance, the beads narrative and the burden narrative are elaborated within the individual narratives section, but were significant in dialogue for multiple contributors and seemed to narrate ideas that people wanted to respond to and share with others, which influenced my choosing to write about them within Leonard and Adele's sections. In the collective narratives section, I then chose to elaborate on Adele's burden narrative from a different angle, to capture how burden not only connected to suicidality for multiple contributors but also connected to the idea of speaking about suicidality and speaking to others about one's suicidality (in an example of Bakhtinian polyphony).

I made the decision to use contributors' own language to name different narratives to stay close to their tellings, and chose to focus on metaphors and stories that seemed to speak to the research questions, seemed to reflect core ideas or messages for the contributors, and were dialogically rich in that they provoked or elicited dialogue between different contributors (myself included).

3.3 Individual Narratives

I first present one core narrative per interviewee, interpreted as a preferred (though not single-voiced) account of selfhood and suicidality, followed by further narratives that deepen their telling.

3.4 Adele – "*No us and them*" (1181)

I felt that Adele's core narrative was that suicidal people are the same as people working in services. Her narrative hope was to dismantle barriers between mental health professionals and suicidal people. She positioned herself as someone with experiential and professional knowledges, and drew on a narrative of suicidality as a natural response to circumstance:

> *"For me [suicidal thoughts] have never gone away and it just doesn't seem to be something that's acknowledged […] If I started from the position of this is natural human distress, and I mean I don't know if it's like this for everyone, but for me there were clear reasons that I felt like this and when I've worked through those reasons or changed my lifestyle and changed the systemic factors around me, I felt better, so rather than there's something wrong with me, there's something wrong with the world around me […] why do we always focus on the person and say they need to do something, when, especially now with current circumstances, it's actually things around them […] I work in [mental health] at the minute, they definitely hold that view of it's medical, there's a problem with that person"* (1083-1104)

She navigated between positions, moving between "*I*", "*we*", "*you*" and "*them*", and narrated her professional responsibility to amplify the narrative that suicidality is a response to circumstance. The effect of her framing is to distance herself from a traditional mental illness narrative and to affectively draw readers into different subject positions, eliding the us/them distinction. By narrating uncertainty, Adele navigates away from an authoritative position, allowing for multiple perspectives on suicidality, whilst also asserting that her experiential knowledges are valuable to performing her professional role.

Adele explicitly narrated the stakes of occupying the lived experience identity at work. Aligning oneself with this identity is narrated as having implications for her identity more broadly and how others relate to her. Not claiming this identity is self-protective but also seen as a personal moral failing:

> *Cheryl: "[…] Is there anything you'd say specifically to other mental health professionals about [suicidality]?"*
> *Adele: "There is no us and them, that would be the biggest thing. I get so annoyed when I sit there and people talk about them like they're a different species […] if I was more confident and not so afraid of the backlash I would sit there and go "well I've gone through that, what does that say about me?". Mainly because I've had people then where I become part of the them so I automatically become ostracized from the us […] if the situation is right, you could be just like the person you're treating"* (1179-1196)

Adele gave the Milgram experiments (1963) as an example of how people's behaviours are shaped by circumstance. With this example, Adele drew on a shared epistemology to speak to an imagined professional audience authoritatively. This example also emphasised how unjust the ostracization of suicidal people is, as it deprives people of resources for understanding themselves and the 'other' as equally human. Adele's movement between subject positions allowed her to narrate the consequences of crossing the us/them boundary. Adele's phrasing drew my attention to the precarity of occupying the professional position, and how the divide acts to dehumanise people on both sides.

3.4.1 "*A burden to others*" (288-289)

Adele's emotional narrative of suicidality was of burden and shame. The burden narrative is central to psychological explanations for suicide (e.g., Joiner, 2005). Adele extended and deepened this narrative by narrating different relationships to the burden concept:

> *"I remember deep cleaning my room making everything spotless. I tried to write a suicide note and I was just like no one will even care […] there's nothing I can say that will change the way people feel about me because I was so convinced that no one liked me and I was a burden on everyone in my life and that actually it would be better for everyone if I wasn't there […] I had towels around me, sort of, so I'd be as less of a burden on people when they found me as I could be"* (74-88)

Adele positioned herself as considering the needs of others even at the point of suicide, underscoring how deeply burdensomeness can infiltrate. This narrative counters notions of suicide as selfish, as Adele emphases her care for others and her unworthiness. Suicide becomes a response to this relationality.

Adele extended the burden narrative to include telling of suicidality. She articulated an emotional struggle to narrate ("*it hurts to say that*" (544)). She connected shame to the idea of burdening others through suggesting she is unworthy of care. In Adele's narration, living with the legacy of suicidality becomes a burden to protect others from. Adele narrated the act of telling as eliciting burdensomeness in the present and as a risky moral endeavour:

> *Adele: "I've never told anyone this and I'm very aware that we've kind of just met"*
> *Cheryl: "It's ok"*
> *Adele: "And this is quite graphic, are you ok"*
> *Cheryl: "Yeah, you're ok, you can tell me, it's fine. If you're ok to talk about it, I'm aware that if you've not spoken about it, it's probably quite difficult to talk about as well"*
> *Adele: "Yeah, it's just that even though I'm better now, when I think about when I was like that then, I still get that feeling like I'm a burden […] and the idea of telling someone what I did is like I am putting more of a burden on you"* (93-105)

Adele's concern elicited caution in my response, and I reflected on how rarely I speak of my own experience in detail. I wondered about the impact of carrying this sense of our stories as unsafe for others to hold, a part of us remaining unacceptable to narrate even within spaces about suicide.

> *"[Suicidal thoughts] is still something I feel quite ashamed to talk about […] whether it is a sign of the idea because it is a lot of work for someone because if you're unwell and you're constantly thinking about ways to die then that's a lot of work for people around you and if it, the idea of someone finding you if you did commit suicide, that's again a lot of work, a big burden for someone to hold, to find you in that way as well and whether […] I am worth that burden for someone and that I suppose I probably wouldn't, it's definitely a core belief that I have that I am not worth it […] why would they want to be there for me or to help or to try and sort of look after me, like I should be ashamed of my own behaviour because I am not worth it essentially"* (524-544)

I was curious about Adele's use of "*work*" to describe talking to others about suicide and wondered if it connected to gendered dimensions of emotional labour in Western society. I wondered what makes someone worthy of another person's care/labour.

Adele narrated burdensomeness as preventative:

> *"My family was one of the contributors to me feeling the way that I did, and the shame and just that kind of family narrative of not being a burden to others meant that that was actually a protective factor […] enough to keep me just a little bit extra safe"* (287-291)

Adele narrated her agency in keeping herself alive by choosing to endure her family, whilst she named burdensomeness as a family narrative. She adopted the language of risk/protective factors, problematising it by linking what kept her alive with what created the conditions for her suicidality. Paradoxically, her care for others both leads to suicidality and prevents her acting on it, therefore bearing suicidality alone becomes the norm.

She distinguished between safety and desire to live:

> *"Getting a job and being of value in a team, where people actually respected me and sort of looked forward to meeting with me, they had a big impact and I started to just generally feel better" (291-294)*

Wanting to live required a sense of feeling valued as a person. It interested me that this value came through employment, in keeping with dominant Western narratives of worth from workforce contribution (e.g., Mills, 2017). Adele also mentions relational value around being respected and welcomed in a team. Burden, value and worth are socially located and relational in Adele's narratives; shame arises from burdening others through word or deed.

3.4.2 "*Not a broken person*" (1065)

Adele situated the medical narrative of mental illness and related treatment responses as limiting and potentially harmful.

> *"Everything I've ever been taught about suicide and depression has come from a medical understanding and that idea that it is something to cure and get rid of […] there is nothing wrong with me as a person but the whole way that we view mental illness means that there's something fundamentally wrong because I am still having these thoughts and that raises questions am I safe to practice and should I be learning, is the training too much, is it because I am too stressed"* (1058-1070)
>
> *"With CBT, it's there is a problem and we need to get rid of the problem […] if I feel like a problem, I feel like a burden"* (760; 780)
>
> *"[on one anti-depressant] I immediately became suicidal and that was the first time […] I got to the point of considering [suicide]"* (239-242)

Adele emphasised her research around suicide and depression, positioning herself as agentic and engaging with evidence. She narrated various consequences of medical and psychological understandings, how they afforded her an impoverished understanding of her experience and sometimes led to inappropriate, ineffective and harmful treatments. She also recounted how contraceptives increased her suicidality and yet her age and gender were employed to discredit her testimony:

> *"When I was younger, [doctors] would still try and force me back on contraceptives despite me saying about becoming depressed, it was like "oh, it's really, really rare, it wouldn't have happened to you" but it clearly did"* (480-482)

> *"I'd had [suicidal] thoughts for five years, and I'd only tried twice, you know, that was how I viewed it. The fear was that actually a mental health professional wouldn't view it like that and they'd view it as you need to go and be admitted right now"* (340-343)

Being repeatedly discredited as an interlocutor made Adele fearful of speaking. It also acted to deny her valuable knowledge:

> *"Being distressed has given me that greater understanding, a bigger drive to make things more equal, and a drive to change the way people view mental illnesses […], a way of connecting with information that people tell me"* (1137-1140)

In narrating this epistemic gain from lived experience, Adele counters the diminishing effect of the dominant deficient personhood narrative. She offers a counter-narrative that lived experience enhances her knowledge of self and others and improves professional practice. It made me reflect on the greater demands placed on marginalised groups to prove their worth, and the narrow margin for error.

3.4.3 "*Nice bright sky and then all the clouds*" (1217-1218)

In her living with suicidality narrative, Adele distinguished between two agentic selves which worked against each other. Both selves are narrated as resourceful:

> *"On the better days I get rid of all the medication, I put the plans in place, I try and hide the knives [...] and then I have a bad day where I go out and I start stockpiling medication, I start to plan again"* (955-957)

Whilst these selves were somewhat oppositional, Adele also problematised the distinction between selves, as her suicidal self might also take actions to protect her:

> *"I do wonder now if actually me sharpening [the knives] was more about making a neat cut in case I couldn't go through with it, so that it would heal as much as it could"* (89-92)

Narrating these protective actions might help Adele counteract the loss of identity that can accompany suicidality, when suicidal thoughts dominate:

> *"When I was actively suicidal, for me, it was almost like I lost who I was, and that was because it was so pressing, and something that was seen as so bad at the time, like, how could you even, such a selfish act […] [suicidal thoughts] became all of who I was but then it was something that I couldn't tell anyone about […] it became all of who I was but something to be ashamed and hidden so then I became something to be ashamed and hidden"* (1158-1167)

Adele's story connects with ideas of shame as self-focused; one is ashamed when one's self is impugned (Tangney & Dearing, 2002). Being suicidal is framed as selfish and is hidden because being selfish is shameful. Here, there is little space to escape an impugned self. Suicidal thoughts dominate so that she loses the distinction between thoughts and self, and yet suicidal thoughts are so shameful (and selfish) she cannot share them. The effect is to silence and isolate her. By narrating the (near-)totalising effect of suicidal thoughts, she also underlined that she *is* more than her thoughts, however consuming they appear.

Adele narrated how trauma therapy and acceptance and commitment therapy (ACT) helped her separate her preferred self from her thoughts. For instance, the

ACT sky-and-weather metaphor normalised her experience and rescued her from the broken-person narrative:

> *"[Suicidal thoughts are] lots of little mini clouds all darkening the sky […] what that's telling you is that you're upset, not that you actually need to die, or there's a real reason for that, that actually there's something around you that needs to change […] actively suicidal would be completely black [weather], with just one dominant [suicide plan] like a lightning strike […] then you've got the one where it's darkness but you can see the clouds but there are lots of different ways to [die], and you've got now, where it's like a nice bright blue sky, but there are like maybe a few clouds dotted, white fluffy clouds, and on those are still written ways like crash your car, walk into traffic"* (1220-1244)

Suicidality is narrated as nuanced and yet meaningful, affording Adele opportunities to intervene on her behalf. Whilst the metaphor evokes the discomfort and damage suicidality can wreak, it also positions thoughts as understandable and temporary, existing outside Adele's control. Its presence is naturalised, becoming background rather than a defining feature of Adele's self.

3.5 Willow – "*Eventful child*" (825)

Willow described having scoliosis and experiencing multiple surgeries from 13 years old. Being an "*eventful child*" was a powerful narrative in response to pain, uncertainty and silence from adults, affording her agency even when immobilised. Willow narrated this preferred self into adulthood as a response to abuse.

> *"I decided to be as obnoxious and as bad and misbehaving so [the doctors] would send me home […] I wouldn't talk to any of the medical team and I was deliberately being difficult, I'd absolutely create havoc by not saying a word […] the surgeon was "all the other children will behave, why won't you behave", and I just shrugged my shoulders, "hmmph, why should I?" […] One day I'd just had enough, I made plans to remove myself from the hospital as continuing to remain there was causing me distress and overwhelmed me. I made plans to get out. I left by climbing*

> *out of the window onto the roof […] I was so stressed at the thought of having to return to the hospital that I felt suicidal.*" (245-279)

This narrative allowed Willow to re-tell the traumatic experience of hospitalisation, centring her agency and resistance. Her younger self speaks up against all-powerful men ("*god*", "*king of England*" 263-264), at a time when a prevailing narrative was 'children are seen not heard', and medical dominance rarely challenged. Her parents were narrated as colluding with, and aligned to, the surgeons. Feeling suicidal was a response to feeling trapped and an impetus for rebellion. It was also positioned as a response to being silenced and controlled:

> *"I felt controlled by the first surgeon. I was a minor and should been treated better. I reacted so much as the consultant would not explain"* (303-305)

Willow's isolation is present in the dominant "*I*" subject-position (e.g., Rullander, Isberg, Karling, Jonsson, & Lindh, 2013). She felt silenced; she stopped speaking as an act of resistance. She has no child allies in her story, only adults telling her to behave. Her rebellion narrative afforded Willow an identity other than invalid, isolated child. Like Adele, she finds meaning in what her suffering can offer others:

> *"I am challenging now to go out there and help people, the children with scoliosis because I see them all around the world, who've had these rods in, who are traumatised by having these rods put in, and as I went through the whole thing, I know exactly how they feel"* (801-805)

Given Willow's experiences of being silenced, speaking-as-resistance seems especially poignant, as does her insistence she can "*see*" children with disabilities, as they are often invisible and disadvantaged in society (e.g., Kuper et al., 2014).

3.5.1 **“*A princess locked in a castle*”** (725)

Willow’s storytelling evoked the fairy-tale genre, with the child facing god-like consultants. She also drew on fairy-tales to speak of her ex-husband:

> *“He was very detrimental to me, he said that I was ugly, I’m talentless, I’m stupid, I have no brains […] he made me co-dependent, so I didn’t know how to pay bills, I didn’t know how to do anything, I was completely and utterly sabotaged and trapped, I felt like I was in jail, and the way I describe myself in my relationship, it was like I was a princess locked up in a castle”* (718-725)

Willow spoke with multiple voices, moving from her abusive ex’s insults to a passive psychologising language and then fairy-tale. I wondered if switching languages reflected her efforts to be heard in the past, a strategy for countering discrimination. Willow might draw on fairy-tale as a sympathetic narrative to counter shame and blame, given prevailing societal narratives still tend to blame women for actions of abusers (e.g., Kennedy & Prock, 2018).

> *“I just feel like I’m at this battle, so no one really gets it, with the narcissistic abuse […] it shuts the entire life down […] emotionally, physically, financially, your independence goes and everything. And basically these people are very evil, they will go out of their way to hurt, and they’ll push someone to distraction, and there’s a lot of women out there who will attempt suicide because of their being abused […] I also believe that the surgeon that did the 2-3 operations on me, was narcissistic […] I got so terrified of this surgeon, and that I probably, that’s the reason I attracted a spouse that was narcissistic”* (748-788)

Willow notably narrated a connection between her abusive ex and her surgeon, using the psychological language of narcissism. Willow narrated narcissism as an illness, rooted in brain architecture. Narcissism as a concept evokes self-centredness and disdain for others to the point of obliteration. The emphasis on illness and “*evil*” operates to counter the victim-blaming narrative.

Willow narrated how she rescued herself through reading psychology texts. She referenced my credentials as a psychologist as helpful to having her story heard. These strategies enabled Willow to use psychology, which has defined her in the past, as a source of credibility. I wondered if having someone with power (in terms of academic and professional credentials) listen to her was part of Willow's moves away from the victim identity often placed on abuse survivors. My listening was an offering I could give Willow, contrasting her past experiences of being silenced.

> *"I had no help, left clueless, constantly crying not sleeping or eating for almost a month, I was deleted. They stop communicating, go silent, completely ignore, stonewalling. Leaving the victim going into despair, heartbroken, distraught, feel suicidal but something inside burning desire to push through and succeed. You feel in utter desperation, confused, intuition is super alert, your flight or fight response is on overdrive, kick in. […] [Willow's ex] crashed my life but I'm empowering myself to come back into this world to use art and my journey to heal myself and others."* (1123-1132)

Willow adopted a preferred identity as healer and survivor. She moved between subject positions in generalising her experience to others. Narrating from second- or third-person might protect against distress and undesirable identities. When she narrated empowerment, she switched to "*I*", claiming the agentic healer identity.

3.5.2 "*A new life amongst uplifting people*" (1080)

Willow told the story of escaping hospital several times. It seemed to act as a symbol of her will to survive. Whilst the window story was a literal example of escape, she also narrated creativity as a survival method.

In these stories, external constraints prevent her from drawing. She brings in allies to help resist the oppressive structures and people:

> *"[my ex-husband would] be encouraging in front of people but behind closed doors he was screaming and he was jealous and he says you cannot do [drawing] […] I used to hide my equipment in a neighbour's house […] go and get them in the week, draw and then take them back"* (114-121)

> *"[In hospital] I learnt about the survival methods and so I used to have my drawing by my side, and the nurse was so sweet, she went and got a drawing board from one of the children's wards, and then I'd draw upside down"* (616-619)

These stories evoke Wade's (1997) acts of living, as Willow carved out moments for creativity despite the strictures of disability and spousal abuse. Willow narrated how important her art is in connecting others to her and sustaining her self-worth:

> *"I've done drawings [of my spine], gone viral all over the world, people are contacting me saying that looking at that drawing makes them feel better, saying that they were in pain, and now they feel, when they looked at the drawing of my spine, I've had people wanting tattoos of it, I mean, basically I'm carrying my spine around with me every single day, and it's going to end up, it looks like it's gone world famous, I mean it's really amazing, but you know, my intention is to help people like myself"* (827-834)

Willow emphasised the fame of her drawing. Perhaps a legacy from her experiences of repeated silencing, she draws on any resources she can to amplify her authority, employing the approval of others as ballast.

In her suicidality narrative, her dog played a role in saving her:

> *"Something switched in my head and I looked at my dog, thinking, if I did this he'd have no one, and that was it […] I got a real spark of energy, no one's going to take this away from me, I'm going to fight"* (26-29)

The dog's wordless reliance grants Willow the resources to fight. As a woman who has experienced abuse, physical suffering and isolation, having a dependent pet offered her self-value and a reason to survive, as does the available 'fighter' identity. She is centred rather than "*deleted*"; by being valued in an utterly accepting way, she is justified in valuing herself.

Willow re-conceptualised physical and mental illness as meaningful and psychological:

> *"Illness will come for a reason […] when there's deep rooted anger, or there's deep rooted suppression, and that's what's happened to me, an illness could come, an illness could go, and the body is self-healing. And then it's also about the subconscious mind"* (931-935)

Her approach to healing reflected this conceptualisation of illness:

> *"What's helped sustain me I would say was my drawing, art of journaling […] when I felt in so desperate a state, I would reach for my sketchbook, and I would just draw out my feelings and write, so I was basically drawing and writing about my health, and that was really what kept me going, that was what saved me […] That gave me grounding, it gave me stability, it gave me something I can clutch to […] drawing and writing your feelings out, which is much better than a therapist, because you become your own therapist"* (64-71)

Self-reliance is narrated as better than relying on a therapist, which might connect to her previous experiences of feeling silenced and defined by authority figures. Willow, like Adele, finds CBT's narrative limiting; for Willow, its focus on fixing problems disavows her continued suffering.

> *"To the medical profession who are listening to this, please explain to patients more, even [though] things have changed since the time I was in hospital, they haven't changed drastically, and I was speaking to my*

> *psychiatrist […]he said things are slightly changing but not enough […] even psychiatrists, they have to get out of the pattern of [prescribing] drugs, how about using more psychologists, natural methods, and get the things that, like CBT fixes things, because it doesn't fix trauma, and I mean I am still in the nightmare, I will get out of this nightmare, but the thing is I want to be doing motivational storytelling with artwork, to teach doctors how, what's it like to [be] put on the patient's side"* (935-45)

Willow adopts a preferred identity as a teacher of doctors, countering typical privileging of clinical expertise in the medical model. Willow joined her voice with a psychiatrist's voice, which helps bolster her assertion of the value of her experience. She narrated self-healing through art and connection as more powerful than treatments that position past experiences as fixable problems. She also problematised linear recovery narratives by using the present tense, emphasising how her efforts to heal through connections are ongoing (Harper & Speed, 2012).

3.6 Leonard – "*No succour or solace*" (389)

> *"I don't think I can talk about suicidal thoughts in a void of context, there is a necessary context"* (190-191)

Leonard's suicide narrative started in childhood, when he was born to parents who "*didn't have capacity to look after a child*" (226-227). He narrated a childhood of physical and emotional abuse, in which there was no way he could win his parents' affection. He created space to consider how contexts shape people, suggesting his mother's autism and his father's itineracy and financial instability ill-prepared them for parenthood.

> *"my parents […] were unschooled in knowing how to provide for a child's needs, unschooled in knowing what was normal behaviour, what was naughty behaviour, so invariably the default was that everything I did was naughty […] my room for expression was already exceedingly limited and that would have very much gone against the nature of what a child is about, children are about exploring the world, testing out, experimenting*

> *[…] there was no win formula that brought parents on my side, because children are always looking for that"* (232-247).

Leonard contextualised his childhood within ideas of normative development, normalising and empathising with his behaviour.

> *"If you're being shouted at and punished or you're being beaten and systematically, capriciously starved as punishment, so you're locked in a room, you're kept there all day and all night […] you just get harsh, harsh words, then you don't develop a very good self-image of yourself because you're left with the feeling that everything about you, so I was left with a feeling that everything about me was bad"* (255-260).

Both the regularity and randomness of his punishment creates a situation where he struggles to make sense of the world, evoking learned helplessness (Seligman, 1972). He cannot control or influence his world, and yet is somehow to blame. Switching subject-positions ("*you*" to "*I*") centres Leonard's suffering, whilst perhaps protecting him from this suffering. He invites the listener to imaginatively occupy the child's space, to recognise the child's response as rational. "*Self-image*" draws attention to relationality, as others' behaviours dictate how he can see himself.

One story illustrated his position's stark precarity:

> *" [my mother] was really, really angry and I remember her screaming at the top of her voice […] to drown myself […] as a child, that's an instruction, so you want to comply and so you don't know about things like the self-preservation instinct, and so I went to the very edge where the river was, you know, if I'd just gone in it, I would have been swept away […] I was so frozen with fear that even though the night came, I didn't dare go back to the house […] I would just be punished therefore for not drowning myself"* (441-453)

The frozen child evoked the impossibility of his situation, yet he narrates his instinct to resist, refuting the command despite facing punishment. Leonard positioned his suicidality as a logical progression from his parental relationships and relationships with others.

> *"My first serious action of suicide was when I was seven years old […] Children are incredibly quick to pick up difference. Imagine, I am in a boarding school, parents are visiting children, yes, and bringing them clothes, bringing them pocket money, etc. I am the one child no one visits […] hearing people say who's that boy, he always seems to be in the same clothes, does anyone visit him, and they said no we haven't seen anyone*" (352-383)

Leonard described suicidality as stemming from a realisation that he was different and excluded from the world of other children with loving parents. Seeing his difference reflected by others renders his neglect unbearable; for the first time perhaps, renders it knowable as different. Seeing others witness his neglect may be the beginnings of shame (Lewis, 2000).

> *"You have to understand […] how cut off I was as a child, there was no succour or solace*" (388-389)

He narrated episodes where strangers prey on his lack of parental protection and his need for food in order to abuse him. His suicidality comes from this time, in which he experienced no love or protection, and was painfully aware of his difference. Evoking "*succour or solace*" emphasised his deprivation, how it felt absolute and inescapable. In this storytelling, he witnesses his own suffering and its injustice, inviting us to not look away but witness it too.

3.6.1 "*You are shamed*" (958-59)

Shame is often evoked in suicide narratives. Leonard centred shame in his narrative, contextualising the emotion within his relational history:

> *"[Shame]'s the most potent [emotion] for suicide. The most basic shame that no one wants you as a child, no one validates you, you get horribly treated, no one to comfort you. As you grow, feeling marginalised and persecuted for your marginalised status that you can't help, it piles on"* (1156-1159)

In contrast to narratives of shame as a self-directed feeling, Leonard emphasises how shame is visited on him by others. He points to his marginalisation, and the injustice of being persecuted for the same status society has afforded him.

> *"You are shamed when your parents don't want you, you are shamed when you become the plaything of strangers and you are mistreated. You are shamed that people find you ugly or they find you a nig nog, or they find this or that"* (958-962)

Using "*you*" positions the reader in his role and allows him to distance himself from shame, placing it within the 'other'. I wondered if "*you*" also functions to connect with the 'other', a position denied him in his marginalised state. The present tense emphasised how shame remains active in his life.

Leonard narrated how different aspects of his being had led to discrimination and abuse. Prior to his "*most serious act of suicide*" (884), Leonard described struggle with his sexuality*:*

> *"In the army, if you are suspected of homosexuality, you are immediately investigated by the military police […] this is a very shaming process […] you are court-martialled, you are put in, you are arraigned in a military court and then you are sentenced to a military jail for six months and then […] you are dishonourably discharged, and that dishonourable discharge follows you for the rest of your life […] That could have been my fate. So, a lot of my unhappiness about the army was just feeling that this was an unsafe environment for me […] this was at the crisis when I felt that my homosexuality was a curse from God, and then I just, I didn't know that I had any will to live, to endure more difference in myself"* (867-889)

Leonard narrated having no access to positive understandings of his sexuality. He emphasised being shamed and its legacy and evoked the cumulative burden of difference. His only narrative resource of sexuality comes from religion, perhaps reinforcing his childhood belief of his ‘badness’. His sexuality threatens his tenuous belonging in a community, however unsafe the community (Baumeister & Leary, 1995). Fear of being shamed and losing this belonging whilst feeling isolated and ‘bad’ understandably brought Leonard despair (similar to McAndrew & Warne, 2010).

Suicidality is narrated as an ongoing presence, more prominent when Leonard experienced challenge or was confronted by his difference. Yet Leonard blamed himself:

> “*There was a failure to thrive […] I didn’t seem to be able to make more of the better side of me […] a lot of that wanting to kill myself also came from anger and anguish about myself, my uselessness, my weaknesses, my failures, my inabilities to manage things like other people could […] every molehill was like a mountain for me*” (692-698)

These metaphors, narrated as personal failures, draw attention to how environment shapes capabilities, as plants and animals only thrive when nourished. Interestingly, Leonard narrates a belief in a ‘better’ him, one that could thrive. I wondered if anger was somehow easier to acknowledge than sadness at how he had been literally and figuratively starved. Targeting himself with anger may feel more agentic and safer than targeting the world. It also dovetails with dominant Western narratives of individualism when he shoulders responsibility for his struggles regardless of their origins (Owens & Lambert, 2012).

3.6.2 “*A certain destiny*” (598-599)

Like Bergmans et al. (2017), Leonard narrated how his suicidality rendered life a series of disconnected moments of present struggle:

> *“Sometimes my life was just a survival act […] There was never any sense that it all made any sense, I just felt like a frog hopping randomly from one stone to another stone to another stone, without understanding what the underlying contours […] joining the stones was like”* (852-55)

Leonard evoked his existence’s precarity and seeming randomness. Throughout his life, Leonard narrated the absence of others to help him create meaning as a deprivation akin to denying him humanity.

Leonard described developing a “*good narrative*” (1031), which brought together:

> *“fragments of […] a chaotic life […] provides you with a sense of direction, a sense of going to somewhere” (601).*

Leonard attributed this narrative to the voices he hears:

> *“The narrative of my voices […] was the narrative of the fact that all my life, the way I had been treated, had a sort of grand purpose to it […] to prepare me for a greater destiny”* (575-77)

His voices seemed to fill a gap created by his marginalisation from meaning systems. Where parents/carers would usually shape a child’s sense of their place in the world, Leonard’s voices instead help him make sense of chaos. The voices offer a classic hero narrative of destiny from suffering, found everywhere from Greek myth to religious texts. They offer a way to make sense of his suffering and feel part of humanity, suggesting his suffering is part of his purpose:

> *“it made sense of a jumble of experiences which you couldn’t make any sense of. I was beaten because I was just beaten. I was starved because I was just starved. That’s not a very nice narrative, it’s chaotic, and it means that you really weren’t worth for shit, but if the narrative is that you were sent all these hardships, because you are being built for this purpose, well I think in a way that’s rather better”* (593-598)

Holding this sense of destiny helped him resist suicidality, offering him solace and purpose otherwise denied him. However, it also justified his continued suffering as destined and to an extent reinforced his responsibility to live up to his destiny.

Leonard positioned his belief in destiny as a fictional narrative; he emphasised fictionality using psychological terms such as "*selective bias*" (99), "*grandiosity*, *narcissism*" (592) to describe it. He also problematised traditional narratives of psychosis as disconnection from reality, as his voices are what connect him to the world by making sense of it.

> *"Small minor words of praise take on a significance that would not otherwise occur, if you had a more regular sort of life […] If you're someone […] whose whole life has been absolutely starved of any praise […] any little bit of nourishing words about you […] have a significance"* (607-19)

The extent of his deprivation drives his hunger for recognition from others, to be seen in any small way as worthwhile. Praise is framed as nourishment, underlining how neglect physically and emotionally starved him.

3.6.3 "***Beads of love***" (667)

Leonard narrated a significant shift in his relationship with suicidality, with suicide now indicating something wrong in his environment not him:

> *"I do sometimes […] get feelings of suicide, but I say to myself I don't want to kill myself, I may feel like I want to commit suicide […] it's just like I want to escape from the situation […] I don't deserve to die*" (673-683)

The linguistic move from an act against himself to an act to escape a situation affords protection, perhaps because it rejects suicidality as a judgement of his worthiness and opens options for resisting suicide.

Leonard explains this shift as due to accumulating goodwill from others:

> *"I started to have more nourishing relationships with people […]an accumulation of thousands of little acts of consideration, kind acts, small acts that don't bubble over the surface, they just keep under the surface, little acts of kindness, consideration, people wanting to celebrate my birthday, people doing me a kindness, people helping me with an essay […] gather in you like beads, coming to sort of critical mass […] I was around my fifties when the beads had gathered enough for it to be a tipping point […] that took me away from constantly walking on the edge of a cliff, of which one side was definitely suicide and the other side was safety"* (652-666)

This accumulation counters "*bad beads*" (703) added by the abuse he experienced. The bead metaphor suggests a gradual process of accumulation across relationships and years. He further emphasised the gradual, relational aspect with a "*mirror*" metaphor, with a positive self-view reflected in the eyes of others:

> *"sometimes I was very appreciated by people […] actually appreciating facets of my character which I hadn't necessarily thought anything of, they would almost show me a mirror, a glimpse of myself, and they would say, oh I really like [that] […] you're getting these little flashes in the mirror […] there's a good side there, there's another good side there"* (729-45)

In his narrative of a significant relationship, he referenced 'Beauty and the Beast':

> *"the Beast had to have love before the last petal of the rose fell and that happened, and I remember crying […] [my ex] was the spring sunshine that melted the ice in my heart. There was something about his persistence that […] stopped me from being a beast […] if I'd been caught by the IRA [Northern Irish terrorist group] as a teenager […] and they had become my parents, I would have planted a bomb for them"* (756-764)

Significantly, he aligned himself with the shamed, angry 'Beast'. I wondered about the story's connection to suicidality, as the Beast's curse requires someone to love him to redeem him, and that love must be earned through the Beast's actions. The 'beast' metaphor, and contrasting the fairy-tale with the terrorist story, emphasise how significant relationships were in altering his relationship to the world and himself, transforming him from beast to human.

3.7 Collective Narratives

The collective narratives draw together workshops and individual interviews where they respond to each other and imagined audiences.

3.7.1 *A Caged Bird*

For most contributors, suicidality was narrated as undesirable and distressing, connected to struggle to live in this world.

> *"I want the emotions and then later the thoughts to go away. They're so unbearable and you've tried every technique in the book that you know about and they're still there"* – Barbra (123-125)

> *Paul's suicidality is about want and need, and it's only dangerous when both co-occur […] the luggage he is carrying sometimes feels too much to bear and then he wants to die. It's only when he needs to die as well that he acts on it […] the luggage has gotten greater as he has continued living – my notes*

The luggage metaphor suggested the accumulating weight of suffering. Paul spoke of multiple bereavements, discriminations and marginalisation he had experienced which he carried with him (evoking intersectionality; Crenshaw, 1989). His talk of want and need related closely to how suicide can offer comfort as a means of escaping suffering but cause distress when it feels inescapable.

For Barbra, mental distress is underestimated as a source of suffering. She highlights the injustice of having agency legally denied; she must live even though others can choose to die. Her narrative highlights how mental distress is conceptualised differently, and treated unequally, in comparison to physical suffering.

> *"You're not legally allowed to join [a euthanasia organisation] unless you're over 50 and have a terminal illness. But how do you define terminal illness? It seems logical in my head that severe mental distress that just goes on and on and on is, I don't know, life is a terminal illness"– Barbra* (129-33)

In the creative workshop, Cristina described suicidality thus:

> *The bird wants to be let out to fly so that it can eat anything it wants. Whilst it's in the cage, it can only get sustenance if it's given to it through the bars. It might just be bits of oats to peck at. But the bird wants more, it wants bread and ice-cream and all sorts. If you're free, suicidal thoughts go away* – my notes

Cristina's narrative evoked how people can feel trapped in their lives, and how their resources can be limited. A contrast is drawn between the meagreness inside and the bounty outside the cage, with suicidality a product of being caged. This resonated with Leonard's narrative of starvation and sustenance.

In response, Paul reflected how this image evoked suicide as a means of escaping the cage. He mentioned how it can be dangerous to talk about suicide, as people may then see it as an option. Paul's response brought audience into focus. Both saw suicide as a product of deprivation; Paul narrated the act of talking as "*dangerous*", touching on contagion and instability narratives around suicide. I wondered about individual responsibility narratives, with the suicidal person shouldering responsibility for their own suffering and coping and for contaminating others if honest about suicidality.

People at the group workshop connected with Adele's fears of being considered mad or abnormal:

> *"In a way it's comforting [to hear], when I'm in it I feel mad in a way, but it's actually quite normal, for when you're depressed"* – Whitney (419-421)

Whitney and Adele spoke of the illogical logic of suicide:

> *“You’ve got the actively suicidal [phase], where you’re planning things […] in a really skewed illogical way because it’s not going to be logical if you’re really unwell and trying to kill yourself”* – Adele (989-911)

> *“I was very suicidal and basically just I sort of got obsessed about [suicide] and all that, which wasn’t logical, and I related to that in [Adele’s] story there’s irrationality but at the same time there’s also a perfect logic to it in a way”* Whitney (193-97)

Both draw on mental illness as an explanation for suicidality. However, they also narrated an experiential narrative of suicidal logic. This tension is evident when people narrated the roots of suicidality:

> *“No wonder you get depressed. My mum got very depressed when she was pregnant, childhood trauma, like the poverty thing, trying to find a way, being sensitive, being a scapegoat of the family […] the idea [depression’s] just this chemical thing I don’t really buy into”* – Whitney (409-412)

> *“[By focusing on suicidality] you’re treating the wound. The root is there […] something must have led to somebody thinking about [suicide]”* – Cristina (451-452)

Most contributors referenced the mental illness narrative and yet seemed uncomfortable with that language, as it seemed insufficient to make sense of suicidality. This narrative of suicide as pathology, and fears of rejection attached to madness, are displayed in the interplay of different voices as participants both claim and reject suicidality as understandable.

3.7.2 “*The burden of telling*” (160)

In the group workshop, contributors responded to Adele’s telling-as-burden narrative. These outsider witnessing narratives evoked the voices of others not present. For Celine, her suicidality is read as a judgement on the value of her loved ones’ love. With Barbra, societal pressure to value life is silencing, for Billie, telling your pain causes others damage. Feeling suicidal is narrated as a transgression against the social contract; speaking of suicide is harmful:

> *“I still do [feel] afraid of telling partly because someone won’t understand, but also I have this feeling of I’m going to destroy our relationship. I’m going to destroy the affection that you have for me. Because you’re someone who’s in my life and cared for me, and yet I have the, almost, the audacity to not want to be alive”* – Celine (181-186)

> *“If you tell somebody else, you’re freaked out and I can see by looking at their face they’re freaked out as well. So now, I’ve caused damage to them […and] they can’t help me”* – Billie (93-96)

> *“The world to me seems to be full of people who want to live as long as possible and have, yes, have good quality of life […] life’s too short, life’s too short, and I’m going round in a constant cloud of life’s too long, I’ve had enough of this, I actually want it to end. But I can never say that, because that’s just so taboo”* – Barbra (160-65)

These burden narratives position people as responsible for the effects of suicidality on others, and it serves to silence and isolate people:

> *“How difficult it is to confide in somebody who’s close to you because of the stigmas […] I personally realised that bottling things up for a long time makes things worse, but the thing is because of lack of trust you don’t know what to say or you don’t know how to say”* – Cristina (215-23)

Cristina narrates how both telling and not telling have harmful outcomes, consequences for the self and others.

The responses of others to suicidality are narrated as meaningful, holding messages about, and consequences for, the speaker.

> *"The silence of having the feelings and feeling like you can't say […] that fear of if you say it to, if you do go to a doctor […] Like are they going to section you? Are they going to tell you it's not true? Like, what are going to be the consequences of speaking?"* - Celine (396-401)

> *Billie finds it hard to pitch talking about how she feels – if she is too much, too distressed, they send police vans and treat her like a criminal; if she is not distressed enough, people don't notice she needs help* – my notes

These stories resonate with fear of the consequences of speaking. Celine expects to be disbelieved or sectioned; Billie to be criminalised or ignored. Fear of being discredited or ignored is silencing. I wondered about this policing of allowable distress, and how it connects with (gendered) privileging of rationality in western societies; 'too much' or the 'wrong' emotions being used to deny one freedom and legitimacy (Jaggar, 1989; Tuana, 2017).

3.7.3 *Looking for a Sign*

Workshop dialogue gravitated towards what helps people live with suicide. Most connections to life were small and meaningful, if not traditional, messages of hope:

> *Katy said that sometimes we are looking for a sign not to end things, a literal sign or anything else, something small, encouraging, that just says "this isn't how it ends"* – my notes

Katy responded to 'dark' pictures of suicide to counter that suicidal moments can also hold one's desire to live. Her response was an offering to other contributors, centring a wilful instinct to live rather than a naïve belief in the future. Billie narrated telling a friend of her suicidality who then asked why she had not died. Billie stated that this question made her feel better:

> *"There is a reason why you don't [kill yourself]. And if you keep looking for the reasons to die, the more you think about reasons to die, the worse you're going to feel. There might be reasons to live […] I'm not dead yet and I've had suicidal thoughts so are they really that dangerous?"* (348-358)

Billie's existence is narrated as a sign she wants to live, even without her conscious knowledge. Like Adele, Billie narrates suicidal thoughts as inert, a narrative move removing much of their power.

Celine spoke of how a non-medicalised response helped her survive:

> *"I started going to a temple and meditating everyday, and being able to go to someone who would listen to me saying "you know I feel constant despair" and talk about hope and the universe and things that aren't just like, "oh that means you're sick" but there could be another way that you could live"* (382-391)

This alternative narrative helps Celine avoid the stigmatised 'ill' identity and to claim agency in her life despite her distress. It counters the dominant narrative of life as an implicit good, which can obscure or deny people's suffering. Celine offers a counter-narrative that there are different ways to live, which do not deny suffering.

Billie emphasised that small interactions make life bearable. She spoke of how childhood neglect and emotional abuse make asking for help difficult. Like Leonard, her history has made her sensitive to, and grateful for, small kindnesses:

> *"Someone in a shop being sort of joking and friendly […] I think can actually keep a person going, especially a person who lives on their own"* (373-77)

I wondered about the fears people face when confronted by suffering, and yet the value of being with someone in small quiet ways seems immeasurable. Cristina and Shirley also narrated connections as sustaining. They contrasted the impersonality and deafness of the system with their experience of being seen and heard by the workshop contributors:

> *Shirley wanted to put her trust in the people around her, rather than the system. People like here at the workshop, next to her on the bus* – my notes

> *Cristina said that receiving the email from Jennifer about the workshop was good, it means somebody knows you're still alive, knows who you are […] sometimes it feels like you're just shovelling energy into a black hole* - my notes

Contributors often spoke of the value of being seen and heard, and yet feared being seen and heard. Histories of abuse and marginalisation made visibility dangerous and they were aware of ways in which their subjectivity and agency could be denied if they spoke of suicide. Views of suicide as irrational/mad made speaking a risky endeavour as their preferred self would not necessarily be recognised or privileged by others.

3.7.4 *Space in Society and Space to Feel*

The mental health system, and society, were narrated by the contributors as focusing on suicide (as the 'wound' to treat) but rarely attending to the 'root' of the wound. This echoed criticism of suicide's medicalisation and how it limits treatment responses in mainstream services (e.g., Marsh, 2010; Wexler & Gone, 2016).

Kelly described how societal pressures limited her opportunities to be viewed as a whole person, and how peer support gave her possibilities. She narrated how the mental health system took away people's rights and identities without addressing suffering. She wanted our collective response to advocate for peer support and alternative ways of responding to suicide. Others agreed that they wanted to create a film that could influence healthcare:

> *Willow wanted to share [the film] with lots of people - Alzheimers society, GPs, psychiatrists, government. Cristina wanted to talk about what should happen <u>before</u> someone dies by suicide, not <u>after</u>. She said so much effort is put into the sorry after someone dies, and sorry does not solve the problems. Sorry does not save lives* - my notes

Cristina positioned the efforts of services as backwards; the effort to understand people and do better is made after death, not before. Change through dialogue is only possible before death. Cristina also challenges the value of traditional suicide investigations (e.g., inquests and psychological autopsies), which react to suicide rather than respond to suffering. She rejected the idea her death should be a lesson to services, when she currently lives and speaks her distress.

Paul summarised the creative workshop experience, saying that the discussion had been about *space in society and space to feel the way you feel* (my notes). Whilst the roots of suicidality differed, there was a common narrative that suicidality had meaning in people's lives and was often worsened by society's response to it. Limited understandings of suicidality were narrated as increasing suffering and fear; responses entailed by these understandings often failed to target the wherefore of suicidality and, therefore, reinforced people's isolation, marginalisation and misapprehension. When Paul spoke of space, he re-connected to the caged bird. "*Space*" evokes being limitless, not restricted by surrounding structures. The caged bird is trapped and deprived of varied nourishment. Paul's metaphor captured a shared desire for rights to belong in society and be unrestricted in ways of feeling and being. It also narrated the effects of marginalisation; being pressed to society's edges, afforded little space to exist, but ultimately still part of the whole (bell hooks, 1984).

3.8 Next Steps

The response to the workshops was overwhelming with over thirty people requesting places; we limited numbers to ensure a safer space and enough time for people to contribute. Most contributors wanted further workshops to be hosted and to collaborate further on creative outputs. The next steps are to continue collating images and ideas for the film and other potential outputs – in our follow-up conversation, Celine suggested theatre might enable a "*productive*" and "*generative*" connection with audiences, as theatre allows for dialogue and open-endedness. As both community spaces have been physically closed by the Coronavirus-related lockdown, further development of these resources has been temporarily delayed but will continue this summer.

4. Discussion

I will discuss the findings in relation to the literature and critically appraise this research within the context of research evidence, clinical practice, policy and experiential knowledges. It is important to approach this chapter as one possible reading, and to acknowledge the "*unfinalizability*" of the contributors (Bakhtin, 1984:53), who are open to change and only partially understood. This reading inevitably attends to some stories more than others.

4.1 Summary and Discussion

This section is organised around the research questions, namely how people live with suicide and narrate suicidality, but the reader is invited to consider both questions as interconnected.

4.1.1 How People Live with Suicide

People narrated contexts for suicidality within their lives, including neglect, abuse, discrimination, physical disability and hospitalisation (as in Ferlatte et al., 2019). There was a shared narrative around suicidality arising from the conditions of people's lives and being a response, sometimes a resistance, to those conditions. Interestingly, how people became suicidal was not usually the storytelling focus; the stories focused on suicide as a means for escaping suffering, a signal that change is needed in a person's life, or an outcome of being shamed and ostracised.

Finding ways to live with suicide often involved entering dialogue with the dominant 'suicide as mental illness' narrative (Marsh, 2020), although most contributors problematised this narrative. This problematising operated on two levels. First, this narrative seemed unable to convey contributor's full experience (e.g., Osafo, 2020; Reynolds, 2016; Scherer, 2020). Second, contributors described epistemic injustice (Fricker, 2007), identity threat and other harmful consequences attached to this narrative, which further isolated them and contributed to distress (e.g., Fitzpatrick & River, 2018; Rose & Thornicroft, 2010). More liveable narratives, that afforded contributors ways to understand their lives without devaluing their identities, included seeing suicidality as a natural response to suffering, lived experience as a valuable resource to help others and one's identity as more than thoughts, labels, and traumatic experiences (e.g., Shaw, 2016).

Several contributors described feeling they failed at life or were shamed in the eyes of society, somehow not meeting the (often restrictive) expectations of others in their ways of being and feeling. This resonates with Fullagar's (2003) analysis of youth suicide, as she highlighted how moral economies of human value, especially around neoliberal notions of productivity and self-regulation, can create impossible conditions for living. Shame is a social and embodied emotion, often implicated in suicide and experienced in response to perceived moral failure, rooted in socio-political contexts (Mills, 2017). The desire to escape shame by ending one's life was also accompanied by further shame as suicide is construed as wasteful and selfish (Chandler, 2020; Fullagar, 2003). Leonard expressed the double bind created by intersecting stigmas in "*failure to thrive*"; failing to fit society's model of a valuable person led people to despair, with resulting suicidality pathologized and taken as further evidence of a person's failure to thrive. Often, the emphasis is placed on the individual's failure to thrive rather than society's failure to nourish (e.g., Kiamanesh, Dyregrov, Haavind, & Diesrud, 2014; Kizza, Knizek, Kinyanda, & Hjelmeland, 2012). Speaking of one's suicidality was a risky endeavour, another way to attract opprobrium.

For some contributors, part of themselves seemed to hold hope, even when all seemed bleak, as in Byng and colleagues (2015). This was not a progressive hope, one that suggests that the future will be better, the individual cured, and suffering ended (Zembylas, 2014). It was a hope that there are other ways of being and living that may not be easily grasped. It was also a recognition of agency, however fragile, in the face of suffering (Freire, 1997). Living with suicidality was often a precarious balance between different states, that could make the future hard to fathom (Bergmans et al., 2017). Billie continued to live, despite her thoughts – suicidality did not determine her fate. For some, narratives focused more on their continued suffering and a desire to lay down one's burdens by dying. These narratives still centred agency, the desire to choose one's responses to suffering rather than feel forced to live or die (Benson et al., 2013;

Blanchard & Farber, 2018), to have control over one's life (Berg, Rørtveit, & Aase, 2017).

Several contributors distinguished between staying alive and valuing life (Mahmood, 2019). As a product of their histories, their starting point was not that living is an unquestioned good. Staying alive was a feat performed despite suffering and was sometimes a resistance to how others defined and denigrated them. To live in the fullest sense of valuing life required relations of value with others, for instance, Leonard's "*beads of love and goodwill*", Kelly's advocacy work, or Willow's desire to influence medical training (Berg et al., 2017; Eriksson, 2006; Lakeman & Fitzgerald, 2008). A subjugated narrative was how the desires and determinations of others can burden people and hamper their flourishing, making it feel impossible to carry the 'luggage' from these relations with others (Canetto & Rezaeian, 2020). These stories highlighted how meaningless it was to consider suicidality as an individual issue, in keeping with Leenaars' (1988) analysis of people's relationality in suicide notes. Both living and wanting to die were states that reflected the relationship between person and world (Mahmood, 2019).

Connecting with others was narrated as key to feeling connected to life, as in previous research (e.g., Dodemaide & Crisp, 2013; Mahmood, 2019; Vatne & Naden, 2016). These connections ranged from small, momentary connections with strangers to longer-term connections in transformative relationships. Connecting with others was valued when it enabled people to occupy preferred identities (e.g., as helper) or escape the negative connotations of identities (e.g., as mad or selfish). The dominant narratives of suicide as selfish or mad contributed to participants feeling unsafe to connect with others, echoing Frey and colleagues (2018). Lived experience spaces allowed people to connect with others without fear that suicide was too threatening a topic to mention or that they would be defined by their suicidality.

4.1.2 Narrating Living with Suicide

Contributors were often versed in professional languages around suicide and mental illness and actively engaging with these languages. Developing expertise in dominant languages can be a survival strategy, as professionals hold epistemic privilege over patients in the current system and to be heard may require speaking in certain ways, as highlighted by Fricker (2007). However, it is a strategy that can be costly in terms of identity and sense-making and can also be a form of epistemic violence (e.g., attributing everything to diagnoses; only listening to stories using acceptable language) (Carel & Kidd, 2014). Contributors recounted numerous experiences of testimonial injustice where they were denied credibility due to assigned labels or identities (Beresford & Boxall, 2013). They described hermeneutic injustice that stemmed from impoverished ways of understanding themselves offered by the medical or psychological lens (Lakeman, 2010; Medina, 2017). The silences around suicide could be understood as acts of resistance, as in Wade (1997) and Seu (2009). Silence can protect people from intolerable othering, and in the context of trauma, abuse and discrimination, silence can be the only space people feel safe from the depredations of others (Wade, 1997). Shame, often characterised by silence, could also be a political statement against one’s positioning in the world (Seu, 2009). The act of being shamed (as Leonard described) highlighted the relational injustice in this affective experience (Chandler, 2020). Contributing to the project afforded a space where people could resist being shamed and narrate stories beyond the confines of the dominant language.

The narrative work people did in their narratives functioned to challenge stigma, marginalisation, and epistemic injustice, highlighting the intersecting ways in which people had been subject to oppression, as in Stout (2010). Speaking from multiple subject positions, positioning the listener in their place, moving between languages and referencing other voices to support one’s perspective are moves to gain credibility and blur self-other boundaries. Similarly, audience choices indicated what people hoped could change in society to prevent suicide or enable living with suicide to be more bearable and externalised suicide into surrounding systems (M. White, 2007). For instance, Adele sought to dismantle the divide between mental health professionals and service users, problematising the existence of such a divide (von Peter & Schulz, 2018).

In responding to Adele’s story, contributors connected to “*the burden of telling*” and the stakes in telling others about suicidality. As in Hom et al., (2019), professional responses were often narrated as undermining and explicitly harmful, and there was a fear that one would lose epistemic credibility and control if one spoke up (Frey et al., 2018). The emotional labour required to disclose suicidality could be significant – finding a level of disclosure that could be tolerated was stressful, as Billie expressed and previously found (e.g., Maple, Frey, McKay, Coker, & Grey, 2019; Sheehan et al., 2019). Claiming a stigmatised identity may cause distress when responses are unhelpful, even though disclosure may relieve concealment stress (Camacho, Reinka, & Quinn, 2020). Within the fear of telling is the concern that one’s whole self will be equated with, and subsumed by, the stigmatised part (Lakoff & Johnson, 1980).

Dialogically, it was difficult for people to articulate their experiences and yet extraordinarily easy to engage people in listening and speaking with each other. The struggle to articulate might reflect the limitations of available narratives and the hermeneutic injustice of these limitations (Fricker, 2007; Maple, McKay & Sandford, 2019). The willingness to offer space to hear others seemed a product of the space itself (and speakers within it) (Alcoff, 1991). Offering our lived experience perspectives and opening the group space with one person’s story was productive, leading to conversation that could have overflowed the allotted time. People were sensitive to each other’s perspectives, seeking not to speak for each other. This dialogue resonated with the (often critical or dismissive) voices of others to whom participants had confided; speaking to enable others to speak (different to speaking *for* others) was a position that contributors embraced and embodied in our collective endeavour. Grey (2016a) speaks of dialogic spaces as an alternative to othering, in which interlocutors seek to share experiences and respond to each other with respect for difference. Perhaps experiences of having one’s being flattened by othering creates a resistance to monologue (Bakhtin, 1984; Grey, 2016b).

4.2 Critical Review and Limitations

This is a small-scale study, centring the unique narratives of contributors rather than seeking to homogenise or generalise. However, in the particularities of people's stories, there are implications for knowledges of suicidality. Each narrative can be conceptualised as an offering, narrated with the intention of sharing with an audience and resonating with multiple voices. I have kept my reading close to participants' words and images, but it is important to contextualise the analysis as only one of many possible readings, formed through my dialogue with the texts.

It feels like the collective heart of this project is ongoing, and I would evaluate it as such. In terms of promoting narrative justice, the study responses suggest that people appreciated the invitation to participate as one which honoured their stories and their value. Each person was offered the opportunity to participate in the ways and to the degree they wished and seemed able to speak within the spaces we collectively curated.

In terms of intentions, it was my hope that I would establish dialogue between two community groups around living with suicide and I was unable to complete this due to several factors. One co-facilitator experiences ongoing physical difficulties and felt unable to host the group with me in the allotted time. To respect the group's integrity and wishes, we decided not to conduct a workshop. I have been in touch with the facilitator about involving the group in the film-making process, and I hope to continue to create links outside the thesis timeframe. Another intention was to create collective resources within workshops, with the option of interviews as secondary. Completing interviews complicated the process of collective creation, as it meant that I needed to maintain connections and honour the flux of people's lives and contexts whilst trying to bring people into each step of the work. All contributions feel tremendously valuable and I have tried to bring them together in a way that honours the particularity of each participant's stories. Inevitably, more space has been allotted to the interviews, and further work is needed to shape collective documents that equally do justice to each contributor.

Finally, I intended to read people's stories with a social justice lens, not simply repeating stories but critically engaging with *"the situated nature of accounts, […] the ways in which broader structures, contexts or ideologies […] may shape these accounts"* (Chandler, 2020, p45). I have tried to attend to the ways in which dominant narratives operate in people's lives and situate people's suicidality in their histories and contexts. I feel I have achieved this to an extent, but there is a need to continue this when creating collective resources.

In terms of process, I was honoured by the support Jennifer and her organisation put into the project. As a result, the project took a different character to what I initially foresaw, in a way that I feel respects collective narrative practice (Denborough, 2008). We ran the workshop in an amended way after discussions between Jennifer, myself and potential contributors suggested that we needed to prepare the ground for sharing stories, and this approach seemed to work well. Perhaps honouring the project's dialogical hopes, I feel we achieved an opening to each other, a relational beginning rather than a finished product.

I invite the reader to evaluate whether this re-telling of the participants' stories, with accompanying links to literature, connects with, and aids in, their comprehension of their own lives (Lieblich et al., 1998). In situating the contributors' narratives in the context of dominant narratives, and responding to them curiously, I have aimed to offer a comprehensive and coherent picture of the participants' lives that connects to their contexts, but I recognise that other connections could be made (ibid). I have not asked contributors to comment on this analysis, owning it as my reading, but each contributor was offered, and some took up, the opportunity to edit their transcripts. To be parsimonious, I have focused on concepts like stigma and epistemic injustice, which seem to relate across stories and sparked recognition in the collective conversations (ibid). The interview participants are afforded more space in the analysis, echoing the time they had in conversation. It is a flaw that some contributors had less time to speak and be witnessed.

Without devaluing the participants' contributions, I want to acknowledge that this project focused on community-based English-speaking adults, and there are other possible contributors with valuable stories. For instance, people in prisons or refugee camps, where self-harm and suicide rates are high and there may be few opportunities to be heard and valued in society (Fazel et al., 2017; Rivlin et al., 2013). It is also important to acknowledge that several contributors spoke of suicidality beginning in childhood, arising from neglect, abuse and trauma. Whilst children and young people were not the study focus, it is important to amplify their presence in these narratives, as children are often epistemically disadvantaged in society (Gilmour, Ring & Maxwell, 2019).

4.2.1 Personal Reflections

In my doctorate journey, I have been confronted with challenges to my security and positioning, dismantling knowledges, learning new ways of being, and operating within a different professional role that is emotionally and ethically demanding, not least due to its position within a psy-complex of power that often pathologises suicidality. When Adele spoke of the dilemmas and fears of speaking from a lived experience perspective as a mental health professional, this resonated deeply, as I have long tried to come to terms with living in multiple knowledges. What does it mean to claim lived knowledge of suicide? How does it shape the possibilities of my being and relating? A feature of my suicidality is to feel unworthy and outside belonging; these can be and often are conceptualised as individual psychological flaws. I feel that this frame does a disservice to me and others who have experienced the world as an unsafe, difficult, exclusionary place. Hearing contributors' stories has given me a greater sense of the complexities of our relations with the world and ourselves, and that finding ways to live in an unjust world is painful, ongoing work, rendered more possible by connecting with each other.

Lived experience is debated in terms of what it offers and the problems that might arise from being 'too close' or 'biased'. I would argue, based on my reflections on conducting this project, that lived experience may offer epistemic privileges due to understandings of a particular experience and ways of living with that experience (Sather & Newman, 2016; Webb, 2010), but it also offers more dialogical and embodied knowledges (Shotwell, 2017). Owning our lived experience created a relational space where people could speak of suicide with multiple narratives, rather than conform to one expected or desired by the listener. Each of us being open to hearing each other created a space where uncertainty was acceptable. I am not arguing that one lived experience is the same as the other or that a monolithic 'lived experience' identity exists (Voronka, 2016); I am arguing the opposite, that each experience is unique and generates alternative knowledges (Epston, 1999; Sather & Newman, 2016). As both Adele and Leonard grapple with in their narrations, it is about an ethics of dialogue; knowing the other can recognise you as fully human enables you to feel safe to be messy and ‘unfinalized’, which in turn enables more nuanced, complex stories to be told (Sather & Newman, 2016). Instead of experiencing difference anxiety and fearing stigmatisation (Morse et al., 2020), people experience belonging, acceptance and mutuality. Speaking from lived experience is an offering, a practice, as well as an epistemic privilege.

This project has reinforced my commitment to an ethics of practice which views each person as uniquely and completely belonging in the world (Reynolds, 2016). I want to embody the same ethics in all parts of my life and continue building the community of people who wish to share stories of suicidality. Following the film’s completion, Jennifer and I will seek funding to host further conversations and I will continue working with the contributors to create resources. I am also choosing to occupy more spaces as someone whose experience transcends the false personal/professional divide and to clinically practice and research in ways that honour the knowledges of the people I encounter.

4.3 Implications and Recommendations

I have presented four sub-sections but encourage the reader to consider these contexts as interactive and intersecting, as actions at one level can have impact across other levels (Morgan et al., 2019).

4.3.1 Clinical

Much suicide prevention focuses on keeping people alive through restriction of means, crisis intervention and safety planning (Mackley, 2019). Therapeutic interventions typically attend to survival skills such as emotion regulation and distress tolerance or problematic cognitive biases and behaviours in the here-and-now (Zalsman et al., 2016). Less attention is paid to the difference between staying alive and living a valued life, or the roots of suicidality in people’s histories and contexts. Herein, suicidality remained present in people’s lives over time, receding in moments of valued living. Understanding suffering as meaningful and unjust, their lives as valuable, and suicidality as a response to suffering was important, and these aspects could be further amplified in clinical practice. There is a risk of iatrogenic harm in approaches that position people as problems, especially in the context of abuse and neglect histories (e.g., Redhead, Johnstone, & Nightingale, 2015). Therapy is experienced in a socio-political and historical context where suicide is taboo, and stigma and devaluation are common. All health professionals should take an explicit stance that promotes an ethics of belonging, recognising and respecting the person and their suffering without further pathologizing them (Hagen, Knizek, & Hjelmeland, 2020; Reynolds, 2016). Narrative therapies may be beneficial as they re-situate problems outside people and open new meanings (M. White, 2007). Likewise, ACT may be helpful due to the separation of thoughts from identity and the focus on values that reframe suffering as natural and people as agentic (Barnes et al., 2017).

Shame was central to people's accounts. Shame can be understood as situated in the social world (Scheff, 2003); whilst one can feel shame alone, it reflects the gaze of the other (Fullagar, 2003). It operates in the domain of being suicidal and of speaking of suicide, as suicidal ways of being carry relational and epistemic risks for people. Therapy is a relational context which also carries risks, embedded within the psy-complex that can define people and determine their fates (Harrop, 2013; Parker, 2007). Questions are not neutral, and each position holds consequences for speaker, hearer and dialogue (Freedman & Combs, 1996). In psychiatric interviews, questions position patients in specific ways and legitimate certain answers (Zi łkowska, 2009). Silences and obfuscations can act as resistance against epistemic injustices in previous therapy spaces and society and as forms of impression management to save oneself or the other from stigma and burden (Han & Oliffe, 2015; Owen et al., 2012).

There are several implications. First, questions and contexts will inevitably frame responses. Contexts need to be named and formulated as part of establishing a safe space, including attending to power and sharing our intentions in asking questions (Afuape, 2011). Second, silence and indirect speech contains meanings and functions for people. Working to understand these meanings alongside people could help identify and amplify subjugated narratives. Re-situating silence as a response to abuse may provide relational safety to speak. Finally, each of us is implicated in the injustice of therapeutic practices that cause harm to or marginalise people (Patel, 2019; White, 2020). Alongside the need to transform clinical practices and theories to counter injustice and oppression, suicide prevention requires alternative non-clinical spaces and ways of being with suicidal people, that can enable safe connections and a sense of belonging (Briggs et al., 2007; Maple, McKay, & Sandford, 2019; Morse et al., 2020).

Whilst these stories were collected before the global pandemic reached the UK, there are some relevant implications. The pandemic and political responses to it are exacerbating inequalities, causing human distress and suffering, and isolating people from their usual networks and strategies for survival, which means suicidality may increase (Gunnell et al., 2020). Due to the stigma and shame attached to suicidality, clinicians need to be proactive in supporting people living with suicidality. People may feel even more unwelcome to access services when the narrative of protecting the NHS is prevalent, and the taboo against suicide more potent when thousands of people are dying and being publicly grieved. An ethics of belonging recognises the rights of everyone to receive care (Reynolds, 2016). The onus is on services to create contexts where suicidality can be acknowledged without shaming the person, as this relational safety can enable hope (Vatne & Naden, 2016). Increasing service accessibility in crisis through diversifying contact modalities will be important (Gunnell et al., 2020), as will ensuring that services proactively follow-up people so they do not feel forgotten (Ghanbari, Malakouti, Nojomi, Alavi, & Khaleghparast, 2015; Mehlum & Mork, 2016).

Paul summarised aptly when he spoke of "*space in society and space to feel the way you feel*". Having both these conditions met was unusual for people living with suicidality. Clinical psychology can honour this desire, by addressing how our discipline and practices are implicated in and can replicate the silences and injustices people experience, taking a political and ethical stance on societal oppression and injustice that make lives unliveable, and working alongside suicidal people to create the spaces to feel how they feel without judgement (Fitzpatrick & River, 2018; Weingarten, 2010; White, 2020).

4.3.2 Policy

Current UK policy focuses on targeting high risk groups and the role of media and the internet in suicide prevention. Policy does not touch upon living with suicidality, except where people are categorised as mentally unwell or in another high-risk group. The study contributors pointed to numerous ways in which they were marginalised from wider discourse and stigmatised by the focus on mental illness over material conditions (Puras, 2017). A greater recognition of suicide and suicidality as products of inequality and discrimination would be of benefit. Suicide prevention policies need to focus on addressing the sources of suffering and shame that underlie suicidality, for instance, through preventing child abuse, domestic abuse, and discrimination (Button, 2016; Pilgrim, Rogers, & Bentall, 2009; Puras, 2017). The language of *preventing suicide* could be unintentionally harmful, as it promotes the idea that people should live but does not necessarily provide policy the impetus to ensure conditions for liveable lives. Whilst inequality and discrimination are recognised in policy, the focus is on understanding them as precursors to mental illness not as intervention targets. Gunnell et al. (2020) make suggestions of government-funded financial safety nets and domestic abuse interventions as ways to reduce suicidality during the pandemic. There is need for widespread, ongoing efforts to create policies that target inequality and discrimination in robust system-level ways, especially for people with intersecting marginalised identities.

Stigma was a dominant topic, especially connected to mental illness and taboos around suicide (Sheehan et al., 2017; Tadros & Jolley, 2001). Anti-stigma campaigns to encourage help-seeking are a prominent feature of suicide prevention, although evidence of their effectiveness is equivocal (Niederkrotenthaler, et al., 2014). Reducing stigma without normalising and encouraging suicidal behaviour is a prominent dilemma (ibid). This tentativeness around normalising suicide may reflect dominant narratives that perpetuate stigma and work against efforts to promote help-seeking. Within UK society, the dominant cultural narratives suggest suicide is a sin or a symptom of pathology.

Further narratives are that suicide is wasteful – in terms of productive years lost and implicitly, the failure to be a model neoliberal citizen – or causes traumatic bereavement – pointing to the relational impact of suicide. This complex of narratives argues for suicide prevention but positions suicidal people as outside the norm and failing to uphold societal expectations (leading to spoiled identities; Goffman, 1963). The effect is a double bind whereby speaking up may reinforce a sense of moral failure but lead to (sometimes harmful) support and treatment whilst not speaking up means not accessing support and experiencing shame for being suicidal and silent. The onus often rests on individuals to reach out for help with less attention paid to the implications of reaching out.

Despite their position as public health campaigns, anti-stigma and public awareness campaigns predominantly act upon attitudes and behaviours at an individual level, and do not challenge dominant narratives and ideologies that create the conditions for stigma. Althusser (1971) argued that ideologies operate through practices as well as through people. Challenging dominant narratives requires attention to the societal practices and apparatuses that enact them. Understanding suicide as a response to suffering and the role of society being the amelioration of suffering could be promoted and embedded in suicide policies and guidance in the public domain. Positioning suicide as abnormal or deviant to some degree allows the underlying suffering to continue (Reynolds, 2016). We should hold a both/and perspective in policy and practice, whereby suicidality is recognised as both a human response to suffering and a stimulus for societal change (Baudelot & Establet, 2009).

4.3.3 Public

Ameliorating shame for the individual would not address the relational nature of shame or suicidality. Another avenue is to attend to the moral economies that determine the value of human lives and how they limit the possibilities of being. For instance, in societies where moral value is attached to economic productivity, people excluded from employment are likely to be stigmatised. This has implications for public policies and discourse, as Mills (2017) described. Notions of human value are continually being constructed and promulgated in the media and policies (e.g., Friedli & Stearn, 2015; ibid). We all have a role in challenging discourses where they devalue people and create or bolster hostile conditions and ideologies (DeFehr, 2016; Harper & Speed, 2012). A human rights lens can help counter pernicious discourses that differentially value people in socio-cultural or economic terms (Patel, 2019).

This study highlights how difficult it can be for people to talk about suicide with loved ones. Relatives and friends of people who died by suicide often find it difficult to interpret and act on distress signs and may fear damaging relationships if they intervene (Owens et al., 2011). Increasing public awareness of barriers in suicide communication could be beneficial, alongside externalising messages which situate suicide outside individuals and relationships. Helplines and trainings for concerned loved ones may also increase people's confidence to intervene (ibid). For some people, spaces outside of their relationships will be safer and easier for them to access; providing peer support groups for people with suicidality and people bereaved by suicide may be beneficial (e.g., Bartone, Bartone, Violanti, & Gileno, 2017; Hom, Davis, & Joiner, 2018). Connecting with others who shared the experience of suicidality and having one's story valued were important resources for the project contributors. Increasing opportunities for suicide stories to be visible in public life is likely to promote belongingness and increase people's narrative resources; the LiveThroughThis website is one example, which originated with a survivor (Dese'Rae L Stage) and hosts survivor stories (https://livethroughthis.org/).

4.3.4 Research

There are three key research implications. From the social justice perspective, the intervention targets are the structural conditions that lead to suicidality. Research which targets these conditions rather than situates suicidality within individuals is imperative. Funding initiatives driven by grassroots needs and located outside the mental health system might generate hopeful means forward. Research should centre communities of need, attending to the ethics underpinning research methods and processes (e.g., Kagan & Burton, 2000; Martin-Baro, 1994; Russo, 2016).

Stigma was an important feature of people’s narratives. It would be beneficial to explore ways to challenge stigma at a political and societal level, especially if co-designed with people with lived experience (Farrelly et al., 2015). Participatory research might help create different ways of understanding suicidality and challenging stigmatising structures and practices at a societal level (e.g., Kagan & Burton, 2000; Mohatt et al., 2013).

I have argued for the importance of context and the relational aspects of care and suggested that lived experience spaces might provide a different, generative experience (e.g., Lezine, 2016; Morse et al., 2020). I have explicated the value of lived experience, moving beyond simplifications to consider its embodied, relational and epistemic value. Research could explore these ideas further; for instance, analysing discourse and embodied space in suicide conversations (in formal and informal settings) (e.g., Owens et al., 2011), and co-designing, delivering and evaluating peer support spaces, led by service users and their knowledges (Byrne & Wykes, 2020; Faulkner & Thomas, 2002; Rose, 2017).

5. Conclusion

Contributors highlighted how stigma and epistemic injustice are powerful forces shaping their suicidality. Their narratives point to a shift in the way we understand suicidality, away from a mental illness perspective towards a relationally-embedded understanding of suicidality as a response to unjust suffering. The double stigma around suicidality and speaking of suicidality needs to be addressed across domains. Co-creating research, services and policies with people with lived experience may lead to more just and sensitive practices around suicidality.

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7. Appendices

7.1 Appendix 1 – Literature Review

I was interested in experiential accounts that mention ongoing suicidality but also accounts of moments of suicidality (e.g., suicide attempts, suicidal ideation, suicidal feelings), as few studies conceptualize suicidality as ongoing. It is worth noting that not all found papers are cited in the thesis, for reasons of space.

Literature Search Question:
How do adults experience ongoing suicidality?

I used the PICOS model to break down the research question and identify relevant search terms, as it is suited to qualitative or mixed methods studies. PICOS has demonstrated reasonable sensitivity and specificity when conducting qualitative systematic narrative reviews (Methley, Campbell, Chew-Graham, McNally, & Cheraghi-Sohi, 2014)

- P– Population = Adults
- I – Intervention/Interest = Suicide or Suicidality
- C – Comparision = No comparison group
- O – Outcomes = Experiences or perceptions
- S – Study type = Qualitative or qualitative method

Categories	Search Terms
P	MH Adult OR TX middle aged OR TX young adult OR TX aged OR TX aged 80 and over
I	MH suicide OR TX suicidal behavior OR TX suicidal ideation OR TX suicidality OR TX suicide attempts
C	n/a
O	TX perception* OR TX perspective* OR TX view* OR TX experience OR TX opinion* OR TX belie* OR MH “Patient Attitudes”
S	AB qualitative OR MH qualitative studies OR TX interview OR TX focus group OR TX narrative OR TX life experiences OR TX lived experience

Databases Search

For the thesis, a scoping review of the following databases (Psycinfo, CINAHL, EBSCO) was conducted.

The search looked for studies using the combined search terms (P and I and O and S). I limited my search to scholarly (peer reviewed journals), in English language. Search was carried out twice, to find articles up to the end of 2019. I searched three databases in EBSCO: Academic Search Complete, Psycinfo and CINAHL.

Database	Rationale
Academic Search Complete	An extensive database which should offer coverage of academic areas beyond psychology (e.g., sociology, anthropology, etc.).
Psycinfo	Comprehensive database for psychology and psychology within related disciplines (e.g., counselling, psychiatry, sociology)
CINAHL	Comprehensive database for nursing and allied health professional journals
Scopus	Citation searches of relevant papers

After initial search was conducted, I removed any studies that focused on children and teenagers, as well as any studies which focused on the experiences of others (e.g., healthcare professionals and families). I reviewed titles and abstracts, discarding any studies which did not focus on the experience of adults of some aspect of suicidality. I discarded studies which focused on non-suicidal self-harm but retained texts which mentioned suicidal intent. Where I was uncertain based on title and abstract, I reviewed the full text. I excluded studies which focused on risk factors, trends or prevalence of suicidality, and duplicates.

Database	No. of Initial Hits Returned
Academic Search Complete	16,958
Psycinfo	6,379
CINAHL	1,091

No. for Title/Abstract Review	No. Retained for Full Text Review	No. Included in Literature Review
3,810	69	44

Key Papers

There were selected as they most closely related to the research question. The two papers were additionally review papers and therefore more likely to include relevant references and be cited by other relevant studies. I conducted a SCOPUS citation search on the first two papers, looking for any papers that cite these papers. For all four references, I hand-searched their reference lists. I checked for publication of journal articles for Roberts and Mahmood, but none were as of yet available.

- Berglund, S., Åström, S., & Lindgren, B-M. (2016). Patients' Experiences After Attempted Suicide: A Literature Review.
- Lakeman, R., & Fitzgerald, M. (2008). How people live with or get over being suicidal: a review of qualitative studies.
- Mahmood, A. (2019). *Surviving thoughts of suicide: experiences of having suicidal ideation and not acting upon them*. Professional Doctorate in Counselling Psychology. University of East London.
- Roberts, A. (2016). *Life after surviving a suicide attempt.* D.Clin.Psych. thesis. Canterbury Christ Church University.

Paper	Relevant Papers from Reference List	Relevant Papers from Citation Search
Berglund et al.	7	2 out of 9
Lakeman & Fitzgerald	5	14 out of 46
Roberts	11	Not applicable (Not indexed on SCOPUS)
Mahmood	6	Not applicable (Not indexed on SCOPUS)
Studies across papers (excluding duplicates)	20	14
TOTAL STUDIES (excludes duplicates with database review)		18

Key Journals

- *Crisis: The Journal of Crisis Intervention and Suicide Prevention*
- *Archives of Suicide Research*
- *Suicide and Life-Threatening Behavior*
- *Omega: Journal of Death and Dying*
- *Suicidology Online*

Searching these journals for relevant papers did not yield any further references not already found in other searches.

Sources of Grey Literature

- Twitter (National Service User Network; Mad in America; Mad in the UK; Suicide ‘n’ Stuff; National Self-Harm Network; Recovery in the Bin; Mental Health Resistance Network; 4MentalHealth; suicidecultures and individual accounts)
- Google (for theses and dissertations on suicide experiences)
- Charity Websites (Samaritans; Mind; Sane)

- Conferences and Professional Networks (Suicide Summit; International Association for Suicide Prevention; American Association of Suicidology; European Symposium for Suicide and Suicidal Behaviour, NetECR – early career network in suicide and self-harm research; IASP Early Career Group; 42nd Street; Critical Suicide Studies Network; International Academy for Suicide Research; National Suicide Prevention Alliance)

I found Mahmood and Roberts via Google searches, and the recent book "Suicide and Social Justice", published in 2020, was mentioned on twitter. Conference proceedings highlighted key authors and studies to check I had found through literature searching.

Study Overview

I categorised studies by their focus.

Category	Studies
Pathways to and Understandings of Suicidality	18
Experience and/or Aftermath of Suicide Attempt	22
Recovery from Suicidality	10
Experiences of Suicidal Ideation	9
Living with Ongoing Suicidality	3
TOTAL INCLUDED	61

Commentary

The database search produced a large number of hits that were not specific to the topic but using this method in combination with searching key papers and journals gave some confidence to the robustness of the search. Dissertations were good sources of books and grey literature, both less likely to be cited in academic texts.

7.2 Appendix 2 – Ethics Application and Approval Letter

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

SECTION 1. Your details

Your name: Cheryl Hunter

Your supervisor's name: Dr Maria Castro Romero

Title of your programme: (e.g. BSc Psychology) Professional Doctorate in Clinical Psychology

Submission date for your BSc/MSc/MA research: not applicable

Please tick if your application includes a copy of a DBS certificate (see page 3) ☐

Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)

☑

Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk ☐

Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics (See links on page 1)

☑

SECTION 2. About your research

What your proposed research is about:

Please be clear and detailed in outlining what your proposed research is about. Include the research question (i.e. what will your proposed investigate?)

Title: Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

Approximately 20% of people experience suicidal thoughts in their lifetime, and 6% attempt suicide (McManus et al., 2016). Experiencing suicidal thoughts and engaging in suicidal acts are key risk factors for dying by suicide (Franklin et al., 2017), and are indicators that people are experiencing significant distress. However, many people who experience these thoughts, feelings and acts do not seek help from formal healthcare services (McManus et al., 2016), or find formal services unhelpful (River, 2018). Their relationship to these experiences can change over time, and they can develop strategies to self-manage (Peterson & Collings, 2015; Stout, 2010) and find ways to continue living or recover from feeling suicidal (Lakeman & FitzGerald, 2008). People who have this experience – of continuing to experience and live with these thoughts, feelings, and acts – hold a valuable source of knowledge for health services, as they can help services to be more responsive towards, and supportive of, people in suicidal crises or significant suicidal distress. The intention behind this project is to engage people living with these experiences in the community in a collective endeavour to explore the effects of living with these experiences and the skills, knowledges and values they feel have helped them live through these experiences (Stout, 2010).

The research seeks to explore the ongoing experience of living with suicidal thoughts, feelings, and acts, and involve people with this experience in producing a resource (a collective document) that can be shared with others.

The main research question is: How do people live with suicidal thoughts, feelings and acts?

A further research question is: How do people want to share their narratives of living with suicidal thoughts, feelings and acts, and to whom do they wish to speak?

Design of the research:

Type of experimental design, variables, questionnaire, survey etc., as relevant to your research. If the research is qualitative what approach will be used and what will the data be?

Qualitative research design.

The research methodology is based on collective narrative practice (Denborough, 2008). People will be invited to take part in a group workshop with the researcher, supported by a co-facilitator, to explore their experience of, and relationship with, suicidal thoughts, feelings and acts. The workshop will aim to produce collective narrative document/s, in a format determined by the group, to be shared with other people who experience suicidality, practitioners in relevant professions (e.g., clinical psychology, social work, medicine) and charities and community groups that work with people who experience suicidality. People will be invited to use words (prose and poetry), images (found or created), and/or music to tell their story of living with suicidality to the group and these experiences will be drawn together into collective document/s.

Whilst group workshops are the primary means of data collection, there is a chance that some people will wish to participate but not want to join a group setting (e.g., they may find the experience of a group anxiety-provoking). In this case, if they meet the inclusion criteria and are keen to be involved, they will be offered a one-to-one interview with the researcher and offered the opportunity to contribute to any collective documents created as a result.

10. Recruitment and participants (Your sample):

Proposed number of participants, method/s of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research.

Inclusion criteria

- People who define themselves as having an ongoing experience of suicidality, i.e. having lived with thoughts, feelings, and/or act/s of suicide for at least a year during their lifetime
- People who currently feel able to participate in a study*
- People who currently feel safe to participate in a study*
- People who can speak English sufficiently well to consent and participate in a study
- Adults aged 25 and over

The rationale for focusing on adults aged 25 and over is that most deaths from suicide occur in adults aged 25-49. Adults of working age are also a relatively neglected group in the research literature (Fincham, Langer, Scourfield, & Shiner, 2013).

The rationale for focusing on those who identify with experiencing suicidality for at

least a year during their lifetime is that they will be able to speak about, and draw on, their lived experience over time in some depth. This experience does not need to be current, although it is likely that those who identify with "ongoing experience of suicidality" may still experience periodic times of suicidal thoughts and feelings.

Only including those who feel able and safe to participate is to foreground a consideration of people's needs during recruitment (and signpost/refer accordingly) and ensure that people who participate are not currently in crisis.

Owing to the financial and time constraints of the project, and the need to form groups who can interact with each other, only those who can speak English will be invited to participate in the study.

* These issues would be explored at each point of contact, and where something has changed for a participant, an appropriate plan to support the participant would be put in place through a collaborative process.

Exclusion criteria

- People who currently identify or present as in crisis (suicidal or otherwise)
- Anyone who lacks capacity to participate at the time of recruitment or contact, as defined by the Mental Capacity Act (2005). As part of the process of consent, capacity would be determined by the ability "*to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, [and] to communicate his decision (whether by talking, using sign language or any other means)*" (Mental Capacity Act, 2005)

Number of participants:

The intent is to seek to conduct a group workshop (2.5-3.5 hours long, including set up and de-briefing time) on two different sites (so two group workshops in total), involving between 3-4 people each time (6-8 people in total).

Some people may wish to participate in an interview format instead, and this preference will be respected. If enough people wish to complete individual interviews, I will either complete one shorter group workshop (with 2-3 people) and 2-3 interviews, or complete 3-4 interviews instead of groups.

	Option 1 (preferred)	**Option 2**	**Option 3**
Data collection format	Group workshops	Group workshop and Interviews	Interviews
No. of participants	6-8 across 2 workshops	4-6	3-4
Time required for participation	2.5-3.5 hours per workshop (6 hours of data maximum)	1.5 hours per interview 2-3 hours per workshop (6 hours of data maximum)	1.5 hours per interview (6 hours of data maximum)

Methods of recruitment:

Multiple methods of recruitment.

Via poster at the two community group locations supporting the study recruitment. On the poster, participants will be invited to contact the researcher by email or telephone, and then provided with the information sheet. They will then be given at least 24 hours to consider the information, to ask questions or discuss with researcher or others before deciding on participation in the study

Via snowballing: People who have expressed an interest in the research or are known to the researcher through her own networks will be invited to let others know about the project, and given the poster and information sheet to pass to people who they feel might be interested. In line with GDPR and ethical practice, the researcher will not contact anyone or take anyone's contact details without that person's express permission (i.e., people need to opt into contact with the researcher). Once someone has made contact, they will be provided with an information sheet with further information. They will then be given at least 24 hours to consider the information, ask questions or discuss the study with researcher or others. No-one who has a personal relationship with the researcher (family, friends, and work colleagues) will be invited to participate in the research.

Via introductory talk at the two community group locations supporting recruitment of the study: the researcher will attend meetings at these locations to introduce the study to any interested attendees. People will be invited to ask questions about the study at the time and then given the information sheet and at least 24 hours to reflect on whether they want to participate in the project

11. Measures, materials or equipment:

Give details about what will be used during the course of the research. For example: equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application.

There is a group workshop question guide and an interview guide attached to the ethics application. There is also a guide to setting up the group interview and a protocol for managing distress if it arises. There is a list of local and national resources to be given to people at the end of participation or if they become distressed and would like some assistance beyond involvement in the research.

Group workshops or interviews will take place either at the university site or at a community centre in either site (where pre-existing self-help groups and community members meet). A lone worker policy will be adhered to, with a buddy being informed of where the researcher is going to be and how long they are likely to be gone. The researcher will also check in with this buddy at the end of a group workshop or interview. No identifying information about participants will be given to the buddy. The policies of the sites (e.g. signing in guests for fire procedures, notifying reception) will be adhered to.

The researcher has a digital audio recorder and a digital camera (not networked to the internet) to be used to record data.

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

NA

13. Outline the data collection procedure involved in your research:

Describe in detail what will be involved in data collection. For example, what will participants be asked to do, where, and for how long? If using online surveys will you be using Qualtrics? Detail what you will include in the Qualtrics page that you intend to make available to potential participants (see the example ethics application for a student study using Qualtrics in the Ethics folder of the Psychology Noticeboard).

Participants will be invited to take part in a group workshop (lasting 2.5-3.5 hours, including set up time and a short break in the middle). If the group feel that this would be too long for one session, the workshop can be split into two shorter sessions. There will be time set aside before and after the workshop for people to ask questions and to debrief. The researcher and co-facilitator will be present before the workshop to greet people, throughout the workshop, and afterwards for debriefing.

If they would rather take part in an interview, this will last about 1.5 hours. There will be time set aside before and after the interview for people to ask questions and to debrief.

The workshop will involve spending some time thinking through and creating their story of living with suicidal thoughts, feelings, and acts (about 30 minutes). They will be invited to draw on words, images and/or music in this process, depending on their preferences. If people create images or documents, the researcher will ask if she can take pictures or copies to incorporate into the collective document. The researcher will facilitate the process of story creation by checking in with participants and asking gentle questions from the workshop guide. Participants will then take about 20 minutes each to talk through their story to the group, and the group will respond with their reflections (about 20 minutes each). At the end of the story-telling, the group will spend some time reflecting on the whole workshop and the collective documents to be created. If people would like this, the researcher will guide people through a grounding exercise to help them release any emotional arousal that may have come up through the group work.

Participants will be given the option to have a short follow-up telephone call with the researcher within a week of the workshop (at an agreed time), to check in with how they are feeling and thinking after the workshop. The researcher will signpost people to relevant services if required.

After the workshop, the researcher will bring together all the narratives the groups and interviews have created, discussed and reflected on, and share these collective documents with those participants who are interested by their preferred method of contact (see debrief sheet). Participants will be offered the option to continue contact with the researcher by email or with a phone call to amend or add to these collective documents but they will be under no obligation to do so. In addition, the researcher will offer to return to each community site for further conversation about the collective documents. If people want to be invited to this further conversation, they can opt in on the debrief sheet. Any continuing contact will be mutually agreed and time-limited (ending either within 3 months, if people decide to contribute to the collective documents by email/telephone, or ending after the further community site conversation, if people opt to be invited to this), and consent and wellbeing re-checked at each contact. Anonymised notes will be kept on all contacts with participants as part of an audit trail of the research.

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

How will you fully inform your participants when inviting them to participate? Will the participant invitation letter be written in a style appropriate for children and young people, if necessary?

Participants will be provided with an information sheet and given at least 24 hours to consider it before written consent. People will be given time to ask questions by telephone or email before agreeing to attend a group/interview, or in person prior to a group/interview. Written consent will be taken before a group or interview takes place, and consent verbally re-checked at the end and at any other points of contact, respecting the dynamic nature of consent (Cutcliffe & Ramcharan, 2002). It will be made clear on the information sheet and the consent form that people can withdraw at any time. It will also be made clear how and for what purposes data will be used, the bounds of confidentiality, and the point beyond which data will be anonymised and hence still retained for research.

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Is the consent form written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians? How will you gain consent if your research is collecting data online (e.g. using Qualtrics)?

Written consent will be taken at the point of participating in a group or interview. Verbal consent will be checked at each point of contact.

16. Engaging in deception, if relevant:

What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.

People will be fully informed of the research purposes.

17. Right of withdrawal:

In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve (1) participants being able to decide to not continue with participation in your research, and (2) the right to have the data they have supplied destroyed on request. You are asked to give participants a three-week window from the time they participate in your study to when they can withdraw their data. Make this clear in your participant invitation letter.

Note: If your study involves data collection through Qualtrics, it is essential that you ask participants to provide their own participant code on Qualtrics (e.g. two letters and two numbers) so that you will be able to identify them if they later want to withdraw their data.

The right to withdraw is clearly specified on the information sheet and the consent form.

18. Will the data be gathered anonymously?

This is where you will not know the names and contact details of your participants? In qualitative research that involves interviews, data is not collected anonymously because you will know the names and contact details of your participants.

NO

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually data will be destroyed after a study is over but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? (suggested time is two years). It is advised that you destroy all names and contact details of participants at the end of your study regardless of how long will keep your data for. Make this clear in your participant invitation letter.

People will be asked to adopt a pseudonym for the duration of their involvement in the research, which will then be used in all written accounts. People will be advised in choosing a pseudonym to avoid using a name of personal significance that could identify them to others. Confidentiality, especially the limits of confidentiality in group settings and the legal obligations to break confidentiality when serious risk of harm is disclosed, will be explicitly addressed in the information sheet and as part of the ground rules for the group activities.

Any personal data (e.g., names, email address, phone number) will be stored securely on the UEL one drive, password protected. Only the researcher will have the password. Personal data will be deleted at the end of the project or at the point of the participant withdrawing or completing their participation in the study (whichever point is soonest).

Consent forms will be scanned into the UEL one drive and password protected and then the hard copies disposed of in confidential waste. The digital copies will be disposed of at the end of the project.

Any audio or image files will be stored securely on the UEL one drive, password protected. Audio files will be securely shredded using encryption software (BitLocker) when fully transcribed. No images of people will be taken but there is a chance that images will contain details that are potentially identifiable. If necessary, images will be edited to remove any identifying information or deleted if editing is not possible. Anonymised transcripts and anonymised images will be retained for two years after the project, to enable publication of academic work and as part of quality assurance practices.

20. Will participants be paid or reimbursed?

This is not necessary but payment/reimbursement must be in the form of redeemable vouchers and not cash. Please note that the School cannot fund participant payment.

YES

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

Interview participants:

Participants may need to travel to participate in an interview (at UEL Stratford campus, or either community centre) and so reimbursement of travel (within reasonable limits) will be offered on the production of a receipt. Reimbursement for travel per person is not likely to be more than £15, as public travel in

[Southern Location] . Where a person is likely to incur significant travel costs, the limitations of the project's budget will be made clear to ensure an informed choice (i.e., that reimbursement is capped at £15).

Group workshop participants:

Both group workshops will take place at community centres. If participants need to travel to the community centre to participate, reimbursement of travel (within reasonable limits) will be offered on the production of a receipt. Reimbursement for travel per person is not likely to be more than £15, as public travel in [Southern Location].

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required? NO

Please see Page 1 of this application for important information and link

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

NO

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?

NO

22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

You need to attach written permission from external institutions/organisations/workplaces if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation.

I have organised with one community-based self-help group [in North of England] to pass on an advert to their attendees, and if a group workshop is organised in [location], the workshop will be organised in the same community centre during the time slot when the self-help self-harm group already meet. The facilitator of this existing self-help group will be invited to be present for the workshop, to help facilitate the workshop and ensure that people within the workshop have an ongoing link with the self-help group if desired/needed.

I am currently in contact with the charity [in South of England]. The managing director of [charity] has written in support of recruiting for the project and has offered the use of the community space at the [location] for the workshop. There will be [charity] staff and volunteers present at the [location] whilst the workshop is running, and participants will be able to link in with activities and support at [charity] if desired. The workshop will be ran on one of the usual evenings when [charity] is open, so there will be support and other activities available onsite, and someone from [charity] will facilitate the workshop with me.

I have made some informal links with individuals in [two locations], who work with or are in contact with people who experience suicidality, and these individuals have agreed to be contacted at a later point with the project advert to disseminate to their networks.

Is permission from an external institution/organisation/workplace required? YES

If YES please give the name and address of the institution/organisation/workplace:

[Redacted from thesis]

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks (can be physical, emotional or psychological)? How will the safety and well-being of participants be ensured? Will contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?

The support organisation or agency that you refer participants to in your debrief letter should be appropriate. That is, is there a more appropriate support organisation than the Samaritans, for example (i.e. anxiety, mental health, young people telephone support help-lines?

The research is on an emotive and often stigmatised topic, so there is potential for people to experience distress or strong emotions when engaged in the research. However, a recent review of suicide research (Dazzi et al., 2014) indicated that there is no evidence that specifically asking people about suicidal thoughts, feelings, and acts increases suicidal thoughts in participants, suggesting that asking about this topic is unlikely to increase risk. Dazzi et al.

(2014) also argued asking questions about suicidal thoughts may in fact reduce them.

The potential for people to experience strong emotions during participation will be clearly explained on the information sheet and checked at each contact with people. The researcher will hold in mind that people are likely to be experienced in living with these thoughts, feelings, and acts (the experts of their own experience), and therefore the starting point will be to respect people's autonomy and right to self-determine, as well as their right to express their stories whether or not these bring up strong emotions.

The only circumstances where a person's preference may be over-ridden would be if there was evidence of immediate risk of serious harm to a participant or someone else. In this case, the researcher will respond by using her clinical skills to assess risk, and draw on the appropriate formal services in line with statutory duty of care. This will be made clear on the information sheet. Given the nature of the group work, it will be made clear at the beginning and during the group or interview, that people should feel free to take space, take breaks, withdraw, re-schedule or cancel, or self-care as needed.

All study materials will be transparent about the scope, aim, purpose and uses of the research, including the bounds of confidentiality and anonymity. Care will be taken to establish participants' preferences for participation, e.g. how they like to be addressed and contacted, what words they wish to use to describe their experience and themselves, where they wish to maintain boundaries regarding sharing personal, sensitive information. Ground rules will be discussed at the beginning of the group workshop, so that everyone in the group has a sense of how to look after themselves and each other in that space and afterwards (e.g. keeping participation confidential).

The researcher will adopt a sensitive and non-judgemental stance in interaction, and will take a proportionate, person-centred approach to managing any issues arising from participation. This means opting for the least intrusive response to people's distress in the first instance, seeking to involve people in a collaborative process of determining the appropriate actions. As people may have negative experiences of various formal services, a varied list of resources will be offered and people will only be signposted to services where they deem it appropriate or when there is dire immediate risk to themselves or others. People will be encouraged to draw on the resources of the community-based organisations supporting the research.

Recruiting via informal networks offers both benefits and risks. A key risk is that people will not necessarily be under the care of mental health services. Potential participants will be carefully screened on first contact to establish a sense of how safe they currently feel, what they understand the project to entail, and what support/resources they have around them in case of any distress arising from participation. Those in crisis will be sensitively signposted or referred onto appropriate services, and thanked for their interest in the research.

Each group/interview will end with an opportunity to debrief and reflect on what participation has brought up for people, and a grounding exercise will be carried out (if the participants consent to this). All participants will be offered a follow-up conversation within a week (at an agreed time and date), and will be provided with a handout of resources.

In keeping with Faulkner (2004), distress will not be equated with harm or seen as a reason to deny participants the opportunity to participate, as research participants often report that having a space to explore distress and suicidality is valued (Taylor et al., 2010; Biddle et al., 2013; Blades et al., 2018). The researcher will endeavour not to deny people the space for expressing difficult or distressing experiences, as this can give the message that people are not allowed to speak (Kennedy, 2005).

25. Protection of the researcher:

Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you and how will you mitigate this? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant’s house?

As this is an emotive topic and work will be carried out in community settings, the following considerations have been put in place to support the researcher (and protect participants):

Clear boundaries around contacting participants

- The pre-paid mobile phone specifically for the study will only be checked during hours set aside for research, and automated messages set up that specify these times. The automated message will also signpost to emergency or crisis services as listed on the resources sheet given to every participant. The email address will have a signature and similar automated messages

- At the beginning of conversations or emails, to protect researcher and participants, clear expectations for the content and duration of contact will be outlined

- Participants will be free to withdraw their consent for contact at any time, and their details securely deleted if they do not wish further contact

- The consent form and debrief sheet will specifically consent for the types and methods of contact preferred by participants

Supervision and therapy

- Supervision will be sought regularly, and will include a reflective space for the impact of the research on the researcher

- Where appropriate, the researcher may also speak with their personal tutor if concerns arise around the impact of the research

- The researcher will engage in her own therapy during the time of the research, to process material in a safe space (whilst maintaining confidentiality of participants in this space)

Self-care and safety

- Where the researcher is conducting research in the community, she will adopt a buddy system to notify a trusted individual of where she is going and when to check in with her. Community sites will either be at the university or at an existing group space (e.g. community centre), and the health and safety policies of those spaces will be followed (e.g. signing in, awareness of fire procedures)

- The researcher will use reflexive journaling as a form of emotional debriefing, again taking care to maintain confidentiality (i.e. not using names, locations or other identifiers)

- The researcher will also use PPD as a space to reflect on the process of conducting research and engaging with such an emotive topic for a prolonged period of time

- Group workshops will be co-facilitated with an experienced volunteer or staff member at either community centre, who typically works facilitating similar groups. The researcher and facilitator will debrief together after sessions and check in with each other during sessions. The co-facilitator will be based at their usual workplace whilst involved in the research and linked in with the support of their colleagues and organisation.

26. Debriefing participants:

How will participants be de-briefed? Will participants be informed about the true nature of the research if they are not told beforehand? Will contact details of a support organisation be made available to participants via the debrief letter? All student research must involve a debrief letter for participants (unless the research involves anonymous surveys) so please attach a copy of your debrief letter to this application (see page 12).

A list of resources both local and national will be provided to each participant at the end of participation or at any point where it is indicated that they have need for support. These resources will also be provided to people who are in contact with the researcher but decide not to participate, if they indicate a desire or need for signposting to available services.

Participants will be fully aware at all times of the nature and purpose of the research.

Participants will be offered a follow up telephone call within a week of participation in a group or interview (at an agreed time), to check how they are doing and how they found the experience of participation.

A debrief will be conducted at the end of the workshop or interview. Where the person or group would like, a short grounding exercise will be carried out at the end of participation, to allow some space for people to re-orient and deal with any emotional arousal from participating.

The debrief sheet specifies what will happen next and gives further information about contributing to the collective documents and options for doing so. At each point of contact, the researcher will check in with how people are doing, and signpost/refer as needed if people are distressed and require further support.

27. Other: Is there anything else the reviewer of this application needs to know to make a properly informed assessment?

The researcher has several years of experience of working with people who self-harm and/or feel suicidal and/or engage in suicidal acts. This experience has been in voluntary settings as well as clinical and research settings. She also has lived experience of feeling suicidal; this experience is no longer current but she is mindful that self-care is important when working in this field (see researcher safety for plans on how to manage this). She is experienced in assessing risk in a collaborative and sensitive manner and will seek guidance from supervision if particular concerns around risk or emotional impact of the research arise and additional advice or support is needed.

28. Will your research involve working with children or vulnerable adults?*

NO

If YES have you obtained and attached a DBS certificate? YES

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

NO

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

Some participants may have historic and/or current diagnoses of mental illnesses, but they should not meet criteria for "vulnerable adults" in the sense of being unable to freely consent or withhold consent. A screening process on first contact will check with the person that they currently feel safe and able to participate freely, that they understand the nature of the research, and that they are not currently in crisis. The researcher will use her clinical training and skills to sensitively assess risk and wellbeing during the contact and, if they are currently in crisis, the most appropriate options for referral or signposting will be discussed and agreed with the participant ("appropriate" being gauged via a discussion of what their need is, what their level of immediate risk is, whether they feel they can cope with how they are feeling or need support to stay safe, what their previous experience of services/help has been like, and where they feel able and safe to seek support from), and they will be thanked for their interest but advised that they are not suitable at that moment in time to participate in the project.

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas? NO

This includes collecting data while you are away from the UK on holiday or visiting your country of origin, and distance learning students who will be collecting data in their overseas country of residence.

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: *CHERYL HUNTER*

Student's number: U1147607 Date: 09/07/19

Supervisor's declaration of support is given upon their electronic submission of the application

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Shashika Vethanayagam

SUPERVISOR: **Maria Castro**

STUDENT: Cheryl Hunter

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

DECISION OPTIONS:

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

This application contains a thoughtful consideration of the potential risks to both participants and researcher. However, applications for research that includes data collection off-campus now require an additional risk assessment form to be completed alongside the application form: https://moodle.uel.ac.uk/pluginfile.php/1447170/mod_folder/content/0/_Forms%20%20templates/Risk%20assessment%20form%20%28general%29%20%282018%29.docx?forcedownload=1

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* CHERYL HUNTER

Student number: u1147607

Date: 23/08/2019

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

HIGH ☐

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

MEDIUM (Please approve but with appropriate recommendations) ☐

LOW ☑

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Martin Willis

Date: 9/8/19

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

UEL Risk Assessment Form

Name of Assessor:	**Cheryl Hunter**	**Date of Assessment**	**23 August 2019**
Activity title:	**RESEARCH PROJECT (AS PART OF PROFESSIONAL DOCTORATE IN CLINCIAL PSYCHOLOGY)**	**Location of activity:**	[Northern Location] [Southern Location] UEL Stratford Campus, Water Lane, London, E15 4LZ)
Signed off by Manager (Print Name)	**Dr Maria Castro Romero**	**Date and time (if applicable)**	**During September and October 2019**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc) If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The research seeks to explore the ongoing experience of living with suicidal thoughts, feelings, and acts, and involve people with this experience in producing a resource (a collective document) to share with others. This is part of a research project undertaken for the Professional Doctorate in Clinical Psychology at UEL - Title of proposed study: **Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality**

Participants will be adults aged 25 and over, who define themselves as having lived with suicidal thoughts, feelings, and/or act/s of suicide for at least a year during their lifetime, who currently feel safe and able to participate, and who can speak English sufficiently well to consent and participate in a study. The intent is to seek to conduct a group workshop (2.5-3.5 hours long, including set up and de-briefing time) on two different sites (so two group workshops in total), involving between 3-4 people each time (6-8 people in total).

Some people may wish to participate in an interview format instead, and this preference will be respected. If enough people wish to complete individual interviews, I will either complete one shorter group workshop (with 2-3 people) and 2-3 interviews, or complete 3-4 interviews instead of groups.

Data collected will be analysed using an in-depth narrative approach.

Participants in [Southern Location] will be interviewed either in an allocated room at the UEL Stratford Campus or [the Southern Location] or take part in the group workshop at the [Southern Location]. Participants will be recruited via mental health charity [name], posters, or informal networks.

Participants in [Northern Location] would be interviewed or take part in the group workshop in an allocated room at the [Northern Location]. This community centre regularly hosts the group on [dates], through which participants would be recruited. Participants will not have a pre-existing relationship with the researcher; participants will need to opt in to contact with the researcher by getting in touch by email or mobile phone (using a phone number and sim specifically dedicated to this purpose). The workshop (or interviews) will aim to produce collective narrative document/s. People will be invited to use words (prose and poetry), images (found or created), and/or music to tell their story of living with suicidality to the group and these experiences will be drawn together into collective document/s to be shared with relevant others, as determined by the participants.
Overview of FIELD TRIP or EVENT:
n/a

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating

Participants may become upset or distressed talking about suicide or experiences of suicidal thoughts, feelings, or acts	Participants	The potential for people to experience strong emotions during participation will be clearly explained on the information sheet and checked at each contact with people. The researcher will use her clinical skills to monitor and evaluate distress. If there was evidence of immediate risk of serious harm to a participant or someone else, the researcher will use her clinical skills to assess risk and draw on the appropriate formal services in line with statutory duty of care. This will be made clear on the information sheet. Researcher will also draw on supervision for any risk arising. Given the nature of the group work, it will be made clear at the beginning and during the group or interview, that people should feel free to take space, take breaks, withdraw, re-schedule or cancel, or self-care as needed. All study materials will be transparent about the scope, aim, purpose and uses of the research. Care will be taken to establish participants' preferences for participation, e.g. how they like to be addressed and contacted, what words they wish to use to describe their experience and themselves, where they wish to maintain boundaries regarding sharing personal, sensitive information. Ground rules will be discussed at the beginning of the group workshop, so that everyone in the group has a sense of how to look after themselves and each other in that space and afterwards (e.g. keeping participation confidential). The researcher will adopt a sensitive and non-judgemental stance in interaction, and will take a proportionate, person-centred approach to managing any issues arising from participation. This means opting for the least intrusive response to people's distress in the first instance, seeking to involve people in a collaborative process of determining the appropriate actions. As people may have negative experiences of various formal services, a varied list of resources will be offered and people will only be signposted to services where they deem it appropriate or when there is dire immediate risk to themselves or others. People will be encouraged to draw on the resources of the community-based organisations supporting the research. Each group/interview will end with an opportunity to debrief and reflect on what participation has brought up for people, and a grounding exercise will be carried out (if the participants consent to this). All participants will be offered a follow-up conversation within a week (at an agreed time and date).	2	1	2	In the group setting, a member of the community group or charity will be present to assist with managing the group if any distress or risk issues arise. During and after each group or interview, researcher will monitor and review how the group/interview went, drawing on supervision to discuss as necessary.	2

Hearing others speak about suicide or suicidal thoughts, feelings or acts or reading about others' experiences could be upsetting or distressing	Participants or Researcher and co-facilitator	As above for protection of participants. For protection of researcher, supervision will be sought regularly, and will include a reflective space for the impact of the research on the researcher. Where appropriate, the researcher may also speak with their personal tutor if concerns arise around the impact of the research. The researcher will engage in her own therapy during the time of the research, to process material in a safe space (whilst maintaining confidentiality of participants in this space) The researcher will use reflexive journaling as a form of emotional debriefing, again taking care to maintain confidentiality (i.e. not using names, locations or other identifiers). The researcher will also use PPD as a space to reflect on the process of conducting research and engaging with such an emotive topic for a prolonged period of time.	2	1	2	Group workshops will be co-facilitated with an experienced volunteer or staff member at either community centre, who typically works facilitating similar groups. The researcher and facilitator will debrief together after sessions and check in with each other during sessions. The co-facilitator will be based at their usual workplace whilst involved in the research and linked in with the support of their colleagues and organisation. During and after each group or interview, researcher will monitor and review how the group/interview went, drawing on supervision to discuss as necessary.	2
Possibility of harm from facilitating interview or group workshop as lone worker	Researcher	When running workshops, researcher will be accompanied by a member of the existing community group or charity. Interviews will take place in buildings with security onsite and reception desks that monitor people coming in and out of the building. The researcher will share her travel plans with a trainee buddy, and check in with them on arrival and departure from the remote location. There will be an agreed protocol (in line with lone working policies) for action if the researcher does not check in as planned. The researcher will also keep her supervisor informed of plans to collect data remotely. Researcher will keep her phone charged and with her.	1	2	2	Monitoring risk during project. Debriefing after each session with co-facilitator and supervisor.	2

Breach of confidentiality and anonymity, leading to distress (when storing data or sharing collective documents)	Participants	People will be asked to adopt a pseudonym to use in all written accounts. People will be advised in choosing a pseudonym to avoid using a name of personal significance that could identify them to others. Confidentiality, especially the limits of confidentiality in group settings and the legal obligations to break confidentiality when serious risk of harm is disclosed, will be explicitly addressed in the information sheet and as part of the ground rules for the group activities. Any personal data (e.g., names, email address, phone number) will be stored securely on the UEL one drive, password protected. Only the researcher will have the password. Personal data will be deleted at the end of the project or at the point of the participant withdrawing or completing their participation in the study (whichever point is soonest). Consent forms will be scanned into the UEL one drive and password protected and then the hard copies disposed of in confidential waste. The digital copies will be disposed of at the end of the project. Any audio or image files will be stored securely on the UEL one drive, password protected. Audio files will be securely shredded using encryption software (BitLocker) when fully transcribed. No images of people will be taken but there is a chance that images will contain details that are potentially identifiable. If necessary, images will be edited to remove any identifying information or deleted if editing is not possible. Participants will have the opportunity (if desired) to review collective documents before dissemination. The collective documents will be group-level accounts and will not identify or link back to individuals directly. Whilst direct quotes or images may be used, these will be identified only with pseudonyms.	1	1	1	Monitoring risk during project. In context of serious risk of harm disclosed, involving supervisor in decisions to breach confidentiality if required.	1

Possibility of harm to researcher when travelling and working remotely (at a site in Manchester and London)	Researcher	The sites are known to the researcher. Each site has a reception desk when the building is open, with someone who signs people in and out for health and safety purposes. The researcher is familiar with the building protocols and will follow them. All data collection will take place during hours that the buildings are open. The researcher will share her travel plans with a trainee buddy, and check in with them on arrival and departure from the remote location. There will be an agreed protocol (in line with lone working policies) for action if the researcher does not check in as planned. The researcher will also keep her supervisor informed of plans to collect data remotely. Researcher will keep her phone charged and with her.	1	2	2	Monitoring risk during project. Limiting number of trips required for data collection.	2
Contacts made to researcher by distressed participants (by virtue of recruitment via charities, posters, community groups and informal networks)	Researcher and Potential participants	Researcher will follow the protocol outlined above regarding risk assessment and management of distress. She will also set clear boundaries around contacting participants - The pre-paid mobile phone specifically for the study will only be checked during hours set aside for research, and automated messages set up that specify these times. The automated message will also signpost to emergency or crisis services as listed on the resources sheet given to every participant. The email address will have a signature and similar automated messages - At the beginning of conversations or emails, to protect researcher and participants, clear expectations for the content and duration of contact will be outlined - Participants will be free to withdraw their consent for contact at any time, and their details securely deleted if they do not wish further contact - The consent form and debrief sheet will specifically consent for the types and methods of contact preferred by participants	1	1	1	Monitoring risk during project.	1

Review Date
30/09/19

7.3 Appendix 3 – Recruitment Materials

Poster

Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

Have you experienced suicidal thoughts and feelings for at least a year during your lifetime?

Have you ever acted upon these thoughts and feelings?

Would you be willing to share your story with others?

What would you like people to know about what it's like to live with these experiences?

One in five people experience suicidal thoughts in their lifetime, and one in fifteen take actions to end their life at some point, yet it is rare that people are asked about their experiences of living with these thoughts, feelings, and acts in their day-to-day life.

In this research project, I want to invite people who experience ongoing suicidal thoughts, feelings and acts, to participate in a group workshop (or individual interview, if preferred) and share their stories.

The aim of the project is to create a resource together that can be shared with others experiencing suicidal thoughts, feelings, and acts, and relevant professionals, services, and charities.

If you are interested in knowing more, or would like to ask any questions, please contact Cheryl Hunter on u1147607@uel.ac.uk or [work mobile].

Please share this poster with anyone you know that you feel might be interested in participating.

Thank you for your time

PARTICIPANT INVITATION LETTER:

Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully and feel free to take time to discuss this or ask questions before you decide whether or not to take part.

Who is conducting the research?

I am a postgraduate student in the School of Psychology at the University of East London, studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research described here.

What is the research?

This research aims to explore how people live with suicidal thoughts, feelings, and acts over time and what effects this experience has on people. The goal is to produce a collective document with you and other participants that reflects your knowledge and experiences, and then share this document with others experiencing suicidal thoughts/feelings/acts, practitioners in relevant professions (e.g., clinical psychology, social work, medicine), charities and community groups.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have I been asked to participate?

You are invited to participate if you are aged 25 and over and have experienced suicidal thoughts, feelings and/or acts for at least a year during your lifetime. This project seeks to value your knowledge and experience as someone who has lived with these thoughts, feelings, and acts, and to offer a space for you to share this knowledge with others.

In taking part in this research, you and your experiences will not be judged in any way and you will be treated with respect.

What would participation involve?

Participation is voluntary. If you agree to participate, you will take part in a group workshop (with 2-3 other people who have experienced suicidal thoughts, feelings, and acts). The workshop will be facilitated by the researcher and a co-facilitator.

The group workshop would take this format:

- At the beginning, you will have time to plan what you want to share with others about your experience and how to live with suicidal thoughts, feelings and/or acts. You can use words, images, music and any forms of expression that you feel would help you to share your story
- In the middle, each person will share their story and hear everyone else's stories. You will also be invited to share reflections on stories you have heard and talk together about how these stories could be shared with others
- At the end, you will have time to ask any questions or share any thoughts. If desired, there will also be a short relaxation exercise at the end of the group

The workshop will either take place at [locations]

It will take place in one 2.5-3.5 hour session or two shorter sessions

There will be a short break, with water/juice and snacks provided

The researcher and co-facilitator will be available to answer any questions and reflect on participation before, during, and after the workshop

What if I don't feel able to take part in a group workshop?

If you would like to participate but do not feel able to participate in a workshop for any reason, you can take part in a one-to-one interview, lasting approximately 1.5 hours.

The interview would take place at the [locations], dependent on which location would be most convenient for you.

I will not be able to pay you for participating but your participation would be very valuable in helping me complete this research and in contributing to a collective resource to share with others. I will reimburse you for travel expenses (up to £15) if you need to travel to complete the research.

What happens after the workshop/interview?

After participating, you can opt to have a follow up phone call within a week at an agreed time. This is to give you the opportunity to reflect on what participation has been like, ask any further questions, and contribute any further thoughts.

I will bring everyone's stories and reflections together into a collective document, which may incorporate images, words, and other forms of expression as used by everyone to tell their stories. You can request copies, contribute changes to this document, and/or attend a follow up session to hear about and discuss these documents if you would like to.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

Participants will be asked to choose a pseudonym (or fake name) for the project

When taking part in a workshop, each participant will be asked to maintain confidentiality outside of the group.

You will not be identifiable in the data collected, the collective documents, or any research write-up. However, it may be possible for people participating in a workshop to recognise each other due to hearing each other's stories in person

What if I get distressed?

If you become distressed during participation, your preferences and needs will be respected. You can take breaks or time-outs at any point, re-schedule participation, withdraw from the study, and speak with the researcher or co-facilitator separately as feels helpful to you. A list of resources will be provided, and you are welcome to discuss these resources/options with the researcher if you have questions.

The only circumstances under which confidentiality could be broken are if you disclosed serious immediate risk of harm to yourself or someone else. In those circumstances, I will discuss next steps with you and involve any relevant services to ensure that safety is maintained and appropriate action taken.

What will happen to the information that I provide?

There are three types of information gathered in this project: personal data; the collective documents; and the research data (e.g. audios, images, and documents) produced as part of my research project. I outline how each would be stored and used below.

Personal data

I will store personal contact details (name, telephone number, email address, postal address if needed) and consent forms securely on a university network drive in a password protected file. These will be deleted at the end of the project or if you decide to stop participating in the project, whichever is sooner

Collective documents

You will be referred to in any collective documents by your chosen pseudonym, and only I will have access to the file linking you to your pseudonym

The collective documents we produce will be shared with others who experience suicidal thoughts, feelings, and acts, with practitioners working with these people, and with charities and community groups working with these people. These documents will be kept indefinitely

Research data

Audio-recordings will be stored securely on a university network drive using encryption software until I type them up. They will then be digitally shredded using encryption software. Only I will have access to and listen to the audios. The typed up documents (transcripts) will be anonymised

Images produced will be anonymised so as not to identify anyone

Research data will be stored for up to two years after the project ends

I will be analysing and writing up the project in a thesis and academic articles. The thesis and articles will use your chosen pseudonyms. The thesis and any academic articles will be available online

What if I want to withdraw?

You are free to withdraw at any time without explanation, disadvantage or consequence. If you withdraw within three weeks of participating in workshop/interview, I will remove any materials you have contributed. After three weeks, I would reserve the right to use any anonymised material you contributed.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me, Cheryl Hunter, on u1147607@uel.ac.uk or the study mobile number [number].

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Maria Castro Romero.
School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.castro@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.lomas@uel.ac.uk)

Thank you for taking the time to read this information sheet

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

Researcher: Cheryl Hunter

Please initial each box

I have read and understand the information sheet (version 1, 8 July 2019) relating to the above research study and have been given a copy to keep ☐

I have had the opportunity to ask questions and discuss any issues with the researcher ☐

I understand that my participation is voluntary ☐

I know that I am free to withdraw at any time without giving a reason ☐

I understand that should I withdraw three weeks after participating in a workshop/interview, data that has already been collected and anonymised will be kept and used for the purposes of the research ☐

I agree to be audio-taped within the workshop/interview ☐

I give my consent for pictures to be taken of work produced during the research ☐

☐

I understand that anything identifying me or others will be edited out or deleted from work produced in the research

I agree to the publication of anonymised direct quotes and images for the purposes of the research ☐

I agree to the sharing of anonymised work produced during the research, with others who share the experience of suicide, and groups, organisations, and practitioners who work with those who have this experience ☐

I have the right to request and be given copies of any of the collective documents produced ☐

At this time, I give my consent to participate in this research study ☐

Participant's Name (BLOCK CAPITALS) ……………………………………………….

Participant's Signature…………………………………………………………………

Researcher's Name (BLOCK CAPITALS) ………………………………………………

Researcher's Signature………………………………………………………………

Date: …………………..…………………………………………………………………….

7.4 Appendix 4 – Follow Up Sheet

University of East London

PARTICIPANT DE-BRIEF LETTER

Living with Suicide: Collective Narrative Practice with People Experiencing Ongoing Suicidality

Thank you for your participation in this project. It is greatly appreciated.

What happens now?

You can opt to have a follow up telephone call within a week at an agreed time. This is to give you the opportunity to reflect on what participation has been like for you, ask any further questions, and contribute any further thoughts about the project.

I would like to receive a follow-up telephone call YES/ NO

Time/date of call:

Preferred telephone number:

The stories shared by all participants will be brought together into collective documents. If you want to receive copies, I will email or post them to you (as you prefer). You are also welcome to contribute further comments to these documents by email or phone call. You will be acknowledged as an author of these documents under your chosen pseudonym and can share them with anyone you want to. I will also come back to the community groups to invite further comments on the documents produced and I can let you know about this meeting if you prefer.

I would like to receive copies of the documents YES/ NO

Email address:

Postal address:

I want to be invited to a meeting about the documents YES/ NO

(Please provide preferred contact details if not provided above)

By email YES/ NO Email address:

By post YES/ NO Postal address:

By telephone YES/ NO Telephone number:

7.5 Appendix 5 – Resources List

This list has been amended to remove reference to specific locations where the research took place.

Immediate crisis

If you are feeling suicidal and do not feel able to keep safe drawing on your usual strategies or support network, please call 999 or go to A&E and ask for the contact number of the nearest crisis resolution team (CRT).

National resources

- Samaritans offer a 24-hours a day, 7 days a week support service. Call them FREE on 116 123. You can also email jo@samaritans.org.

- NHS Choices: 24-hour national helpline providing health advice and information. Call them free on 111.

- C.A.L.M.: National helpline for men to talk about any issues they are feeling. Call 0800 58 58 58. The Campaign Against Living Miserably offers confidential, anonymous and free support, information and signposting to men anywhere in the UK through their helpline. Monday-Friday from 1pm-11pm every day, calls free from landlines and most mobiles. Webchat (5pm - midnight) www.thecalmzone.net

- Support After Suicide Partnership offers practical and emotional support on their website for people bereaved and affected by suicide

- Papyrus is a dedicated service for young people up to the age of 35 who are worried about how they are feeling or anyone concerned about a young person. You can call the HOPElineUK number on 0800 068 4141, you can text 07786 209697 or email pat@papyrus-uk.org. The helpline is open 10am-10pm Monday-Friday, Weekends 2pm-10pm, and Bank Holidays 2pm-5pm. Calls and texts are free from all providers and do not appear on bills.

- Mind - MindInfoline: 0300 123 3393; mind.org.uk. The MindinfoLine offers thousands of callers confidential help on a range of mental health issues.
- Mind helps people take control of their mental health, by providing high-quality information and advice, and campaigning to promote and protect good mental health for everyone. They also provide a special legal service to the public, lawyers and mental health workers.

- Rethink - Information & support related to mental illness; www.rethink.org

- SANE Mental Health Helpline. SANE's helpline is a national, 7 days a week, out-of-hours (6-11pm) telephone helpline for anyone coping with mental illness, including concerned relatives or friends. Tel: 0845 767 8000. www.sane.org.uk

- Depression Alliance - Support & info for people with depression www.depressionalliance.org

- London LGBT Switchboard - Support to LGBT communities in the UK. Free and confidential support & information to lesbian, gay, bisexual & transgendered communities throughout the UK. https://switchboard.lgbt/

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

- Helplines Partnership - Allows you to find a helpline for your particular need. Tel: 0300 330 7777. https://helplines.org/helplines/

Local resources

Hub of Hope

A UK website that uses your location or postcode to search for local services around you. An easily searchable database of local support groups and organisations within the UK. www.hubofhope.co.uk

Free Psychotherapy Network

The free psychotherapy network lists the free or low-cost counselling options for those on benefits or low incomes: https://freepsychotherapynetwork.com/organisations-offering-low-cost-psychotherapy/

GP/NHS resources

GPs can usually refer people for therapy within the NHS or to appropriate services as needed

You can self-refer to free local NHS psychological therapy services by searching using your postcode at this website to find your local one: https://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008

[Resources in Southern Location]

[Resources in Northern Location]

Online resources

- **Unsuicide**
  Online suicide help
  This web page might be helpful. It contains tweets from people with thoughts of suicide about what helps them cope with these thoughts.
  unsuicide.wikispaces.com

- **Elefriends**
  Supportive online community where you can be yourself.
  Elefriends is a supportive online community where you can be yourself; a safe place to listen, share and be heard.
  www.elefriends.org.uk

- **Big White Wall**
  A peer support network.
  Big White Wall is a peer support network available that encourages you to be open about what is on your mind, to learn more about yourself and to work through what is troubling you. The service does cost to join, but is free in many areas.
  www.bigwhitewall.com

- **HelpGuide.org**
  Helps you to cope with suicidal thoughts.
  Coping with suicidal thoughts.
  www.helpguide.org

- **Reddit Suicide Watch**
  Moderated peer support forum.
  Reddit Suicide Watch, a moderated peer support forum.
  www.reddit.com/r/SuicideWatch/

- **Depression Sanctuary**
  Moderated chat rooms and forums
  A safe and supportive place to talk with other people for those going through depression or other mental illnesses.
  www.depressionsanctuary.org

- **MindOut Online Support**
  Daily, out of hours, online support service for LGBT people.
  MindOut Online Support: daily, out of hours, online support service for LGBT people.
  www.mindout.org.uk

- **Online suicide prevention toolkit**
  Suicide prevention video for people with learning disabilities
  Contains very practical guidance about thoughts of suicide and how to ask

for help from trusted sources.
www.youtube.com/watch?v=6ZpjtvAgJns

- **Metanoia.org**
  Read this first.
  If you are thinking about suicide... read this first.
  www.metanoia.org/suicide/

- **Live Through This**
  A collection of interviews with people who have survived a suicide attempt.
  Live Through This: a collection of interviews with people who have survived a suicide attempt.
  www.livethroughthis.org

- **Conversations Matter**
  A practical online resource to support safe and effective community discussions.
  www.conversationsmatter.com.au

7.6 Appendix 6 – Reflexive Journal Extract

Here I include extracts from my reflexive journal, to complement the reader's consideration of the research process.

Reflections After Interviews

Interview 1

> … [On recruitment poster] Having being open about my own lived experience felt really exposing, even though I have spoken about having experience of suicidal thoughts, feelings and acts in other places and at other times. There were two layers to it, I think. One was the layer of putting myself out there, in public, saying that I've wanted to end my own life. That felt exposing and difficult and I wasn't sure about what response I might get. And yet. I follow people all the time who talk about their experiences, and promote these experiences, and celebrate them, and support them – and ask other people in this project and at work, to do the same – so I felt like I should not feel so tentative about it. I can't very well challenge the stigma and shame surrounding suicide if I won't even put my name to it. The other layer was more in response to people I respect letting others know about my project and effectively endorsing my work, and feeling the pressure and the fraudulence of "I'm not good enough", "how can I do justice to this faith people have in me", "I don't deserve this support". It was hard to go through it and still be ok with the poster being out there, and the worry about how people will read it and react to it and what I might do to people by involving them in the work and how I can ensure that I don't do more harm than good, don't over-promise, don't bite off more than I can chew. It was a mess of emotions, and I didn't know what to do with them, and I think I was ambivalent about starting the research because I care about it and I fear I can't do it justice, and I was worried about what impact it might have on others. Yet I firmly believe that there are so many people out there experiencing suicidality (in some shape or form) who are so resourceful and able to keep themselves alive through their worst experiences and darkest moments, and what can my small project do? How could it help them? How could it harm them? I felt

a weight of responsibility that kept stopping me from reaching out to people who can help me recruit, stopped me from asking my networks to share the advert (in fact, I still haven't really fully shared it round, or shared it more than once). I guess I didn't expect that I would have so many qualms about doing this, and I think the qualms were in line with how much I feel this is a topic worth doing.

…The first interviewee explained that she almost missed our appointment because she didn't know if she'd be able to make sense and talk through her experience. I both can and can't imagine how hard it must have been for her to take this risk (because it feels like a risk) to speak to a stranger about the hardest things she's experienced. The darkest moments in her life, one's which she can't fully emotionally connect to because it's so difficult. I too was pretty avoidant of doing the interview. I didn't get dressed until 11 that morning and didn't re-read the interview guide until 10 minutes before we were due to speak. I felt again am I up to this work, do I know what I am doing, is it ok to ask people to speak with me, is the project worth the emotions it will bring up for people? I am sure there were some other things I was feeling too, about my own worthiness to ask these questions and to expect answers. I struggled a lot with this in the first year of the course – what right do we have to ask people to tell us stuff that cuts right to the heart, to the bone of who they are? How sure are we that it will help them? Are we up to really hearing what people have been through?

… In the end, the interview went well. When she asked if it was ok to tell her the details of what she had done, because she feels she does not want to burden others with this and worries about asking other people to hold it, I felt both responsible for asking her to speak of this and connected with it personally. I felt like I know the feeling of not wanting to burden other people with my difficulties and experiences. I felt like I could offer her somewhere to put these experiences as I could hear them, if she could tell them. It was a hard interview because of how much I could hear my own experiences in what she's been through, around how she felt about herself, how she didn't want to upset or disturb anyone. How she worried how it would make others treat her and see her. There was a lot around burden and not wanting to be a burden. A lot about subsuming her own needs to survive – so putting someone else first as a protective factor but also as a perpetuating factor of how she undervalues herself. It was hard to stay connected the whole time, and I was concerned that I would only read my own experience if I asked too many questions. I tried to ask as few as possible so as not to guide the story in the direction I felt it was going. She used these wonderful ACT based metaphors at the end to talk about what helped, and I was struck by her talk about the contraceptive pill and how that affected her. That's something I stopped because of how it muted my sex drive and I am very conscious of how my periods affect my mood – now that I know, I am aware that every month I will have this dip in my mood that can be greater or lesser, but it means I can be conscious of myself at those times. When I was younger, there was no conversation with doctors or nurses about this – even when I asked, I was reassured there were no known long-term effects of these things. It feels like an area that I've seen more talk about in recent times (there was a news article a while ago), but in my early twenties, no talk at all. A silence around what is a female experience. I also really was struck by how she talked about suicidal thoughts as "little flags" that indicate she needs a break, or to look out for herself more. I think that really struck me because it's an experience I connect with. That the experience of suicide is not necessarily a straight-forward suicidal thoughts means risk of suicide. It can mean something else, something more productive in a sense, but they can feel so overwhelming and strange and unwanted that the fears and worries around them make the experience more threatening.

We had an interesting conversation about psychology and lived experience. I am not sure how to use, but it felt wonderful to be connecting with another mental health professional over what the experience is like. I am still struggling with whether I want to be in this profession or not, but I need to keep thinking about what it means to be me with this identity and experience, as well as what the profession seems to want from people or offer people. I wonder about my conversations with Jennifer and others and how this changes my view on what can and should be done.

Interview 2

The second interviewee was very vocal on the message she left me on the phone, saying she disliked my answer message and was frustrated that I didn't answer the phone. I called her, and we had a very long conversation about her experiences. I find that she is very keen to talk and get her experience out, which makes me feel more inadequate to the task of meeting what she wants. We have conversations about how she wants to change the NHS and share her story with lots of people, and I try to put my work in a smaller context and perspective, and she tells me to be more positive about the change that is possible. I am caught between grateful that she believes in the work, guilty that I am more cautious and pessimistic, and concerned that I don't want to overpromise. The day before the interview, we had a conversation about her desire to have her story out there under her name, and I advised against using her own name in the thesis or collective document, but said she could share it more personally saying her story is included. I feel really cautious because it may have negative unintended consequences if she shares without control over where and how, but it feels almost counter to the idea of collective practice for me to advise so strongly to stay anonymous, at least in the official accounts. It may be that I can help her craft her story and tell it more publicly in another forum. I agreed that I would send her the transcript and that she can do what she wants with it, and that I could read over any account she decides to produce and help her make it coherent and "less angry". I felt that her account had moments of anger but was on the whole balanced between what really distressed and upset her and pushed her to the brink, and what helped her get past this. It was striking how much of her account (across physical illness and experience of domestic abuse) was about being trapped and silenced, and how she used small acts of resistance from childhood to resist this control and prison-like circumstances. I am full of admiration for her strength and passion.

Things that struck me from her account – that sense of being trapped, “in Borstal” as she put it, and how desperate this made her. Her sense of herself as a “fighter” and not someone who would give up, and how that kept her going through dark times. Similarly to interviewee 1, some ambivalence of what kept her going – drawing as central to her identity and a way to keep herself “grounded” and “balanced”, but also something that was in some ways foisted upon her, representing her father’s hopes and dreams for her. Drawing as a way that she was undermined and controlled by her ex, who would take it away – give her materials but then destroy her works or her confidence in her work – and how she found ways to continue working creatively to keep herself going but how this required her to go behind his back and keep secrets and hide it. As I said to her, and above, I could not help but find her inventive resourceful resistance inspiring. She found ways to live in impossible situations, to escape when she needed (literally and figuratively!). It’s also worth highlighting the role her dog played, which she mentioned to me before we met and during the interview (but only in a fleeting message). Having her dog there helped her re-connect to a desire to stay alive. Similarly to interviewee 1 speaking of how other’s needs could keep her going, knowing someone needs you is so important. What occurred to me right now, is this interviewee as “the escape artist”, in her words a “eventful” child.

I am trying to be braver, as my interviewees are, and reach out more to others, and speak from my experience as well as from my diplomatic hat where I want to protect others. I feel that my research will be better for being more open and transparent and myself in the spaces I enter.

Interview 3

The interviewee was happy to take part; I feel I was much more nervous than they were and it's worth thinking about why that is. I think my confidence in whether I should be doing this project, whether I as a person was capable of doing this project well and safely for people, came into play as a result of the workshop cancellation before Christmas. I think I have started to worry that even asking people to think about these things and put them into words might be harmful and that it's almost cruel of me to keep trying to set it up. Yet I always held before a belief or an idea that this the reality that people are experiencing daily and that it's worthwhile for them and more generally to open up conversations about this. I wonder what is making me so much more uncertain and unhappy about what I am doing. It felt to me that this uncertainty and lack of faith I am experiencing will probably communicate itself in the room and may create the very issues I wish to avoid (or exacerbate them) and then I get into an unhelpful cycle in myself.

… I think I burnt out a little over Christmas, and symbolically, leaving my keys in my bedroom and not taking them home with me felt like a bit of a metaphor for that. Maybe I didn't want to come back at all. Maybe I wanted to reject the whole idea of the role/s that I am in of thinking of others so much. Maybe coming back to my flat became a representation of all my adult responsibilities that I felt unwilling to engage in and inadequate to fulfil. It's a lot of things to be carrying around in my head and heart.

I think ultimately the interview was really fruitful and had a lot of potent powerful imagery in it. I started at one point to feel really inadequate and torn between different positions, and feeling that I wasn't filling any of them very well, or being authentic. Which I guess is part of what many people who are doing research and clinical work at the same time might feel. He was describing the most awful circumstances of abuse, neglect, and consistent continued cruelty, and I was - it felt – just nodding or saying

> yeah or staying silent. At one point, I felt I needed to acknowledge what I was doing and try to say something about why – I am not sure how useful this was. Of course, the interviewee is someone coming into the interview having already processed – insofar as one perhaps can – his experiences to be able to talk about them – and was more prepared to vocalise such experiences than I was to react to them, but it did make me seriously think about this project and how ethical it is, given this type of story – to some degree, at some level – will underpin many people's experiences of suicide. Feeling (fully, embodied, continued, engrained) unworthy, unloved, inadequate to the task of existing – it's part of the situation. And how to respond? What's the position to take? I felt torn between multiple positions – respecting his space to speak, the inadequacy of words, being human, not overstepping boundaries into a psychological space.

From the Creative Workshop

> … The more people who are involved, the harder it is to feel a measure of control over what is happening and the more you get buffeted and pushed around by other people's anxieties and goals. After the conversation with Jennifer about evaluating the group workshop, I had sent her some feedback from two participants of the first workshop. This was a mixture of good and not so good, but I felt at least it seemed honest by way of feedback and aligned with how I had felt it went on the day. They had both felt that the workshop ended up being a bit rushed. However, the thing that seemed most important to me, and felt both scary and hopeful, was that they had come away feeling glad the space had existed and more able (at least one of them) to speak openly with others in her life as a result. She had called the experience "generative", and the space "neutral", in the sense that there was no judgement or repercussions of speaking honestly, which made her feel she could take this honesty to other spaces.
>
> So I was feeling a bit ambivalent and unsure about the film workshop and what would happen in it and what my role would be.

… So much conversation at the workshop was about the audience and who they wanted to speak to, and I was kind of overwhelmed by it, as I could hear how important this conversation was and yet it was hard to keep the whole session from becoming about the audience and not the message. Both are of course important. Yet we had not put in time to speak of the audience first in the workshop; it was organically brought up by the group. I mentioned how I could reach out to some people connected with politics (if that was one avenue for an audience) as well as some people involved in research into the public attitudes and role in suicide prevention, as the conversation also moved into that arena. People in the room were talking about neighbours and the public and how they might benefit from knowing more about what they could to help people who are suicidal. Someone mentioned how important it is to connect up with people so that something is done, and someone else talked about how we are the people outside of that, we are part of change.

People spoke about wanting to fight against the system, with capacity law being brought in, and the MHA and how people can lose their rights. Cristina said that everyone is affected by suicide and spoke of how you can feel that the media is against you, society is against you. It can feel like an onslaught against you.

… People left gradually, chatting to each other on the way out.
Jennifer told me afterwards that Billie had been worried about Whitney at the first workshop, as she had also expressed to me in the follow up phone call. But then Jennifer saw them both meet each other accidentally at the community group, greeting each other like old friends. She said both their faces lit up when they saw each other. I reflected on how Celine from the first workshop also experienced a shift in telling people she loves in her life about her experience. I wondered after what effects this work is having that is rippling out from these conversations that seem so unlike other conversations people are having, and how would we know what these effects are. Even Willow, who I had been a bit concerned about in the group setting, because she is recently bereaved and she can feel quite

rejected by minor things, she was buzzing when we walked back to the station. She was saying how she felt empowered and how she felt what she said might have empowered others, and she commented on how what one or two of the others had said things that she thought were really powerful.

In my check in at the end of the workshop, I said to people how I felt very moved by what people had shared and also very hopeful about the film, as people had brought so much to discuss. I was wary of the word “hopeful”, as it can be taken to mean something blanket positive, so I held it quite lightly. I said I felt a lot of different emotions and thought I would think about the workshop for a few days. I didn’t really think about it much over the weekend, as I was exhausted from last week and all the coronavirus stuff and just generally feeling run down with my period and a sore throat. I spent some time with the filmmaker and Jennifer before I went home, and we were all quite passionate about what people had shared and how we would like things to change. I think we all three felt like we did and didn’t want to influence the direction of conversation too much. It’s hard operating in the lived experience and facilitator position at the same time. Jennifer commented how she at several times felt quite tearful and passionate, especially hearing conversations about what people wanted to change in the system. She said she didn’t want to jump in but she felt YES!! When she heard it. Likewise, I tried to navigate between my feelings about how people immediately brought up society, structures in services and human rights and my desire to allow people the space to talk about what they thought important. At a couple of points, the conversation did derail somewhat into one person’s story about a thing that’s important to them but not related to the joint endeavour – this was somewhat difficult to manage, but mostly seemed to work out. I appreciated when one of the workshop members requested that another sticks to the check-out rather than talks about something else that she is passionate about – it was kindly done, and helpful to everyone.

I felt quite moved and emotional after the event, but also very drained. It felt like I had done a lot of work in the room, even though perhaps I had not done as much as I might in an interview. I felt very avoidant of doing these reflections. It feels really hard to not put my own spin and stamp on everything, and almost the clinical skills can get in the way of hearing the stories, if that makes sense. I can understand people from multiple perspectives, which then becomes quite confused and confusing in my mind, when I want to really attend to their voices. But I can't help but respond to things. When Willow and Shirley had a disagreement about diagnosis, I brought in a reflection designed to move them to hearing where they agreed not disagreed (they were both arguing for choice, and for not having choice stripped away from them – Willow was saying how she was not given the right care, she was given a diagnosis that stigmatised her but did not lead to a helpful response from services; Shirley was saying how getting a diagnosis enabled access to care which otherwise she wouldn't get). I also connected Willow to Billie when Willow talked about breathing, nature and art as helpful things for dealing with how she feels. I mentioned how Billie had also talked of yoga, breathing and the body as important for managing her emotions, much more so than talking about them. Each time I did something like this, I was conscious that I was intervening, and yet trying not to close any views down.

… I was struck by all the things people are doing, small and big, to change things. It feels like there are pockets of optimism all over the place, but not terribly well linked together. For instance, Kelly mentioned a newsletter she sends to people of where they can get help. Someone had also mentioned the Listening Place, which offers spaces for people who are suicidal to be supported for a time. It made me wonder about how so many people feel alone with these feelings and like society is against them, and there are pockets of people who want to reach each other but may not be able to – for various reasons. It's not so simple that only isolated people feel suicidal – plenty of the people involved in the workshops have loved ones – but there is something about people not always having spaces to express how they feel without repercussions that are beyond their control, and potentially harmful. I am not sure I am really able to capture the nuance in some of this. I think Cristina talking about how she can feel like she's shouting at the wall but no one responds – she looks for herself, but she's not there. And Billie speaking about how her biggest fear is being abandoned and yet she is trained to almost not show that to others. Or Celine speaking of how she had never talked about suicidality to her sister or husband because she didn't think it was somehow ok for her to do so – for her to take that space, to tell that burden. Think about shame as this big experience, and how relational this all is. People are sensitive to the responses of those around them. Even in this room, that was what felt so important to balance, creating a space where people can speak, hear and respond without fear or shame. I am not sure how well we did that completely, but it felt almost like floodgates opened and people wanted to say more than they had space to.

7.7 Appendix 7 – Workshop Plan

This is a guide to be used to aid the production of individual narratives and the witnessing of those narratives within the group. The questions are subject to change, as participants will be encouraged to guide the discussion, with the researcher acting as a facilitator. Questions for guiding the production of narratives are informed by Denborough (2008) and Ncube (2006), and questions guiding witnessing and re-telling are derived from White (2007).

Production of narratives

The purpose of this session is to tell your story of how you have lived with suicidality, namely, thoughts, feelings, and acts of suicide. People are invited to create this story in the way/s that feels most acceptable to them, e.g. they may incorporate words, images and music into the telling.

- How would you describe your experience of suicide in your life? *Or* Tell us the story of how suicide has been a presence in your life? *Or* Tell us about your experience of suicide in your life?

- What effects has this relationship with suicide had on you and other parts of your life? *(prompts if necessary around different aspects of life)*

- What has sustained you through your experience of suicide? *And/or* What have these sustaining practices brought into your life?

- How do these sustaining practices connect to your values, wishes, anyone or anything else in your life?

- What have you learnt because of all of this? *Or* What has this experience brought into your life?

- What would you like others to know about you and your experience?

Witnessing of narratives

People will be invited to share their stories with the group, so that each member can witness their experience. Questions to guide reflection:

- What words, phrases or expressions struck you the most about [participant's] telling?
- What images or ideas came to your mind?
- What did this resonate with in your life?
- How are you different as a result of hearing this telling?

Retelling

The person who has had their story witnessed will be invited to respond to the same questions, in relation to the witnessing:

- What words, phrases or expressions struck you the most in hearing people's responses to your story?
- What images or ideas were evoked for you in their response?
- What did this resonate with in your life?
- Where have these expressions taken you in your thoughts, understanding and perceptions of your own life?

Collective narrative creation

At the end of the telling and re-telling process, asking the group to begin the process of creating collective documents, using prompts as below if necessary:

- What are the key ideas or knowledges you feel have come out of today's story-tellings?

- What are the key images or metaphors that come to mind?

- Who do you feel would benefit from this knowledge? How do you feel they would benefit?

- What are your hopes for this knowledge?

Post-group debrief

Ensure that some refreshments are available during and at the end of the group (water, squash, fruit and snacks), and that there is time for participants to wind down from participation.

If the group would like it, do a grounding exercise (e.g. a body scan) at the end of the story-telling session.

Spend time asking group how they found participation (checking in on their current emotional state), what being part of the group has given them, what they feel they have given to the group, and what they plan to do now.

Participants will be given the option of a follow-up phone call with the researcher within a week, to check in.

Participants will also be given the option to contribute further to the collective documents produced as part of the group activities. Documents will be shared by email or post, depending on participant preference, and comments/additions sought and incorporated into the document.

7.8 Appendix 8 – Amendments to Workshop Plan

2.00-2.20pm

- Introductions to each other
- Introduction to the workshop
- Creating a group agreement

2.20-2.40pm

- Cheryl and Jennifer share a story
- Story will be read in brief paragraphs with pauses (there will also be copies for people to read if preferred)

2.40-3.10pm

- Group are invited to share responses to the story
- Questions to help guide responses:
  - What words, phrases or expressions struck you the most about the story you have heard?
  - What images or ideas came to mind?
  - What did this resonate with in your life?
  - How are you different as a result of hearing this story?

3.10-3.15pm

- Break for refreshments

3.15-3.30pm

- Group discussion about what has been shared so far
  - What ideas and images have resonated with everyone?
  - Who do we feel would benefit from this knowledge?
  - How would they benefit?
  - What are our hopes for this knowledge?

3.30-3.50pm

- Closing the workshop
  - Explanation of what happens next
  - Invitation to stay in touch if desired
  - Conversation about the experience of taking part

7.9 Appendix 9 – Interview Guide

This interview guide is produced for participants who are unable or unwilling (for any reason) to attend the group workshop but who are keen to contribute.

Pre-amble: The purpose of this interview is to give you some space to tell your story of how you have lived with suicidality, namely, thoughts, feelings, and acts of suicide.

Feel free to create this story in any way/s that help you, e.g. you can draw on words, images and music to help you tell it.

- How would you describe your experience of suicide in your life? Or Tell us the story of how suicide has been a presence in your life? Or Tell us about your experience of suicide in your life?

- What effects has this relationship with suicide had on you and other parts of your life? (prompts if necessary around different aspects of life)

- What has sustained you through your experience of suicide? And/or What have these sustaining practices brought into your life?

- How do these sustaining practices connect to your values, wishes, anyone or anything else in your life?

- What have you learnt because of all of this? Or What has this experience brought into your life?

- What would you like others to know about you and your experience?

- Are there any key images or ideas that come to mind?

If the participant would like it, do a grounding exercise (e.g., a body scan) at the end of the interview.

Ask the participant how they found participation (checking in on their current emotional state), and what they plan to do now.

Participants will be given the option of a follow-up phone call with the researcher within a week, to check in.

Participants will also be given the option to contribute further to the collective documents produced as part of the project. Documents will be shared by email or post, depending on participant preference, and comments/additions sought and incorporated into the document.

7.10 Appendix 10 – Creative Workshop Plan

3:00pm - 3:30pm - Welcome, teas and coffees, introduction to the project and session (from Jennifer), intros from Cheryl and Tom, check-in and group agreement (Jennifer and Cheryl to write down people's contributions to the agreement on post-its and stick in the middle of the table)

3:30pm - 3:50pm - Handover to Tom to introduce the principles of successful visual storytelling, showing his animation showreel and Charity promo for examples (Jennifer to bring laptop to screen films)

3:50pm - 4:30pm - Tom to lead a question for group discussion: What do we want our film to say about living with suicide? Group to create a collective mindmap of ideas (and Cheryl to bring in what people have shared in her research to add to this). Group to create two piles of images - those to include and those to avoid and discuss the colour scheme (Jennifer to bring print outs of typical Google Image Search results for 'suicide' and 'suicidal' for critical discussion and reflection, plus a selection of coloured card)

4:30pm - 4:40pm - Break

4:40pm - 5:15pm - Tom to lead on collective storyboarding and scripting - group beginning to develop the narrative and sharing personal testimonies for the script (Jennifer to audio record the full session with permission for quotes that we can rerecord with actors)

5:15pm - 5:30pm - Reflection, winding down and next steps (Jennifer to bring support information and consent forms for those who've contributed to the script)

List of Imagery from Google

- birds
- silhouetted person next to train station
- bridges
- hospitals
- handwritten goodbye/I love you
- tall buildings
- gardens
- chinese lantern
- hand in water
- black and white woodland
- bluebells
- help sign
- warning sign
- dark clouds
- barbed wire fence
- tears
- head clutcher/face clutcher
- empty shoes
- grey seascape
- person by water
- hearts
- candles
- hands
- forest
- person sitting on floor
- silhouetted person in front of window
- head clutcher on park bench at night
- black and white
- blue
- shadows
- broken head shape

Images/Ideas from the interviews and group workshop, using people's actual words as much as possible.

- Having a racing mind
- Stamped on for speaking about how I feel
- People saying "be positive" and hearing it as "fuck off and die"
- Suicidality being like on a sea, experiencing a heavy squall and losing the horizon, being tossed about and losing your reference points. Being unable to see anything.
- Walked away from the cliff edge
- The experience of every day like hobbling around with a caliper
- (more than one person said) learning not to show my feelings as a way to survive
- Suicidal thoughts as little red flags telling me there's something wrong
- Fight or flight – wanting to get away from pain/emotions
- The body keeps the score
- Causing damage by speaking
- Bottling things up
- Treating the wound but the root is there and untreated
- Not judge the book by the cover – people can look perfect on the outside
- I have lots of things upstairs – but they're not written on my forehead
- People's responses shutting you up – they don't want to hear it
- It would be lots of little mini clouds all darkening the sky but in each cloud there'd be a different way to kill yourself, it was just constant downpour of rain
- Dropping the anchor – being able to weather the storm and stay present and not caught up in it
- Three weather conditions
    - Actively suicidal would be completely black, with just one dominant feature like a lightning strike
    - Then feeling suicidal but not with a plan is darkness but you can see the clouds

    - Other times, you can see a nice bright blue sky, but there are a few clouds dotted, white fluffy clouds, that are the presence of suicidal thoughts in your life
- Being discarded
- Deep rooted pain
- Being driven to suicide by the things that have happened
- Feeling stuck in a nightmare
- Telling people about your suicidal thoughts/feelings as a burden
- Telling people about your suicidal thoughts/feelings as destructive – can it destroy their affection?
- Seeing people well up when you tell them
- Suicidal thoughts as intrusions – wanting the thoughts and emotions to go away but they don’t
- The fight inside of you goes, when you’re really depressed
- Silence – having feelings but feeling you can’t say
- Impossibility of communicating – feeling far away from someone even when you’re near
- How do you change things from the roots, from inside out?