RESULTANT SUICIDE FROM PROLONGED GRIEF FOR CAREGIVERS OF CANCER VICTIMS

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Abstract:

Aim:

The aim of this work was based around the question “How can suicide from prolonged grief for family members/caregivers of cancer victims be identified earlier and treated successfully?”

Problem/Purpose:

The research focus was the impact of suicidal ideation, identifying areas of improvement to provide a substantial and robust support system.

The purpose was to identify red flags in Prolonged Grief sufferers, to prevent initial and consequential suicides, highlighting the impact both emotionally and financially needing addressing.

Methodology:

The research consisted of four participants made up equally of therapists and clients, providing a holistic observation.

The methodology adopted was Interpretative Phenomenological Analysis to conduct semi-structured interviews, providing open answers.

Interpretative Phenomenological Analysis revealed Main themes of Pre-Death, Medical Profession, Those Left Behind and Personal Therapy.

Key Findings:

The key findings developed were the need to normalise grief, for NHS to focus on carers from cancer diagnosis. Psycho-education is necessary, both within the industry and in the public domain. Isolation in bereaved carers is a huge problem, and mental health practitioners need to have an in-depth awareness and understanding of attachment styles.

Conclusions:

The main conclusions from this research identified inadequate resources, lack of clarity of focus and a desire for improved services. A path is needed to identify those with potential suicidal ideation and put a support network into place, reducing suicidal acts.

Recommendations are made for practice and further research is recommended.

Key words: Prolonged Grief (Disorder) PGD, Complicated grief, Bereavement, Grief, Suicide, Carers, IPA

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: …Deborah Wilson……. (candidate)

Date: 30/06/2025……………………….

STATEMENT 1

This dissertation is being submitted in partial fulfilment of the requirements for the degree of …MA Psychotherapeutic Practice: Humanistic…..

Signed: Deborah Wilson ….. (candidate)

Date: 30/06/2025…………………………………………..

STATEMENT 2

This dissertation is the result of my own independent work / investigation, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed: Deborah Wilson …. (candidate)

Date: 30/06/2025…………………………………….

STATEMENT 3

I hereby give consent for my dissertation, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Date: 30/06/2025…………..……………………………

STATEMENT 4

I confirm that I have not used any AI tool in the research and creation of this assignment. I confirm that I have not presented any AI generated materials as my own work. I confirm I have copies of my drafts, notes, and other resources I used, which I may be asked to provide in evidence.

Signed: Deborah Wilson …… (candidate)

Date: 30/06/2025…………..……………………………

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Chapter 1. Introduction

“*To be or not to be, that is the question*”. (Encyclopaedia Britannica Inc, 2025). Over four centuries ago, Shakespeare, arguably one of the world’s most constant voices, drew attention to ‘Suicide’. Suicide is an emotive, controversial yet very real issue, about which people often react strongly. It needs further discussion and understanding, and where possible, prevention.

This research addresses the question, “How can suicide from prolonged grief for family members/caregivers of cancer victims be identified earlier and treated successfully?” This study is about emphasising how caregivers of cancer victims can be overlooked, their needs neither acknowledged nor addressed which has the potential to lead to both suicidal ideation and suicide itself. The aim is to identify prolonged grief (PG) before it turns into suicidality in carers of cancer victims.

O’Dwyer et al. (2021) identified suicidality as a significant public health issue in caregivers, markedly when examining their considerable contribution within social care and health systems, globally. Their study encapsulated other international studies to include Korea, Australia, USA and Northern Ireland. Challenges experienced by caregivers include high rates of mental and physical illness, financial distress and social isolation. O’Dwyer et al. (2021) discovered that statistics of suicidal ideation in caregivers range from 2.7 to 71%. Molina et al. (2019) shares O’Dwyer et al.’s (2021) belief and established its impact on both physical and mental health, identifying the high probability of suicide. O’Dwyer et al. (2021) highlighted that consideration to the differences in relationship, cause of death or country held little account. Molina et al.

(2019) and O’Dwyer et al. (2021) also agree that this subject requires global research with swift action in practice and policy to take place as a result. Previously, Frumkin et al. (2021) used logistic regression to investigate predictors of suicide risk and Sekowski and Prigerson (2021) defined the importance of predicting prolonged grief disorder’s (PGD) intensity to enable targeted preventive actions.

With the researcher’s lived experience of the loss of a partner and having lived through the trauma of anticipatory grieving (Papadatou, 2001), confusion, distress and eventual post-loss grieving, this subject was chosen due to current lack of academic backing and practical support presently provided (Sutherland, 2009). Many areas were deficient in essential services, and a relevant, up-to-date analysis of the current climate was deemed to be an important addition to the body of qualitative research within the mental health field. This study will highlight red flags within the system that appear neither addressed nor prioritised. It supports research undertaken (Frumkin et al., 2021; Sekowski and Prigerson, 2021, 2022a; 2022b) to the present time, identifying that further research is necessary in this field.

A part of this study addresses the flow of information for the caregiver/family often coming in a feast and/or famine format; information overload at the beginning, with little support and acknowledgement going through the process, tailing off to nothing once the loved one has died. Post death of the loved one, clients are signposted to charities (often with overwhelming leaflets) which invariably have long waiting lists, sometimes leading into years. This study looks at the caregiver’s attachment style, and access to bereavement education (or the lack thereof) which can affect the ability to handle bereavement, with grief potentially heading into PGD (> 12 months).

PG is now recognized as a disorder, having been added to the ICD-11 and DSM-5-TR (Eisma et al., 2023). The simplicity of this phrase does not prepare for its disabling and far-reaching impact on both the individual and society as a whole.

It is also recognized under alternative names such as Complicated Grief (Shear, 2015) and Persistent Complex Bereavement Disorder (PCBD) (Boelen et al., 2019). Boelen et al. (2019) identifies that there have been minimal studies to compare criteria set out for both DSM-5 and ICD-11, and Treml (2024) further states that the diagnostic approach and the criteria content vary. Both opinions provide opportunities for further research. For the purposes of this study however, all the above descriptions will be referred to as prolonged grief/PG/PGD.

Sekowski and Prigerson (2021) investigated 221 individuals via a non-probability sampling method, the relationship between attachment and grief in adults 18 years and older. They concluded that their findings deepened and broadened the understanding between emotional dependency and PGD. This further emphasised that further research exploration was essential between PGD and interpersonal dependency. In 2022 (2022a), Sekowski and Prigerson's research progressed, correlating that PGD and suicidal ideation are linked. Molina et al. (2019) agreed, stating that there was a core link between bereavement and suicidal ideation. In opposition however, Janshen (2024) couldn't find the links between attachment and PGD.

Between 2017 and 2019, Cancer Research UK (2023) identified that the UK loses approximately 167,000 souls to cancer each year, with one in four deaths diagnosed as cancer, identifying cancer to be the leading cause of death in England and Wales. This therefore raises the question of whether carers of 167,000 people, are provided with enough support both during and post their loved one's death or are they heading towards PGD and potential suicide due to a lack of understanding and support?

The Samaritans state the average suicide costs the country £1.46m (Samaritans and McDaid, 2024, p 3). The Office for National Statistics states that as of 2022, low survival cancer victims, one year after diagnosis, stood at 22.2 deaths per 100,000 people (Nafilyan et al. 2022).

The aims of this research are:

- Explore the lived experience
- Identify gaps in support provision for care givers
- Identify red flags for prolonged grief disorder
- Understand where and when support would be most suitable
- Identify suitable support systems for those with suicidal ideation in an effort to prevent it

Through these aims, key areas will be identified where the medical profession is currently failing families/carers of cancer victims and thus demonstrate how they can be in a stronger position to prevent potential suicide. This research topic also supports identifying potential areas of transformation to current practice, moving from reactive to proactive practice based on experiential evidence. The objectives of this study will be to explore the lived experience from both client and therapist focusing on areas of required change for implementation.

Working within an Interpretative Phenomenological Analysis (IPA) perspective, data were gathered from semi-structured interviews to expand knowledge on realistic/actual perspectives of both the individual and therapist, to provide a solid foundation of understanding for further research and action.

This chapter has outlined the purpose of this research. Chapter Two will review extant literature. Chapter Three will explain the methodology used to gain the research information and present its implementation. Chapter Four will analyse the data, looking at the participants' interviews and presenting the findings. Chapter Five will draw the research to a close by providing a discussion on the analysis and findings with a conclusion observing identifiable factors arising from the research, in answer to the question posed, with suggestions for forward progression.

Chapter 2. Literature Review

On researching this topic, numerous collections were accessed through the UWTSD library portal and Google Scholar. Peer-reviewed journals were utilised. The largest providers for this research were Elsevier Science Direct Journals Complete, Proquest Central, Sage Journal, Wiley Online Library (and Open Access), Taylor and Francis and Cambridge University Press. Dates for journals were searched between 2019 – 2025 excepting seminal texts and referenced articles which identified further research.

Key words/search terms utilised in this research were as follows:

Grief, Prolonged Grief (Disorder), PGD, Complicated Grief, suicide, suicidal ideation, caregivers, Cancer, suicide statistics, bereavement, bereavement and attachment styles, grief and attachment styles, suicide and attachment styles, Prigerson (key researcher on this topic).

2.1 What Prolonged Grief is

As explained by the organisation Marie Curie (2024), complicated grief is addressed under various names, including Prolonged Grief Disorder (PGD), traumatic grief and persistent complex bereavement disorder. Gross (2016) compared complicated grief with PG. Quoting Stroebe et al. on CG, Gross shared,

> *In general terms, complicated grief (CG) can be understood as something like a 'derailing' of the normal, usually painful process of adapting to the loss of a significant person.* (Gross, 2016, p.142).

Parkes and Prigerson (2010, referred to in Gross, 2016, p. 143) argued that PG is more intense than the above description of CG, namely falling into a chronic state which Gross (2016) expanded with observations of prolonged separation distress and compromised social and psychological adaptation of the mourner, therefore not comparable.

DSM-5-TR posed a new diagnostic criterion for PGD as indicated by the American Psychiatric Association (Prigerson and Sekowski, 2021; Prigerson, Shear and Reynolds, 2022). Indicators suggested that distressing grief symptoms continue for at least 12 months post loss. This is characterised by intense feelings of loss such as yearning and longing. It describes eight specific symptoms. These are intense loneliness after death, life is felt to be meaningless post death, being emotionally numb, struggling to join life post death, painful emotional intensity in relation to the death, avoidance of evidence of the death, a clear shock and sense of disbelief that the person has died and feeling that a part of themselves has also died. Prigerson, Shear and Reynolds (2022), after extensive research, reported the PG-13-R was a useful self-measuring tool, to be used to screen for diagnosis and assess its acuteness. Asmat et al. (2024) went on to research actual mental health experts, identifying key factors within PGD, looking into behavioural, emotional, cognitive, personality and environment factors. The result of this was providing advice, showing that the development of preventative strategies was needed to reduce PGD, in agreement with Wen et al. (2024). To enhance overall wellbeing, Asmat et al. (2024) also advised that a greater understanding of the risks mentioned above was necessary for swifter detection, calling attention to the importance of medical care, community support and cultural influences.

Reynolds et al.'s (2023) work, explains how Andreas Maercker (ICD-11 Workgroup chair on Stress-Associated Disorders), backed by studies from cultures validating the criteria of both East and West, recommended PGD to be included as an official psychiatric illness (in ICD-11) due to its "*abnormally persistent and disabling responses to bereavement*" (p88). The ICD-11 and PGD diagnosis differed on the number of symptoms (some not tested), arguably providing more adaptability with ICD-11, enabling an application across cultures, which the DSM was unable to achieve. This brought about critique from other quarters, criticising the measurement of symptoms such as guilt and blame, claiming these words could be misconstrued and misleading.

Looking further into PGD and depression as separate syndromes, Wen et al. (2022a; 2022b) analysed bereaved family caregivers of cancer patients over a longitudinal study, stating that both PGD and depression can co-exist. They advised that where PGD is suspected, the bereaved should be assessed for Major Depressive Disorder (MDD), with effective interventions being provided earlier to prevent a PGD-depression comorbid state. Wen et al. (2022b) and Asmat et al. (2024) both advised the support from family, friends and culture aided resilience and recovery, alongside various treatments.

Despite culture providing a varied path to healing, Weeratung, Goonewardena and Meegoda (2024) believed a comprehensive needs assessment tool (CNAT-ICs) for informal cancer caregivers was required for Sri Lanka, concluding it was a requirement cross culturally to caregivers, enabling further research. The NHS in the UK meets this need via Integrated Care Systems (INCs) in place (NHS, 2024).

2.2 Grief to Prolonged Grief

Those bereaved, whose grief turns into PGD, experiencing persistent symptoms, is estimated to be around 7 – 10% (Szuhany et al., 2021). Sekowski and Prigerson (2022a) further confirmed that the severity of PGD positively correlates with bereaved individuals who suffer from suicidal ideation, thus stressing the gravity of understanding PGD as a risk factor for suicidal ideation amongst bereaved individuals.

2.3 Suicidal Thoughts and Behaviours

Molina et al. (2019) by means of a systematic review, investigated via a sample of bereavement group articles, connections between reason for death and suicidal thoughts within those who were bereaved, and bereavement was found to be core to suicidal ideation, dependent upon the cause of original death. Results suggest multiple causes of death are associated with suicidal ideation in bereavement, although suicide bereavement may be the highest risk of suicidal ideation. McDonnell et al. (2022) confirms this, clarifying 77% of their own research participants had been majorly impacted by suicide and elaborated that 65% of adults were more likely to attempt suicide themselves following on from a suicide bereavement. Looking at cancer victims, O'Rourke (2022) points out that patients with cancer are nearly twice as likely as the general population, to die by suicide, stressing the importance of how clinicians need to be aware of this, for early recognition, enabling open and frank discussions with both the patients and their families and working collaboratively with the different specialists. It was also advised that there was a need for recognition early on with follow up of treatment and monitoring, with care provision from a collaborative specialist care group.

2.4 Caregivers / Cancer

Early recognition is clearly advisable, especially with the loss of a significant other to cancer. It is viewed to be distinguishable from bereavement of other kinds, according to Jerome et al. (2018), observing that family and friends are often subjected to additional sources of mental distress to include visible physical changes in their loved ones, the lack of clarity regarding the diagnosis and subsequent prognoses. They often witness distressing events such as when their loved ones are admitted to hospital.

O’Dwyer et al. (2021) apparently agreed and studied a diverse range of caregivers. They also identified suicidality as a significant public health issue in caregivers, especially when examining their considerable contribution previously mentioned. Caregivers experience significant challenges, with high rates of mental and physical illness, financial distress and social isolation backed by O’Dwyer et al.’s (2021) statistical data of suicidal ideation in caregivers. Molina et al. (2019) shared O’Dwyer et al.’s (2021) belief and agreed about its impact on both physical and mental health, emphasizing the high probability of suicide. O’Dwyer et al. (2021) observed that consideration to the differences in relationship, cause of death or country held little account. This subject requires thorough research globally with swift action in practice and policy to take place as a result (Molina, 2019; O’Dwyer, 2021).

The National Institute for Health and Care Excellence (NICE) prioritises bereavement, evidenced by their own appraisals for the benefit of supporting the NHS and the taxpayer (NICE, 2025). They have Highly Specialised Technology (HST) appraisals. Wentzel and Malottki (2022) wanted to understand how fully bereaved caregivers had been considered by NICE to get a picture of their inclusion. They found that despite a 30% inclusion of bereavement covering rare diseases, the capturing data were challenging for bereaved/anticipatory grief of caregivers in general.

The prediction of quality of life for both cancer victim and caregiver was researched by Hoerger et al. (2022). They concluded that increased negativity from the caregiver ensured lower expectations of a positive outcome for the sufferer, resulting in worse bereavement outcomes, looking at power purpose in life, depression and PG.

Caregivers experience significant challenges (O'Dwyer et al, 2021), with high rates of mental and physical illness, financial distress and social isolation. With research sharing the proportion of suicidal ideation (to include plans made) experienced by caregivers, the expansive range from 2.7% to 71% (to include deaths by homicide-suicide, deaths by suicide and suicide attempts), identifies that these statistics state this as an important area needing further research. It should also be coupled with actionable practices and policies (safeguarding being key) to be implemented, to save lives. Further discussed is the implementation and establishment of suicide prevention training programmes to be taken by healthcare professionals. It was highlighted however that risks associated with and for family caregivers were not emphasised to the family caregivers, with no education provided. Support for caregivers worldwide was advocated as an *'urgent imperative for immediate action to identify and support at-risk caregivers'* (O'Dwyer et al., 2021, p 21). Research was undertaken for this literature review via Arskey and O'Malley's five-stage framework, and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Scoping Review. Lived experience of caregivers (researchers JM, LR, AW, CA) were involved in stages one and five, enabling them to refine the questions required for a critical review of literature. Participants were limited to caregivers aged 18 and over. It was noted that the existing literature researched by this paper, was not co-produced with caregivers and a limitation highlighted was the lack of consistency across studies. It was also pointed out to be the first known study of its kind and therefore further research is required using robust samples and rigorous methods, to *"inform evidence-based policy and practice going forward …".* (O'Dwyer et al., p 21). This research paper was a rich source of information, becoming a keystone for this current study. It is seeking to address that which was observed to be lacking – the fact *"that caregiver suicide/ideation was not measured or reported"* (O'Dwyer et al., 2021, p3).

Stone et al. (2024) studied the younger population, linking bereavement with attachment styles, noting that anxious attachment seemed to be the primary player with ongoing bereavement complications (as found in PG disorder), following the loss of a key responsible adult to cancer. Anxious attachment and bereavement guilt was found to be positively related (Kho et al., 2015), due to the heavy investment of emotions and dependency with greater yearning, creating intense reactions throughout bereavement. Other research (Lenzo et al., 2022) in contrast, offered avoidant as the primary player, due to distant behaviour. Waskowic and Chartier (2003) heralded an era of exploring potential connections between grief and attachment, concluding that insecure (avoidant and anxious) attachment styles simply affected grief reactions, noting that those securely attached experienced less despair, isolation, guilt, anger, somatic symptoms and death anxiety, than their insecure attached counterparts.

Conversely however, in the same year, Janshen et al. (2024) conducted a study on insecure attachment predicting PG symptoms. Their findings proved contrary to both their own expectations and Stone et al.'s (2024) findings. Their hypothesis of insecure attachment forecasting lingering change in PG symptoms was not endorsed by the evidence they found, thus finding the level of attachment does not impact on PG, which is in line with earlier studies, such as Fraley and Bonanno, (2004) and Wijngaards-de Meij et. al, (2007). And in some cases the pain of loss can be mitigated by the 'continuing bond', (lovely memories, speaking to the deceased individual) as expanded upon by Fraley and Bonanno (2004).

With the understanding of insecure attachment, avoidant attachment styles are not emotionally drawn in by grief (unattached to their emotion) not reacting to the loss in the same way anxious attachment styles would, with greater yearning for the deceased. Wijngaards-de Meij et al. (2007) does however warn about this assumption being incorrect, as their findings outlined within their studies of child-loss, avoidant style parents were impacted, contrary to their expected resilience. Anxious attachment styles will invariably make their distress known by searching out support and help.

Worthy of note, Bjerre et al. (2023) concluded there is a real problem developing with the focus on attachment, in as much as this term is overused and heavily relied upon. An example used is the weighty reliance social workers have upon this term, dependent upon informational rather than social input – from facts and evidence to normative and moral. It is also observed that attachment styles fit neatly into the Western culture, indicating that it does not fit so well into a global perspective, due to different norms of raising children.

Abbott et al. (2013; 2014) identified that family caregivers experiencing and/or witnessing their loved one's greater suffering at the end of life are more likely to suffer from psychological distress themselves, in turn, their own bereavement journey potentially resulting in PG associated with psychosocial distress, including suicidal ideation. It is further discussed that bereavement is generally a suicidal risk factor when grief is prolonged and intense. In turn, this increases the chance for grievers to develop PGD, of itself, a risk of suicide. Abbott et al. (2013; 2014) also expand, stating how little information is available about the quality of life and end of life experience of the patient, and upon “caregiver suicidality in bereavement”. The Yale Evaluation of Suicidality Scale (YES) was used to assess suicidal ideation of caregivers.

To expand, the YES scale measures current suicidal thoughts and actions, of past and planned attempts (Latham and Prigerson, 2004). In 2019, Oestergaard (2019) took a step further by finding genes associated with suicidal behaviour, identifying that suicide is one of the top 10 leading causes of death worldwide. Their research also informed a significant genetic overlap with major depressive disorder, alongside suicidal behaviour.

2.5 The Cost of Suicide

The Samaritans, alongside David McDaid (London School of Economics and Political Science) conducted a study of the economic cost of suicide in the UK (Samaritans and McDaid, 2024). Looking at 2022, 6588 deaths were recorded as death by suicide. The previously mentioned cost of £1.46m per suicide, stems from employment productivity loss, other productivity loss, intangible costs, suicide healthcare costs, self-harm costs, emergency services costs, coroner/legal costs and family costs. It is made clear that these are conservative calculations. Total costs for people of all ages came out at £7,704,790,325. PG sufferers are a part of these statistics.

According to Cancer Research UK (2023), the proportion of UK deaths stands at 25% directly from cancer. Between 2017-2019 figures stood at 167,142 deaths. Pointing out that despite other forms of death having decreased, death from cancer has increased over the last couple of decades, classifying cancer to be the ‘leading cause of death’ identified in England and Wales.

Based on O'Rourke's (2022) studies, 1% of cancer patients engage in forms of self-harm post diagnosis of cancer, with a higher rate when a prior psychiatric diagnosis was found, resulting in a hazard ratio of 44.1, compared to non-self-harmers which stood at 6.8.

Looking at the above figures, Cancer Research UK's (2023) stated figure of 167,142 deaths across 2017-2019, coupled with O'Rourke's 2022 studies claiming 1% of cancer patients engage in forms of self-harm the following calculations can be deduced. 1% of 167,142 is 16,714. With a hazard ratio of 44.1 of patients dying of unnatural causes, that equates to 7,371 deaths. With a cost of £1.46m, this results in a direct cost of over £10.76bn. Based on the 65% statistic of potential follow-up cases (McDonnell et al, 2022), potentially preventable suicides have approximately cost the UK £7bn. Further research is required to understand the death toll and monetary impact of PGD.

Sekowski and Prigerson (2022a) explored associations between symptoms of PGD, depression and suicidal ideation, concluding that PGD, with or without depression, forcefully explained the frequency of suicidal thoughts; that PGD symptoms could rise, increasing mental pain, quality of life and distress. They also presented that unresolved longing (symptom of PGD) potentially provided a convincing argument to the PGD sufferer, to create an opportunity to join their lost loved one by suicide.

With such a lack of support present for PGD sufferers, Kim et.al. (2020) ran a longitudinal study (measuring at both five- and eight-years post-loss), researching into the unmet needs of bereaved family cancer caregivers. An exploratory study identified two key factors that were unmet. These were, the lack of reintegration for the bereaved, and a lack of support for managing their loss (showing as a strong sign of poor adaptation to bereavement at both the five- and eight-year anniversaries). On the strength of this research, they created Needs Assessment of Family Caregivers-Bereaved to Cancer (NAFC-BvC) in adult patients. It was found to be affective even after numerous years. They are also suggesting that current bereavement programmes require an overhaul, develop new programmes to support both whilst in the role of caregiver and years after the loss.

As indicated within this literature review, various assessment tools have been developed and advised where the needs of support can be found, with a complete overhaul to be conducted.

The charity The Loss Foundation, requested research to be compiled, after user-requests were mounting, to see if structured therapeutic group intervention is worthwhile. Initial results showed a positive result in helping people move forward with their lives, having lost a loved one to cancer (Jerome et al., 2018).

Research into attachment styles is ongoing and is an identifiable factor in those who suffer from suicidal ideation. There are methods of prevention if they can be brought together and utilised.

An increasing amount of academic work is being done around understanding and diagnosing PG which has enabled understanding of the long-term catastrophic and tragic outcomes such as the final act of suicide, when undetected and undiagnosed. The emotional and financial cost have been addressed for suicides and cancer sufferers, identifying that community and family support are key, but further research is required to investigate the onslaught of grieving and its impact on welfare and the community/family system. Work has begun, looking at caregivers of cancer victims internationally. With these results, it would be beneficial to have international longitudinal studies, to see the impact from carer support provision, from cancer diagnosis onwards, with a focus on attachment styles to further discover its implications on global societal infrastructures. Unfortunately, in the UK, focus seems limited with compelling research/proof still awaited/required for process changes to be agreed and adopted by the healthcare profession. Western Culture is not equipped to equal levels of community support as international communities' counterparts, with loneliness and isolation playing key roles. Does the Western Culture need to adopt other systems to function in a greater supportive manner? The research question was based on lived experience, which brought to light the gaps in the system and inequality of care provided from hospital to hospital.

Having delved into some of the research amassed with suggested ways forward, the next chapter investigates the methodology chosen for this study and how it was fit for purpose.

Chapter 3. Methodology

In the last chapter, key research was identified to show how much this topic has been identified as significant, bringing to prominence the growing concern about loss of/inadequate support resulting in premature/untimely deaths due to lack of understanding and infrastructure relating to the needs of carers and consequential PGD. This chapter will address how research was conducted, starting with ethical approval, describing participants, looking at the methodology and methods of research. Further details of the interview process are presented and how data were recorded and transcribed culminating in the sequence of analysis.

This research was undertaken across a nine-month period. Areas to be considered were ethical approval, participants, research methodology, methods and the interview process.

3.1 Ethical Approval

The research proposal was approved by the University of Wales, Trinity Saint David (UWTSD) ethical committee.

3.2 Recruitment of Participants

A poster to attract candidates was created (Appendix I), interview guides were designed and created around the knowledge of desired subjects to be covered and provided to the participants in advance. Ensuring the participants were well informed and able to provide informed consent, the research documentation consisted of, a) a covering letter, b) consent form, c) interview schedule (topics), d) research interview covering letter, and e) a debriefing / feedback form (Appendix II). This provided clarity for the participants and ensured they understood every step with the understanding that they could withdraw at any time.

3.3 Participants

The decision to interview two clients and two therapists provided a holistic viewpoint of qualitative data. To ensure that participants had lived experience of grief, purposive sampling (non-probability, intentional sampling) took place to enable analysing both divergent and convergent patterns within the data collected (Smith et al., 2022). This involved providing informative invitations to participate, placed on noticeboards within potential recruitment areas at therapeutic establishments and doctors' surgeries. Nevertheless, ultimately, professional contacts facilitated access to this difficult-to-reach participant group.

Participant Profiles were as follows:

Homogenous qualities included the commonality that all participants had lived experience of prolonged grief disorder and suicidal ideation, through bereavement or therapeutic encounters (as client and/or therapist) and all were white British women, between the ages of 50 and 70 approximately.

3.3.1 Clients:

Client 1: The first client was receiving current therapy due to continuous grief from the loss of their partner > 12 months ago.

Client 2: The second client had also lost their partner > 12 months ago but not in present therapy.

3.3.2 Therapists:

Therapist 1: The first therapist, specialised in loss, with a wealth of experience in bereavement counselling and as a bereavement supervisor.

Therapist 2: The second therapist was an integrative, self-employed psychotherapist with many years' skill/knowledge in both practice and teaching, covering suicide and bereavement.

3.4 Research Methodology - Interpretative Phenomenological Analysis

Amongst qualitative research methodologies, such as narrative, grounded theory, case studies and ethnography, Interpretative Phenomenological Analysis (IPA) was the chosen qualitative methodology for this research (Smith et al., 2022). Moustakas (1994) noted that interviewing was beneficial in obtaining common themes across the sample or finding unique conceptual links. It is the most direct option to enable understanding of contexts, addressing ongoing and arising problems. It is essential to both understand and describe the essence of the 'lived phenomenon' (Cresswell and Poth, 2018), to make sense of/infer/interpret what is being experienced, which helps to bring meaning and understanding. It is for the reader to decide whether the conclusions are both credible and plausible, based on the strong research trail evidenced, and the information laid out within this document (Thomas, 2023).

IPA is ideographic (taking the lived experience on an individual basis), phenomenological (looking at our inwards perception) and interpretative and was chosen as the best qualitative and experiential research approach (Smith et al., 2022) for this study's research question, examining the lived experience of bereaved people's path to making sense of their major life losses – or adversely, how they find it impossible to do so, and the consequences therein. It is phenomenological as it is concerned with exploring experience in its own terms. It addresses what happens when experiences take on a particular significance which allows for participants to provide a fulsome, thorough and 'rich' account of their experiences (Smith et al., 2022). The term 'rich' is clearly subjective, however it enables participants to be free to say their truth in a time-friendly manner, to develop their narrative as they digest what they are saying simultaneously. It focuses on the 'lived experience', tempered by the researcher's own understanding, experience and interpretation (Sutherland, 2009).

As this study is focused on a small sample of four participants, again, IPA is the best choice for detailed investigation of the participant's experience, gaining stories, thoughts and feelings. Both researcher and participant are equally involved, allowing the conversation to develop further or alternatively signifying to the researcher to modify questions if required.

3.4.1 Research Methods

Face-to-face and online interviews took place as follows, with information sheets and consent forms signed and returned prior to attendance for both parties (Appendix II).

3.4.1.1 Face-to-face Interviews

One client and one therapist were interviewed face-to-face. Copies of the interview topics were provided as a refresher to the participants. As explained in the research documentation and revisited at the beginning of the interview, interviews were recorded, with participants alerted when recording began. Upon interview completion, the participants were thanked for their attendance and for their openness to sharing their experience. A debrief took place and Information was available for signposting should this have been necessary.

3.4.1.2 Online Interviews

Online interviews were conducted over the medium of Teams. Attention was drawn to the privacy and data storage policies of this platform. At the start of the interview, the researcher selected record and transcribe options with participants being reminded of this. The participants were advised again of the topics to be covered. Following the interview, the debriefing stage was conducted, with the opportunity of discussion regarding potential triggering. Information was available for signposting should this have been necessary.

To facilitate both face-to-face and online interviews, client and therapist interview guides were designed appropriate to the participant's position (client or therapist) within the grieving context.

3.4.2 The Interview Process

Participants were thanked for their involvement in the research, with a little small talk to relax the atmosphere to promote participant wellbeing.

Before recording, it was explained that there were no right or wrong answers. With both clients, the opening question was a request for them to share their story in their own time and own words. The therapists were asked to share their experiences of clients dealing with loss.

The semi-structured interviews were conducted in a conversational tone, with an overall message that the researcher was there to listen, witness and understand the lived experience. Participants were sensitively probed for greater depth of information and for clarification. Conversation occasionally took unexpected directions which, depending on the route, were then investigated or brought back on track to what was being said, especially if meaningful. The researcher observed that occasionally issues touched upon were then avoided, which was challenging when meaningful observations were made. When clients were perceived to be getting emotional and finding it difficult to continue, space and time were given by the researcher for the client to collect themselves. Throughout the interview, affirmations were given by the researcher, indicating listening, empathy and encouragement to continue. Upon interview completion, the participants were thanked for their time, for their openness to sharing their experience and affirming that their voices had a right to be heard. Debriefing and signposting stages mentioned above, were then adhered to.

3.4.3 How Data were Recorded and Transcribed

For face-to-face participants, data were recorded using a Sony HDR-CX240E Handycam, capturing both video and audible, which was then downloaded onto the researcher's password protected computer for transcription. For online participants, Teams recorded both video and audible and was downloadable from the system.

PC (participant client) 1 and PT (participant therapist) 2 were conducted face-to-face in interview/therapy rooms. PC1's transcript was touch-typed by the researcher, directly from the video taken. Due to time constraints PC2's transcript was achieved using TurboScribe, an online transcription service which was consequently amended by the researcher, sifting through it minutely utilising the video for accuracy. PC2 and PT1 were recorded using Teams. The Teams transcripts were sifted through minutely by the researcher, utilising the video for accuracy.

3.4.4 Sequence of Analysis

Upon completion of the interviews and transcriptions for analysis purposes, the researcher followed the process exampled by Smith et al. (2022). This was accomplished by reading and re-reading the individual interviews to understand each participant separately from each other (ideography). For each interviewee, individual exploration was conducted, constructing experiential statements, searching for connections within statements and naming the personal experiential themes (PETs) (Appendix VII). This occurred before developing cross-themed analysis. These were then organised into a table. Once disseminated and organised, for compare and contrast, group experiential themes were brought together (GETs) across all participants.

Having looked in this chapter at the research's methodology in detail, Chapter Four will analyse the findings discovered throughout the interviews described above, identifying themes of Pre-Death, Medical Profession, Those Left Behind and Personal Therapy investigating appropriate sub sections.

Chapter 4. Analysis and Findings

Having delved into the 'how' of this study's methodology in the previous chapter, Chapter Four focuses on evaluating the evidence found within the interview process, through two clients and two therapists, analysing the findings.

Using IPA methodology (Smith et al., 2022), the Main Themes arising were Pre-Death, Medical Profession, Those Left Behind and Personal Therapy arising from the sub-themes. Two clients (PC) and two therapists (PT) participated, referred to as PC1, PC2, PT1 and PT2. Quotations from themes and associated sub themes from the interviews have been tabulated and are found in Appendices II – VI.

Table I (shown below) provides the detail of the developed Main Themes identified above.

Table I **Main and Sub Themes**

Main Themes	**Pre-Death**	**Medical Profession**	**Those Left Behind**	**Personal Therapy**
Sub-Themes	Cancer Victim's Attitude	Private Healthcare	Attachment	Personal Experience
	Feelings of Inadequacy/Guilt	NHS	Isolation	Therapeutic Alliance
	Fear	Charities	Suicidal Ideation	Impact on Therapist

4.1 Main Theme Pre-Death – sub themes Cancer Victim's Attitude, Feelings of Inadequacy and Guilt and Fear

The main Pre-Death Theme (Table II – Appendix III) developed from the sub themes arising from participants sharing their experiences, which addressed shared experiences of the cancer victim's attitude, feelings of inadequacy/guilt and fear itself.

4.1.1 Cancer Victim's Attitude

Where attitude became evident, research identified a reliance on society's expectations (of both victim and carer). This was demonstrated by observed stoicism, denial of the diagnosis, reality of the death diagnosis's realisation and care from the cancer victim for their 'significant other' left behind. *"He worked from home a lot and he was such a strong stoical person*" and "*I was the one in pieces you know, and he's the strong one and you'd think it'd be the other way around..."* [PC1-P2].

Society's expectations are ever changing with the times, hence the validity of the word 'era'. Expectations can change from community to community, however there are consistencies. Kalish, (1981, quoted in San Filippo, 2007, p6) said, *"The ways in which we mourn are heavily influenced by our culture"*, emphasising the power which culture has in decisions made, actions, reactions, guilt and shame, to name a few. The 'stiff upper lip' is still evident in today's British society which encompasses emotional repression and difficulty expressing feelings due to a need to have self-control, showing resilience with no evidence of vulnerability. PC1 frequently described her husband as stoic. The analytic process raised the question whether this was in fact stoicism or the proverbial 'stiff upper lip', often confused.

Optional death by suicide was addressed, for the victim to go out on their terms/reduce suffering, with the potential for ensuing follow-up suicides, and Kübler-Ross's five stages of grief (Corr, 2020). *"...it can be that somebody knows they're going to die and doesn't want to die painfully from cancer, ...so they'll end their life"* [PT2-P11].

Across all interviews, Elisabeth Kübler-Ross's five stage model (Kübler-Ross, 2009; Corr, 2020) which includes denial, anger, bargaining, depression and acceptance, was discussed with evidence in all themes. Corr's (2020) findings drew attention to the lack of examples of all five stages in one person being witnessed, however, Kübler-Ross (Corr, 2020), noted stages running parallel.

Denial - PC1 shared that reality hit her and her husband through conversations with the local hospice. Examining the following statement, various indications emerged from the lived experience, primarily lack of being prepared for this eventuality, being confronted with pain of the harsh truth and fear of the future with its implications for both husband and wife.

> *We had an appointment ...and it just brought it home ...people saying it out loud that it's the end of your life [asking]which way do you want to go, and he was like, ..., saying it out loud, it's a different thing to thinking it.... When someone else says it out loud, it's real, this is happening ...! It's not gonna go away you know. So it was quite hard for us both....* [PC1-P12].

Anger - PT1's client and husband experienced anger about the prognosis. The lived experience expressed in the below statement regarding PT1's client, was the impact of anger. Both client and her deceased husband were lost in their own individual anger – his at the diagnosis and hers about his levels of anger directed at her, noticeable to the therapist at the time of delivery, as the memory '*stuck'* many years post therapy session. *"And that's what always stuck with me. Was the anger. And that's with her as well. That's what she struggled with. He was angry at his diagnosis. He was angry at everything."* [PT1-P2]. The five stage model evidently covers different modes of grief suffering.

Bargaining - PT2 discussed the impact of the bargaining process witnessed as a part of attachment styles. It was unmistakable that she fully understood her clients; complete empathy was shown, living the feelings with the clients themselves. It is exampled in the emphasis relayed with the 'if only' statement, displaying the power and intensity of only one part of the whole of the grieving process.

> *I mean that's one of the most painful bits of grieving isn't it, is that bit where you are saying if only, if only I could, if only I had another day, if only I could tell them, if only I hadn't done this, if only I hadn't said that, if only I'd realised how much they meant to me.* [PT2-P5].

Depression - PT2 described cancer victims dying by suicide rather than living with cancer. She progressed, describing potential inter-connected reasons for the decision to die by suicide. Entrenched with these words were the result of and/or encased in guilt, self-loathing and shame. The understanding and use of Roger's Conditions were visibly in evidence when PT2 described this scenario; there was no judgement, simply empathy, understanding and to witness reality in its rawest form with acceptance.

> *It can be that somebody knows they're going to die and [don't] want to die painfully from cancer, and so they'll end their life but often times there'll be other stuff in the background. It may be that their cancer's come about through drug addiction, through alcohol misuse, it may be stress from other related issues that have made their immune system pack up and therefore resulted in cancer.* [PT2-P11].

And lastly,

Acceptance - PC2's husband halted chemotherapy, taking off his oxygen mask pre-death, indicating he'd had enough. Analysis revealed that PC2 displayed symptoms of disorganised attachment style, therefore running both to and from her husband who she evidently loved. Having initially been informed that the cancer he was suffering from provided the best results with treatment, she dismissed the likelihood of him dying. The following excerpts of her words indicate how this suggests her fear of abandonment. *"...from diagnosis, as I say that the messaging was, you know, fairly positive really and that gave [Redacted] particularly, you know, a good dose of positiveness"* [PC2-P4]; *"Where was this attitude of we're treating him to cure him. Why? Why have you not cured him?"* [PC2-P3].

> *"it's very much a case of we're here and you know where we are, if you need us, whereas for me, I would feel better, if they reached out to me, you know...*
>
> *INT: So proactive contact.*

> *PC2: yeah. And just kept that contact with you so that you didn't feel as though, I hate to say the word abandoned because I don't. You know, I can't speak highly enough of [Redacted], but it's very much that 18 months is the deadline. The cut off point. And that's it. from beyond.*
>
> *INT: So, you do feel abandoned?*
>
> *PC2: To a certain extent, yeah* [PC2-P18].

Her husband's decision to stop the chemotherapy ended hope for a continued shared life. In complete opposite position to PC2, her husband reached acceptance and stopped fighting his perceived inevitable outcome. Exploring the lived experience of this client's experience, brings into question whether stopping chemotherapy was a form of suicide, as death was the only outcome of this choice. *[Redacted], I think, had had time to get used to the idea that he wasn't going to live. And therefore, he stopped the chemotherapy"* [PC2-P2]

4.1.2 Feelings of Inadequacy and Guilt

Hoerger et al. (2022) focused on the impact of the caregiver, on the outcome of both the cancer victim and the caregiver themselves, finding the greater the negativity pre-death, the more powerful the grief. Inadequacy/guilt arose as a common theme. Observing the differences between PC1 and PC2, PC1 though feeling inadequate in the face of the unknown and judging herself harshly for being 'useless', fought hard for her husband's wishes. She supported him as much as possible, to live the rest of his life with as much verve as possible, eventually finding succour in writing him a letter to open communication lines previously closed by Cancer's trauma, providing a healing release for the both of them.

> *… every time I wanted to say something I couldn't … I wrote him a letter, and I wrote everything down …I went up to bed as I normally would do, and then he came up and I said, "there's a letter there" and he said, "this time of day?" … he saw that I'd written it, you know, and he opened and read it and he just [explaining with hand gestures] he just, the tears you know? The release? From him? And erm … he just hugged me and … the elephant disappeared then, you know. We could both talk about things that we couldn't talk about, that we hadn't allowed ourselves to…* [PC1-P6]

Her focus was on enabling her husband's last stage in life, to be the best it could be, and in turn potentially provided an opportunity for herself to know she was doing everything she possibly could. Carl Rogers is attributed to have said, "*listening to the music behind the words*" (Counselling Tutor, 2025), meaning listening to underlying emotions and the themes which underline the meaning. That which was heard through analysis, suggested that the basis of this depicted her need to be needed; to be doing something positive and active (as oppose to feeling useless, unable to contribute anything useful). It provided focus, kept her busy 'battling' with the system, fighting for her husband's needs. Analysis of the findings also implied that this was a way to focus on something positive whilst being surrounded by death and pain. PC2 was buoyed up at the beginning by the medical profession providing hope that her husband would survive. It raised the question whether it enabled her to deny what was in fact, happening. When the chemotherapy didn't work and her husband accepted his situation, deciding not to pursue further chemotherapy, the reality of the situation fully registered with PC2. Thus began her anticipatory grief journey, moving into survival mode. This was witnessed in her own needs taking priority over those of her husband's. For example, he wanted to be at home, but he agreed to stay in the hospital for his last few months, because of her need to have the house alone, to be able to escape his ensuing death.

> *"[His] sort of wish was to BE at home. And I knew that again, selfishly, I didn't want him at home because I knew I just wouldn't be able to cope with it"* and, *"he [was] very much of the opinion that whatever I wanted in terms of where I wanted him to be, then he was happy with that"* [PC2-P2].

This observation ties in with the cancer victim's attitude. The analysis process identified however, the decision to be alone at home proved to cause guilt for PC2 which was then carried into her future.

Both carers sought validation without giving value to their own contribution in an area they had no understanding of (cancer) and through their inexperience in the cancer process, they carried guilt created pre-death, into their futures. This pattern supports Hoerger et al. (2022).

4.1.3 Fear

Fear surfaced, recognisable in anticipatory grief within the client participants, alongside therapists confirming observations of grief, anger, upset and being scared. It manifested with participants in several ways. Fear was evident in discussions about being alone/feeling isolated/loneliness. The pressure of societal (especially employers, but also friends and family) expectations to get back to work/living was in evidence, as was the loss of living friends and family with minimal/no understanding of the grieving process. This increased the feeling of isolation and worry about survival alone. Monetary fears, ability to cope with both ‘his and her’ jobs (household chores), inability to function as they were, fearful of the loss of ‘together’ dreams; these are all areas that are not immediately apparent. *"There was grief. There was anger, there was upset. I was scared"* [PC2-P5].

Fear is evident in so many parts of the process. PC1 described as indicated in Kübler-Ross’s denial section above, that the palliative care team induced fear due to the realisation that the certainty of death was assured. Hospitalisation, drugs working inefficiently, when significant family members are requested by the medical team to come as soon as possible and the clinical signs of death such as reduced urine output and decreased breathing (Hui et al., 2014) are present, are all fear inducing signs that time is running out for loved ones. Once the loved one has passed, those left experience wanting to join the loved one, which is not unusual (Latham and Prigerson, 2004).

4.2 Main Theme Medical Profession – sub themes of Private, NHS and Charities

The main theme of Medical Profession (Table III – Appendix IV) arrived from three sub-categories of Private Healthcare, NHS and Charities.

4.2.1 Private Healthcare

PC1 disclosed they opted to go private, due to insurance and the ability to use trial drugs unavailable on the NHS. The analytic process revealed, however, that this carried its own burden with ensuing guilt arising from this action. PC1 felt the need to justify their decision to go private rather than with the NHS. PC1 clarified that her late husband was a big believer in the NHS and felt the need to provide explanations and reasoning for choosing private healthcare. A post interview question arose to ask why it was necessary to explain this decision away? What was the cause of the guilt/need to explain? Whose voice was at the end of the inferred criticism? This examples society's expectations, expected criticisms and potentially being seen as stepping out of the perceived class society they were in. Private medical care is for gentry/the wealthy, NHS for others.

> *…the only reason he went down the private route is because he couldn't have had this drug on the NHS, this drug that they were trialling. It wouldn't have been available, and he just wanted to try any option he could get…* [PC1-P10].

Findings identified that pursuing private medical treatment also resulted in the necessity of hiring equipment rather than it being provided by Occupational Health in the NHS.

PC2 explained that private medical treatment was also under discussion for her husband, however, post-loss discussion with a family member concluded it was already too late by the time of her husband's diagnosis. Post-interview, the researcher considered the possibility of this being a lifeline, to keep a handle on the grief and guilt of the "What-if…" and "if-only…" questions.

PT1 revealed that her client, a nurse, had changed her nursing job from the NHS to the private sector enabling to greater support her husband. When the client's husband died, her immediate return to work was expected, disregarding the impact and magnitude of her grief. PT1 called attention to the need for organisations to understand that grief persists, thus opening the argument for greater education provision for all, but especially for businesses who are financially focused.

4.2.2 NHS

It was generally accepted that the NHS is overworked/overburdened across all participants. The cancer pathway was recorded at 71% between 2015 – 2018, of meeting the 62 days referral target for gastrointestinal cancer (Haste et al., 2020), which questions the outcome for the remaining 29%. Research feedback indicated there was minimal support given at home and disjointed information (leaflets from different departments and supportive organisations were too numerous), which caused overwhelm and confusion.

> *INT: OK. So you were describing all of these leaflets heading your way.*
>
> *PC2: Yeah.*
>
> *INT: Did that feel overwhelming and confusing?*
>
> *PC2: Yeah, I picked them up and I didn't read them. ...I can tell you now that I definitely didn't read them. Yeah, ...it's almost like going back to that thing about a manual.* [PC2-P17].

Preparation by staff for upcoming death was observed by PC1 to be less compassionate than anticipated as she was being ‘prepared’ for her husband’s imminent death which initially turned out to be a false alarm due to her husband’s ‘rallying’. The ‘preparation’ was then repeated …

> *Then one of the other doctors called me in again ...had the same conversation and he had a rapid decline ...I thought, I've heard all this before, you know and I thought is this going to be another one of those things that he's gonna pick back up again, and do I get my son back over or don't I ...* [PC1-P16].

Consequent analysis brought to light suffering and trauma experienced by the nursing/medical profession, if they do become numb to death and suffering, in turn questioning how to protect them. With this foreseeable trauma in mind, it queries how much caring the medical profession can provide, if they are so numbed to the trauma experienced daily, by so many impacted individuals to include cancer victim, carer and other healthcare and services workforce members. *"I certainly remember from my own personal experience having a parent that died of cancer, that the hospital staff are so used to that happening."* [PT2-P3].

Analysis revealed both PC1 and PC2 were left exhausted by anticipatory grief and through fighting for needed answers, support and knowing how to progress to the next stage. PC1 required getting her husband home. PC2 required information on what comes next and how to look after her husband in the hospital, feeling abandoned by staff with the felt expectation of providing for his emotional and physical needs. Grief obscured their vision, disabling knowing what to ask. *"I think if I hadn't had that extra push and if the staff hadn't done what they did, he wouldn't have been home"* [PC1-P17]; *"I think, [Redacted] was drawing strength from me in his darkest days".* [PC2-P5].

With NHS staff overworked, and presumably the same questions asked on repeat by anxious carers, it raises the question as to whether staff (who are already at risk of becoming ‘numb’) no longer hear the anxious enquiries as part of the numbing process, adding to the carer’s stress/distress and overwhelmed feelings of not being heard/being ignored. PC2 was allocated a ‘go-to’ specialist nurse who was never available (one nurse for all carers). PC2 felt ignored by staff; that all discourse was with her late husband who struggled to understand what was happening. PC1’s husband was often also confused, asking his wife for clarification when they arrived home. It was suggested by PC2 that an instruction manual would have been helpful. The potential for the provision of an ‘easy-to-understand’ instruction manual as an NHS norm, could allay distress/stress experienced by patients/carers, but also provide a reprieve to medical staff. The hospital environment was discussed, how cold the environment was. “*The hospital, the ward, it’s very ... it's very cold... Whitewashed walls, doors shut into rooms. Nurses haven't got time to sit with patients and hold their hand. They just haven’t got time to do that..."* [PC2-P11].

PT2 suggested that investment by the NHS in post-death would be beneficial. The NHS was however praised by the same, for signposting that if someone dies in hospital, the funeral is paid for, where funds are unavailable. *"The hospital I can remember they were very good at telling me because he died in the hospital, they would be able to pay for a basic funeral"*. [PT2-P14].

The analytic process revealed that care stopped at the point of the cancer victim dying. This raises questions where resources are allocated (monetary and physical) with the holistic approach going unaddressed, due to day-by-day demands, thus reactive opposed to proactive management. *"The underfunded NHS is obviously ... the culture in the NHS is ... "right ok, we've reached the conclusion, your person died and there is no ... they're treating the patient not the patient's family"* [PT2-P14].

4.2.3 Charities

This analysis identified that charities are relied upon significantly by the NHS/UK infrastructure, specifically within Mental Health. Within this research, several charities supporting cancer were providing support to both PC1 and PC2 –signposted by the NHS and individual pursuance. One signpost was for wheelchair hire, another provided a place for both cancer victim and carer to become familiar with their offerings, trained staff in cancer on hand. A place to be understood by other grievers and staff, providing an eight-week course on what was happening to them.

> *"They are all trained staff. It's just a nice little safe place if there's too much going off in your head, even if you're the person with cancer and you need to go there, or the person that is suffering isn't with you and you want to go there…".* [PC1-P20].

Some charities were overwhelmed by need and found to have lengthy waiting lists for counselling, with another redefining its offerings, reducing/cancelling café mornings and one-to-one counselling concurrently with another charity offering the same support. It became apparent that supply and demand (the ability to provide the service required -v- the demand for the service) for charities is imbalanced, with the need outweighing supply. *"I phoned [Redacted] to see what they could offer. ...unfortunately, there was a waiting list with them as well."* [PC2-P9].

> *After the bereavement group had all finished for a couple of months, I felt at a bit of a loss then because … … the disadvantage with the bereavement group is once it ended, it was like, "OK, bye…", there wasn't say, "if you wanna come another week or if you wanna talk to someone ….* [PC1-P22].

PC1 found a specific charity to be a lifeline, receiving the above-mentioned support. Conversely, PC2 found the same to be unsuitable and uncomfortable for her. The notable difference observed was PC1's arrival was accompanied by her husband before he died, whereas PC2 was alone, experiencing isolation. This prompted reflection that a place for both carer and cancer victim to feel understood, and for the carer to feel at home and welcome in, is ostensibly a powerful tool in helping support the surviving carer. An alternative charity was however, a perfect fit for PC2, receiving similar offerings, described as grief training, a bereavement café and a carer who visited and listened before her counselling came into effect. PC2 investigated support from overwhelmed charities where the waiting list lengths discouraged support pursuance.

PC1 received counselling sessions from a local charity, who despite being informed of limited sessions availability, gained extra sessions enabling her to learn when she felt able to proceed with life, without additional support. *"they would reassess, and reassess you again …and then she said, "until you're ready". "well", I said, "How will I know when I'm ready?". "You'll know" [she said]."* [PC1-P23/24].

4.3 Main Theme of Those Left Behind – sub themes of Attachment, Isolation and Suicidal Ideation

The Main theme of "Those Left Behind" (Table IV - Appendix V) encompassed Attachment styles, Isolation and Suicidal Ideation.

4.3.1 Attachment

Bowlby's attachment theory (Mooney, 2010) connected to studying the whole of the human life-span used within the clinical arena (Robledo et al., 2022). This is supported by Mary Ainsworth's continuous research, including disorganised attachment into the model as showcased by Sekowski and Prigerson (2022b).

PC1 discussed her family's lack of hugging, detailing her brother's experience of their mother's inability to hug her children. Avoidance was evident in PC1's interview, however awareness was displayed in her verbalising that 'opening up' was vulnerable. Not wishing to appear vulnerable is based in previous life experiences, often stemming from previous trauma and learned behaviour from childhood, using avoidance as a coping strategy (Eggert et al., 2024), as demonstrated in her brother's experience of their mother. Vulnerability can invite judgement, hurt, victimisation, rejection, betrayal and criticism, as examples of what is avoided. These results lead to low self-esteem, detrimental to mental health. PC1 is observed acknowledging lack of disclosing her truth to avoid confrontation, thereby coping by avoiding.

> *I was talking to [sister-in-law] and she [asked] …have you got just someone you can talk to and I said I have, but I don't. I just won't; I can't. I've got this barrier that stops me opening up because I'm frightened. I'm*

> *frightened of revealing a vulnerability or a weakness and I think, well if I keep it to myself, nobody will know. So I find it very difficult to be very open with people.* [PC1-P29].

Conversely however, is the self-awareness PC1 displayed, with her willingness to express vulnerability to the researcher, previously unknown to her. The experiences of sharing with therapists/counsellors appeared to have enabled her to build her trust within the psychotherapeutic profession, expanding her inner resources. It also shows attachment style regulation, displaying the result of a strong therapeutic alliance (Bar-Sella et al., 2024).

Ability to discuss and connect was exampled in the hugging of her son and other loved ones, noting the effects of not sharing, and the importance of not carrying past trauma forward i.e. breaking the familial cycle. PC1 prioritised self-care in abundance with one therapist identifying that she was practising all the things she herself would advocate such as walking and yoga.

PC2 favoured the avoidance of being triggered, keeping herself safe, however showed feelings of abandonment by the loss of her husband and latterly by [Redacted] upon withdrawal of their services, displaying a strong emotional attachment. *"And in terms of coping with those triggers? I do find ...I try and not put me in a situation where I know I might be triggered. I avoid those situations because that helps me cope."* [PC2-P14].

Despite Janshen's (2024) null findings regarding PG and attachment styles, PC2's interview responses appeared to show disorganised attachment styles within PG (> 12 months, with visible signs of significant impairment in daily life). It was also observed in her need to be pursued by charities to support her, clinging to the charity where she felt supported and rejecting those who were not immediately available in her time of need. *"it's very much a case of we're here and you know where we are, if you need us, whereas for me, I would feel better, if they reached out to me"*. [PC2-P18].

Sekowski and Prigerson (2022b) characterised it by the absence of coherent and consistent coping mechanisms whilst coping with separation and loss. They pointed out that the child *"…is prone to dissociate in the attachment relationship"* (Sekowski and Prigerson, 2022b, p1809). Evidence is found in PC2's need to go home without her husband; to distance herself from the person she needed to hold on to. The guilt however is marked with the use of the word "selfishly…".

> *The hospital offered me to … in the later stages, but did I want to stay? … it was just so painful being with him. I just really selfishly needed to take some time away so I would come home.""* [PC2–P2].

Neither PC1 nor PC2 believed they were questioned about their early history indicating that attachment was not on the therapists' radar despite both presenting with insecure attachment within the interviews. This is an immediate indication of prolonged grief burgeoning, confirmed by Parkes (2009) who observed lasting problems in widowers and widows identified with insecure attachment. Suffering was acute, with a host of symptoms (such as isolation, loneliness, anger, anxiety, despair, somatic symptoms, guilt) unseen in securely attached peers, measuring approximately 8.6 years post-loss.

It was clarified by PT2 she would never work with a client without exploring attachment as it repeatedly shows in the therapy room, with the fear of rejection prevalent. Emphasis was placed on the therapists' need to understand what may present, to work with it. Attachment is also emphasized when clients discuss their bargaining (Corr, 2020) as clarified by PT2 to be a most painful part of the process. Loss of hope was identified as the crucial point of unresolved issues and the therapist role as identified by PT2, was to align focus on supporting clients to feel peace, concentrating on reinvigorating hope.

4.3.2 Isolation

The outset of isolation was identified by PC1 in the anticipated grief stage. An inability to share her problems and ask for advice was ascertained, because her go-to person was the one dying. Post-death, the house, which had already witnessed grief with the loss of the son moving to America, was now empty, increasing and consolidating the isolating experience.

> *It was …very difficult. …Going in the empty house. It's bad enough when my son used to fly back [to America] and my husband was there, …it sounds dramatic but I used to be …a form of grief when my son would fly back home, you know, but my husband would be there to comfort me and support me through it, but… both of them are gone.* [PC1-P19].

Despite the loss of PC1's husband, knowing his mind-set, she continued asking his advice. Her bereavement experience revealed the lack of understanding from friends and family, *"you can speak to family members, you know, friends, and they say "well I don't know how you're feeling" and you say, "no, you don't know how I'm feeling"*. [PC1-

P21] which was correlated by PC2 - *“although friends are great, they'll sit and listen to me, but they don't know, you know. Thankfully they've not been through this.”* [PC2-P12]. PC2 elaborated that despite numerous bereavements, there was no loss like spousal loss. *"I'd lost three family members before, but losing my brother and then my mom and then my dad, yes, you grieve, but this grief for my husband, it's like nothing I've ever experienced."* [PC2-P10].

PT2 further explained whilst many family members move on swiftly, others grieve, resulting in isolation.

The burden of being alone was discussed by PC2, expanding that the journey or worrying was lonely, having to build a new norm. PT1’s client spoke of her isolation in terms of no support, having nobody to talk to; identifying that 18-months post death, the expectation (societal and familial) was for her not to be sharing her struggles. This was exacerbated by pretending in everyday life that she was ok. *"So she didn't have a lot of people she could talk to…she felt …after 18 months, that she shouldn't be talking …about how she was struggling with loss. So. …quite isolated I would say".* [PT1-P6].

A systematic review conducted by Wanza et al. (2025) supported the view that health problems following bereavement, show a key factor as loneliness. It emphasised how cultural and societal norms dictate ideas of what is/is not acceptable expressions/behaviours of grief. PT2 described family members feeling isolated within the family unit by their grief. An example was presented where one parent died with the other parent moving on very quickly. The children didn’t know what to do with their grief, with no outlet with the remaining parent.

> *"a couple of people who were very young... when their parent passed away through cancer ...found themselves very isolated because the ...other parent moved on very quickly ...siblings were grieving in their way [which]... meant that they didn't know quite what to do with their grief."* [PT2-P3/4].

PT2 shared in her opinion, support at school is insufficient post-loss. Peers do not understand the impact and if it's a teenager, learning how to be part of a tribe (new group of origin) is fractured with consequential isolation (Appendix V, Table IV).

4.3.3 Suicidal Ideation

PC1 admitted that she had had suicidal thoughts picturing different plan options; that living was becoming too much and there was no point in life. Her son was her anchor, and described she couldn't put him through the trauma, leaving him with that imprint for the rest of his life. *"I have sort of thought .... Different things ... then I go to the practical side then and I think that it's not a very nice thing to do ... to my son"* [PC1-P36].

This demonstrates the importance of anchors, especially for PG sufferers. Anniversaries were revealed to be impactful, with time not being a healer to grief, demonstrated by Tonkin's Growing around Grief model (Cruse Bereavement Support, 2025). This emphasizes the importance of therapists identifying any crucial dates within a client's experience. Tonkin explains that grief doesn't change, is always present, however life grows around the grief, enabling greater management of the grief itself. Sometimes grief is closer than others. [Redacted] provided template 'plans' for when grief becomes unmanageable, conveying reminders of why to stay alive and who to contact. PC1 explained, *"you get to the point where you feel there's no hope anymore, and I had to write down a little plan to help …"*. [PC1-P32].

PC2 had no active suicidal plans but explained how ready she was for death, waiting for life to be over. Depression was clearly present. "*What I'm leaving behind will be for the benefit of others. And it's like I'm in this waiting room, waiting to go. And that's when I'll see him"* [PC2-P19].

PT2 expanded on working with suicidal clients. *"when there's one suicide, I'm always watching out for whether they're going to be the next one because quite often a suicide in a family with a young person can lead to another one quite often"* [PT2-P10].

This is backed by McDonnell et al. (2022) quoting a 65% chance for further suicide within the immediate society, also looking for joined up thinking with the deceased, which can predict another tragedy.

Upon discussing cancer victims, PT2 clarified that to die by suicide is to both escape future pain and go out on their own terms. The meaning of suicide was discussed with the client, with the summation that suicide is a result of the complete loss of hope.

Effective therapist tools for suicidal ideation were discussed with PT2. Talk of suicide in graphic detail was indicated to be an efficient technique, elaborating who and how many people would be affected, to include support services as well as family and friends.

"I always talk about suicide in graphic detail with clients who are talking about suicide, as in how difficult it is to actually do it." [PT2-P12].

How difficult it would be to enact suicide was flagged to be a powerful tool. An example of a clients' answer for not following through, was that they consider themselves to be a coward as they couldn't go through with it. A solution focused tool is used by PT2 with the use of safety nets. A Likert scale is utilised, if 0 equals 'I don't want to live another minute' and 10 equals 'as happy as could be', where do you stand on the scale right now. If one was used, it would be used as a springboard, celebrating it not being a 0, with potential to work towards.

The worst scenario was discussed, regarding clients considered by the therapist to still be in danger of dying by suicide. PT2 described a client where therapy hadn't ended, with the client failing to return to her care. There was no further action to be taken such as home visits or phone calls, as return to therapy needs to be by the clients' own agency. PT2 looked sad, biting/licking her lips, holding her hands in front of her. When saying,

> *I can remember one client who I've still felt concern for, when they didn't finish therapy; they just stopped coming. ... I had an inkling they may be about to stop coming and had discussed with them. I know that they had other areas they could go to, therapeutic relationship was good and strong, just their relationship with themselves.* [PT2-P13],

her body moved in response to her memory. Fidgeting with rings was noted when mentioning other sources of support, and although the complete interview was spoken clearly and concisely, this part was even more pronounced.

This client's memory still had a powerful impact. It emphasises the importance of self-care for therapists going forward such as seeking supervision and personal therapy. This burden can have a detrimental effect going forward, bringing up emotions within the therapist as indicated with the body movement and ring fidgeting, in this instance.

4.4 Main Theme of Personal Therapy – sub themes of Personal Experience, Therapeutic Alliance and the Impact on Therapist

The Main theme of Personal Therapy (Table V – Appendix VI) resulted from sub themes of Personal Experience, Therapeutic Alliance and the Impact on Therapist.

4.4.1 Personal Experience

[Redacted] provided PC1 with approximately 10 counselling sessions (although normally limited to 6-8 sessions), received approximately 9 months post her husband's death. She found improvement was always small, but it was there, and she did feel better for it, even when not feeling engaged.

> *I heard about [Redacted] ... I'd think Oh I'm not going this week, I can't be bothered, or what's the point you know? And then ... like I said, I'd come out and I'd always feel that tiny bit better. ...I'd always feel it you know, feeling more positive coming out of there than going in.* [PC1-P22].

PC2 had 6-7 sessions privately before gaining [Redacted] charity support. PT1 confirmed working with [Redacted], she provided approximately 14 sessions with her client. As a private practitioner, PT2 supplied as many sessions as the client desired. It is interesting to find that sessions took place after a certain time period had elapsed as opposed to immediately post-loss. Further studies on the impact of this could be enlightening.

Both PC1 and PC2 observed no mental health toolbox was created with/by the therapist; in contrast however PT1 confirmed breathing and grounding exercises were taught and PT2 described the importance of providing clients with psycho-education for normalisation of their situation. This is backed by Simonsen and Cooper (2015) who studied helpful practices for bereaved clients. These were identified as the independence of having a counsellor, counsellor's active listening skills, the non-directive stance of counselling enabling client led sessions, the challenging of unhelpful thinking and psycho-education normalising the bereavement experience. This study confirms their findings. It was however also noted by Simonsen and Cooper (2015) that although non-directive stances were found to be positive, directive counselling was found to help them find hope and integration.

PC2 experienced several individuals simply providing active listening skills enabled her to talk. Counselling was described to be a new experience therefore expectations were unknown.

There were issues with an employer's inability to understand how grief works. PC2 received support in how to handle said employer's immediate return expectations from her therapist. Other benefits noted by participants included enabling clients to get out of their homes to see the therapist, facilitated to be authentic and dig deep, embracing the ethos of therapy and incremental positive changes. One reason for personal therapy presented by PT1, was to provide understanding of what their children would be facing as they were also going into therapy. *"...she was quite keen to understand a bit more about how therapy works in that way. Because of her children going through it"* [PT1-P11].

PT2 clarified that often-times people who have suffered the loss of a loved one by cancer, bring other things to the therapy room, dropping in old grief as an addition. This was like PG walking into the therapy room, with clients not attributing feelings to their grief. It was noted that the expectation of cancer resulting in death, lessens clients' grief expectations, however permission for grief seemed to be of note. PT2 observed that when she asked the client the form of loss (what type of cancer for example), it enabled the client to acknowledge the loss, having observed that they had never been asked that before.

> *The cancer comes up. And it often surprises me that that's not something that comes to the fore, that it's something that's pushed ...And that it takes a little bit of discussion before the details of that will come forward.* [PT2-P2].

The impact of societal dictations impacts people's abilities to grieve. In explanation, PT2 said,

> *...It’s not okay to be angry. In particular when a whole family unit have had that same loss. And there can be a lot of falling out. Quite often if it’s a matriarch that’s passed away, there can be a lot of falling out within the family.* [PT2-P5].

Clients’ expectations can differ. As can therapists’. PT2’s expectation is to provide clients with having their own autonomy, providing them with the means of meeting their own needs.

Focus assumed the carer would be an adult, however PT2 introduced the reality of a minor being the designated carer of a single parent cancer victim. This can have an enormous effect, especially considering tribal growth and the needs of teenagers’ development becoming stunted and isolation becoming a primary setting. *"Sometimes it's a single parent with a child caring for them towards the end; a teenage child. Designated carer"* [PT2-P9].

> *...especially the teenagers, at a time when they are meant to be integrating with their peers more than their family; they're in that transitional tribal bit, around 14 onwards they can feel totally isolated which sets up a pattern of them not feeling confident with making new relationships, and that can have a huge impact.* [PT2-P9].

4.4.2 Therapeutic Alliance

PC1 described the first session with any therapist to be uncomfortable due to both parties being an unknown quantity. *"It’s uncomfortable the first time because you’re opening up* *to a complete stranger, ... But once you get, ...through the first one... going forward you're OK."* [PC1-P23/24].

It is providing an opportunity for a relationship to be built. PT1 enlarged upon its value, categorising trust, safety, comfort, acceptance and the ability for the client to have no filter on what was being said. PT1 pointed out that personal therapy enables clients to share their truths, describing her client as experiencing a difficult situation where therapy was the only place to verbalise her situation. This need, amply demonstrates the necessity for therapy within society, without which, PT1's client would have had to shoulder alone, consequently increasing the risk of greater mental health issues.

> *...it's the therapeutic alliance, ...that's what really matters and we were able to form one, where there was trust and a safety and a comfort where she could speak and she could talk openly and that was accepted and that was the really important thing, that she was able to talk about these things that she hadn't spoken about with anyone else.* [PT1-P8].

Schecter, Goldblatt and Malsberger (2013) wrote a paper called "The therapeutic alliance and suicide: when words are not enough". The therapeutic alliance was described as a relational experience between therapist and client. Delving deeper, responsibilities of the therapist were outlined, sharing how uncertainty was a strong part of the relationship each time the client left, how ruptures could affect both client and therapist, affecting strong feelings and fluctuating between suicide risk assessment and empathic listening. It also fell to the therapist for continuous awareness of the clients' safety and attachments during sessions, endlessly observing. It emphasised the importance of the emotional bond built by the therapeutic alliance, with clear agreement on tasks and goals to be worked on together.

4.4.3 Impact on the Therapist

The previous paragraph focused on Schecter, Goldblatt and Malsberger's (2013) work, highlighting the impact on the therapist of working with suicidal clients. PC1 indicated that one of her therapists expressed admiration of her putting into practice her own unspoken recommendations, namely walking, yoga, mindfulness etc. PT1 shared the impact of death and grief resulted in wanting to live a fuller life, that time is precious, and self-care becomes a vital part of life.

Triggering was discussed, with PT1 not having any relatable experience. PT2 however raised her own personal losses as growing awareness. When this occurs, she takes it to therapy, reflects, journals and is gentle with herself for the next few days. It was evident that witnessing the lived experience of clients, for therapists, personally impacted both the outlook on future experiences and the understanding of their own needs for providing opportunities for self-care.

> *…thinking about death and ..about what can happen …actually then gives you a different perspective. You come to an acceptance of it, and then you can see … you want to live more fulfilled in the moment when you live …and… think like that. So it changes your perception…. And people like her have been instrumental in changing my thinking about it.* [PT1-P7].

Transference was addressed, with PT2 suggesting that therapists need to be vigilant, being aware of their own parts and working on their own grief.

> *I've had personal losses …it does bring up an awareness for me …if there's anything new there then that's something I'll take to therapy because there are different layers to it... I'll go to therapy …if there's something that comes up …I'm aware of that sense of feeling[s] being revisited, then I'll give myself a bit of time afterwards [for reflection].... I might write in my own journal and I'll be a bit gentle with myself for the rest of that day or two.* [PT2-P4].

The way businesses operate with their expectations of return-to-work post-bereavement, has a negative impact. Training is required for understanding the process, providing autonomy for the client to understand their own needs and expectations.

Chapter 5. Discussion and Conclusion

5.1 Discussion

After presenting an analysis of the interviews with findings, this chapter discusses findings, putting forward recommendations for the individual, profession, and further research opportunities.

Lessons were concluded by the outcome of this research, both individual and professional. Limitations of the research became evident and paths for further research developed.

5.1.1 The Individual Lessons

The loss of hope is arguably one of the most powerful keys to winning the battle with suicidal ideation and eventual suicide. A therapist's journey is to keep hope burning for both parties, as suicidality also impacts the therapist. This concurs with previous research by Chang et al. (2018) backed by Hirsch et al. (2012) who ascertained the higher the level of hope, the lower the levels of suicidal ideation and actualisation.

Always be wholly present and aware of the client, staying attuned to unspoken needs demonstrated by certain phrases, how the body is held, how their attachment styles present within the therapy arena. This is reinforced by previous research into attachment styles, psychotherapy and clinical interventions (Geller and Farber, 2015), finding the maintenance of internal working models of attachment is supported by therapists benefitting from an empirical understanding of a client's needs rather than simply theoretical.

If suicidal ideation is present, be aware of the need to once again be vigilant between the clients' need for empathy and safeguarding. This supports the proposal of Schecter, Goldblatt and Malsberger (2013) who discussed the need for flexibility between empathic listening with ongoing risk assessments for suicide.

The impact of the basic principles of being person-centred is powerful. Meeting the conditions of Roger's Core Conditions (McLeod, 2025b) is very influential and can often be enough.

5.1.2 Lessons for the profession

A greater investment to the mental health service would be to provide talking therapy for clients, as earlier research by Iacobucci (2006) also suggests. To delve into and understand emotions and actions, rather than simply creating action plans. This empowers the client to take back their own power, provide understanding and compassion for their own path, in turn enabling more positive and informed choices. It provides clarity to see where society and the client's own upbringings have impacted life choices and support them on their own path to self-actualisation (McLeod, 2025a). This path encourages a hope for the future, which both past (Kim et al., 2020; O'Dwyer et al., 2021; O'Rourke, 2022) and this research agrees is a suicide-reducing factor.

A link between attachment styles and bereavement was evidenced by Ribera-Asensi, Valeri-Moreno and Pérez-Marín (2024). However, current research disclosed awareness of attachment styles in clients has not been a key observation for all therapists when counselling the bereaved. The learnings and consequent help provided to clients by initial observation provides the therapist with direction and consequent focus for supporting clients to achieve peace and reclaim hope. Therapists would benefit from the inclusion of grief and bereavement as part of the educational path to initial qualification and a core continuous professional development element for all.

Research has been ongoing, and an overhaul/review of research already conducted, provides proof of a continuous demand for services to be updated and preventative methods to be implemented. Wen et al. (2024), focused on bereaved individuals from an ICU perspective. Findings included greater suicidal ideation, poorer quality of life, impaired mental health functioning and overall vulnerability, with intense deterioration. Marriage (loss of a spouse/partner) was found to be a significant connection to decreased recovery likelihood. Clinicians were urged to identify family members who are at risk (giving examples of younger, unmarried, older and those who have lost/are losing their spouse), and providing psychological support, but also advising primary care providers to have high anxiety, bereaved individuals on their radar, to provide the required support. This research emphasised the importance of a coherent, communicative mental health network of professionals to be able to provide a proactive service.

Educating society on grief and bereavement would benefit all (starting at school level). Key focus on educating employers of the intricacies and presentation of grief needs implementation, to enable the provision of beneficial support, managing management's expectations of their own staff. Businesses, as presented by this research, can have negative impacts with their expectations of return-to-work post-bereavement, resulting in staff loss. Training is required to understand the process, providing autonomy to further understanding of clients' needs and expectations of themselves.

The BACP advocate reflectivity, and careerlong personal and professional development (BACP, 2025). Therapists need to be vigilant with their own transference and work on their own grief enabling clients to benefit from their therapist's experience.

5.1.3 Limitations

As research progressed, certain pitfalls became evident in questions asked within the interview, which could have been termed as leading and/or over-empathic. It was also noted that despite being provided with Interview Schedules, displaying topics to be covered, not all interviewees paid full attention to what would be addressed. This did however lead to interesting angles being pursued. The researcher's own bias became evident in the questioning and answering, especially with both qualified therapists, and research myopia was observed during the interviews. Due to this, conversely, opportunities arose for learning and a widening of the research capacity. This observation was backed by MacMahon (2020) who conducted IPA research into researcher's experiences of their own blindspots. Three identified themes discovered that unacknowledged shame impacts a therapist's ability to provide emotional responsiveness towards their clients and is a source of therapeutic ruptures.

The narrow field of participants (to include gender, age and ethnic background), difficulties in accessing this participant group, and time restrictions could potentially have impacted outcomes.

5.1.4 Further Research

Research highlighted further research recommendations. There is currently inadequate focus and research on the connection between PG and suicide with inadequate service provision. What is needed? Is it changing with societal changes? There is a need to understand the death toll and impact of PGD on current suicidal statistics to inform policy decisions/changes. Therapists need a deeper understanding of their weight of responsibility carried within the therapeutic alliance. An expanded study with increased participants to develop the grief experience between therapist and client and the impact of death on caregivers, researching what could be put into place to support caregivers from the day of diagnosis, continuously through until >12 months to observe if PGD develops.

Further areas of research surfaced such as adolescent primary caregivers' needs in single parent families, caregivers experience to inform evidence-based policy, the impact of PGD on suicidal statistics to inform the cost both to life and the economy and longitudinal studies across different cultures.

The unfolding research themes within this study were Pre-Death, The Medical Profession (to include Allied Health Professionals), Those Left Behind and Personal Therapy. Linking findings from both the literature review and research, it has become evident that there is a greater requirement for continued research within this scope of study.

Prolonged Grief is now officially identified as a disorder (Eisma et al., 2023) yet current research implies that awareness needs increasing to identify potential suicide around the field of caregivers within cancer (Frumkin et al., 2021; Molina et al., 2019; O'Dwyer et al., 2021; Sekowski and Prigerson, 2021, 2022a, 2022b). These interviews identified Kübler-Ross's (2009) 'five stages of grief' presence in both cancer victim and carer pre-death as precursors for PGD. O'Dwyer et al. (2021) confirms that unpaid carers provide a considerable contribution globally within healthcare, therefore the economic cost of caregivers to suicide is considerable, covering both savings of unpaid salaries and suicide itself to the state in general (Samaritans and McDaid, 2024). This in turn identifies an area for greater investment in money, time and resources.

Within the medical profession, research identified healthcare provision changes from district to district. The NHS is overwhelmed with great need, versus inadequate resources of money and staff (British Medical Association, 2025), having a disabling effect on support provision by staff. NHS England (2024) proactively developed Integrated Care Systems (ICS) to combat this. The purpose was to combine the strengths of services across sectors to include the fire service, colleges, NHS, Local Government. The focus provided a holistic approach to pro-actively ensure people "most at risk" were never left wanting. This planning however, seems to have disconnected with actual life experiences. Consequently, charities who are heavily relied upon by the NHS as evidenced by this research, are in their turn overwhelmed, capable of providing limited care, having to manage boundaries. This in turn creates a feeling of abandonment within those they care for as indicated by both PC1 and PC2 in this study.

Taking it one step further, this research evidences that attachment styles do count when looking at PGD (with the codicil that all interview participants were British Nationals), as supported by current studies (Stone et al., 2024; Waskowic and Chartier, 2003), in contrast to research by Janshen et al. (2024). Bjerre et al. (2023) does however provide a cautionary note around using attachment styles, especially when used by professionals whose understanding of attachment is limited (social workers for example), highlighting how cultural differences impact the efficacy of the theory itself. With PC2's potential disorganised attachment style in mind, those necessary (due to financial and manpower issues?) boundaries implemented by healthcare professionals are continuously impacting people's quality of life. In the case of PC2, suicide wasn't a solution, however the potential is there for others in the same situation, to be drawn to suicide, with the loss of hope experienced and expressed.

Isolation was identified as a key component for caregivers both pre and post death; Social isolation was highlighted by O'Dwyer (2021), isolation created by attachment styles emphasised by Waskowic and Chartier (2003) and within this study (Appendix V – Table IV) both PC1 and PC2 indicated their need to have the opportunity to meet other likeminded/like-experienced individuals which signifies the importance of having places to meet in person. Financial implications are identified and as indicated in this study, charities are making decisions to close these avenues of care. Individuals can arguably re-create coffee-clubs by organising them personally, however not everybody is capable/inclined to do so. Isolation however, comes under different guises. Both clients indicated how their lives had been dramatically altered by loss, and they underscored how families and friends couldn't possibly understand the depth and savagery of the pain felt/experienced. It was emphasised people around them often didn't understand how to act/react around them and awkward conversations ensued, with sometimes very painful and insensitive comments issuing (resulting in further loss of friendships/relationships), or the subject of the lost one being avoided as if the deceased had never existed. Both behaviours are painful for the recipient. Evidence indicates that this is due to the lack of normalising grief (as indicated by observing Western Culture).

Suicidal Ideation (SI) exhibited as a continuous crisis which supports current literature and the findings of this research. O'Dwyer et al. (2021) reported SI leading up to 71% in caregivers, to include plans made, which is not easily dismissed. A core link was found between bereavement and SI (Molina et al., 2019) backed up and enlarged upon by

Sekowski and Prigerson (2022a) clarifying PGD and SI to be partners. Abbott et al. (2013; 2014) found that caregivers who witnessed their loved ones' suffering, was a powerful indicator of SI, with a strong possibility of resultant suicide. PC1 experienced suicidal ideation, to the point of visualising different methods (despite her son acting as an anchor), and PC2, although claiming she would never pursue suicide, made it clear that she is waiting for life to be over. In the case of PC1, hope appeared lost, but her son provided a light to aim towards. With PC2, the light proved diminished with life being lived in order for it to be over. An interviewee suggested the necessity of having effective tools/training for therapists to deal with this. With all the evidence shown in this study, this action is highly advised.

The impact of Personal Therapy (PT), although not necessarily immediate, can be powerful. Research (Appendix VI - Table V) found that therapists providing a mental health toolbox enabled clients to actively engage in their own recovery. PT2 clarified that Psycho-education was shown to normalise experience providing the opportunity to engage in therapy whilst Simonsen and Cooper (2015) confirmed that listening skills was a helpful practice with bereaved clients. Both PC1 and PC2 attested to this. PT1 and PT2 were able to dig deeper and find connections requiring healing. It provided the opportunity for authentic truths to be spoken in a safe environment, as emphasised by PT1. This was also identified as a strengthener to the creation of a healthy therapeutic alliance, especially required by those with suicidal ideation (Schechter, Goldblatt and Malsberger, 2013), describing the therapeutic alliance as a relational experience between both therapist and client.

PT1 and PT2 indicated working with bereaved clients emphasised that life increased its value; that clients provided continuous lessons, to be careful with respect to transference and have a continuous process of self-care to continue supporting clients.

5.2 Conclusion

In answer to the research question of "How can suicide from prolonged grief for family members/caregivers of cancer victims be identified earlier and treated successfully?", numerous factors need addressing.

Grief needs to be normalised within society and the sub-groups within. Enabling speech around death and the deceased brings healing for both griever and community, reducing stigma and taboo subjects, providing freedom to grieve as and when the need arises. Primary care/NHS mental health specialists would be advised to have primary carers on their radars from initial diagnosis until approximately 18 months post loss, to ascertain if PGD is a presenting factor. If it is, a forward plan needs implementing to prevent PGD turning into suicidal ideation and potentially suicide itself. The mind and the body require to be viewed with equal importance within society, an example being a broken leg to be deemed acceptable and taken more seriously than a mental health issue for work absence, gaining a more structured return-to-work approach. This approach is also advised to be introduced into education at a young age which will consequently turn into employing organisations. Included under this umbrella, bereavement leave is an important factor for current organisations to harness, as grief, as identified throughout this research, is disabling, often with a physically negative and incapacitating reaction.

Education in grief/bereavement/PGD needs to be a part of the general mental health education curriculum to be able to recognise and diagnose at earlier intervals, enabling proactive action, to help fight this overwhelming and unattended need.

Isolation is clearly a factor and a proactive way for grieving people to come together, would be the creation of community coffee clubs as currently created by charities but which are sadly disintegrating due to lack of funds.

Therapists require a greater awareness of the impact of attachment styles and be actively vigilant, especially in cases of cancer victims and their carers.

Hawkes (2014) illustrated how continuous information flow is an ongoing battle, with the article written in the British Medical Journal, outlining how campaigners won the right to retain UK stats for the General Lifestyle Report, due to the Office for National Statistics planning to eliminate this due to financial constraints. MacMillan Cancer Support were vocal in their support of its validity, describing the UK in a catch-up situation with its European counterparts, to increase cancer survival rates.

Several surprises arose from this research. Both active therapists seemed to have opposing views of the value and consequence of ascertaining a clients' attachment style within the grieving process. Suicidal ideation begins with weariness of life and not wanting its continuation, even if there are no and never will be, any wishes and/or plans to create and implement suicidal plans. Despite the level of pain felt, life can be tenacious tightening its hold, despite when life is deemed unbearable. This field of study seems to have seen a sudden increase in research/literature which is promising, due to awareness rising.

With the above literature reviewed and qualitative research analysed and appraised, future pathways have been identified as a result driven and practical approach from this research. The research question has been unquestionably answered, accomplishing what it set out to do. Resolution has been identified with the ability to recognise and diagnose at earlier intervals, enabling proactive action to help this overwhelming and unattended mental health war. There is a clear need for an overhaul of services recognised and offered, both nationally and globally.

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Appendices

I) Advert

II) Participants Documentation

  a. Consent Form

  b. Covering Letter

  c. Interview Schedule (Topics)

  d. Research Interview Letter

  e. Debriefing/Feedback form

III) Table II – Pre-Death GETs

IV) Table III – Medical Profession GETs

V) Table IV – Those Left Behind GETs

VI) Table V – Personal Therapy GETs

Appendix II – Research Documentation

Appendix II.i – Covering Letter

Date: 05 February 2025

Title of Study:

The identification of prolonged grief in unofficial carers whose loved ones have died by cancer pulling out the new growth roots before it takes a stronghold and causes potential suicide.

You are invited to take part in a research study to explore suicidal ideation in prolonged grief, in an effort to identify carers whose suffering could be supported pre and post loss, how it presents, what the red flags are and what shape that support would look like.

Before you decide whether you wish to participate, it is important that you understand why the research is being undertaken and what it entails. You should therefore read the attached information carefully and discuss it with others if you wish.

This MA research is supervised by Dr Beverly Cole [UWTSD] and has been approved by the university's Research Ethics Committee. The research is bound by the ethical guidelines of the British Psychological Society and the British Association for Counselling and Psychology and it is hoped that this research will enhance understanding of suicidality in prolonged grief.

Taking part in this study is voluntary and the attached information should clarify any questions you may have. If you still have concerns, please feel free to contact me using the contact details given in the information sheet.

Thank you for taking the time to read this information.

Name and contact details of Student:
Deborah Wilson 07XXX 4XXXXX

Name and contact details of Supervisor:
Dr Beverly Cole 01792 XXXXXX xXXXX beverly.cole@uwtsd.ac.uk

Appendix II.ii – Consent Form

Consent Form: **Research Project:** ***The identification of prolonged grief in unofficial carers whose loved ones have died by cancer pulling out the new growth roots before it takes a stronghold and causes potential suicide.***

Please read this form carefully, initialling each box to indicate agreement as appropriate. In the unlikely event that an interview participant discloses information about any form of potential or actual illegal activity then this will be disclosed to the appropriate authorities.

Initials

	I have read and I understand the information provided about this research, I have a copy of the information sheet for future reference [dated ______] and I have no reservations regarding content.
	I have had the opportunity to consider the information and ask questions. I have had these answered satisfactorily and I understand that there will be a further opportunity to address any questions at the end of the research period, just prior to the point where I am able to withdraw.
	I have a telephone number and an e-mail address for the researcher, and contact details of the main project supervisor should I have any concerns.
	I understand that if e-mail is the mode of communication, data will be exchanged, stored and retrieved, electronically. If MS Teams is used, I understand that any and all information is protected by GDPR, that both video and audible will be automatically recorded and that the data will be classed as highly restricted. I also understand that actual quotations from my contributions may be used to support the research. (Privacy terms provided on this link) https://learn.microsoft.com/en-us/microsoftteams/privacy/location-of-data-in-teams. My involvement in the study will be confidential. Findings may be the subject of journal articles/conference presentations and/or any other related educational or research work. Data collected will be destroyed once the research project is finalised and the degree is awarded.
	I understand that I can refuse to answer any particular question, and can withdraw from this study at any time up to the designated cut-off point, without giving any reason. If I do so, data collected relating to me will be destroyed and not used in the study.
	I consent to participate in a MS Teams / face-to-face interview and to this being recorded.

Signature:________________________ Date: _______________ Tel No: ________________

Print Name:______________________________ Email:_____________________________

Postal
Address:____

____
___

If you return this form via email, you may be able to sign it electronically. If this is not the case, please note that **receipt of this form via your email address will be taken as informed consent.**

Appendix II.iii – Interview Schedule

The identification of prolonged grief in unofficial carers whose loved ones have died by cancer pulling out the new growth roots before it takes a stronghold and causes potential suicide

Date: Time of Interview: Start: Finish:

Venue/Mode of

Interview:

Interview with participant [_______________] recorded on [________________]

The purpose of this study is to identify prolonged grief in unofficial carers at the earliest opportunity to provide the support required, in order to prevent suicidal ideation taking hold and eventually eliminate people dying by suicide through neglect and lack of understanding.

The research will take place via interviews, either in person face-to-face or online face-to-face via Teams. The interviews will be recorded both visually and auditory. The interviewee will be provided with a copy of the information sheet and asked to sign the consent form. They will have the option of withdrawing at any time during the interview and up to 1 month after data collection.

Topic 1:	Describe your own experience of loss
Topic 2:	What went well with your therapy/counselling/post-loss experience
Topic 3:	What needs were not met
Topic 4:	What could have helped you
Topic 5:	What makes/made you wish to end it all
Topic 6:	What message/lessons (if any) do you want people (both professional and general) to hear

[we have a little time left] is there anything you would like to add? [please use this time to continue until you have discussed your thoughts and feelings as completely as possible]

Appendix II.iv – Research Interview Letter

You will have received an invitation to take part in a research interview and the following information will explain this process to you. Boundaries will be maintained in a similar format to counselling relationships, with open ended, general questions asked which identify and explore your view and perceptions. Discussion will flow from these and all interviews will be recorded and transcribed.

After transcription and processing interview notes, a copy of the transcript of your interview will be returned to you [unless you indicate that you do not want sight of these]. You will be asked to check the content, censor anything you are not happy to be included and to confirm that your meaning remains intact.

Format for the interviews will be as follows:

Interviews will be relaxed and open in nature and will be conducted on MS Teams/Face-to-face at a time most convenient for us both;

Interviews will last for approximately one hour and will take the form of a one-to-one conversation. If at any time you wish to draw the interview to a close you will be able to do so without giving a reason. No data supplied by you will then be used;

You will be reminded at the start of the interview of the consent form you signed and returned [attached], the anonymity of information shared, the fact that the interview is being recorded and that the interview and participation in the study can be terminated at any time up to the cut-off point of one month after the date of the interview.

Although the interview will be recorded, the interviewer will take notes of the most relevant points. Only the researcher will hear the recording and have sight of the notes; recorded and written material will be kept securely and destroyed once research is complete. Involvement in the study will be confidential, data collected will be made anonymous and no comment or circumstance which could be directly connected to any participant, or person named in the research will be identifiable;

Topics for discussion are provided on the interview schedule which is also attached. These will give some structure to the interview; however the interview will be 'participant led' and go where you lead; you will not have to answer any questions which you feel could be too stressful for you to reflect upon.

The interview will close with the researcher thanking you for your time and participation, and reminding you of the procedures should you feel distressed by taking part or have any concerns about the conduct or process of the research. You will be reminded that a copy of the interview transcript will be sent to you along with a copy of the signed consent form for your records [you can decide at this time whether you want to receive these].

There will be a short 'cool down', or debriefing period immediately following the interview where you will have the opportunity to reflect upon and discuss the research process.

Appendix II.v– Debriefing Form

DEBRIEFING/FEEDBACK FORM

How to identify prolonged grief in unofficial carers whose loved ones have died by cancer, pulling out the new growth roots before it takes a stronghold and causes potential suicide

Date:

Thank you for participating in this study. Your time and effort are appreciated.

This research is exploring the reality of prolonged grief with unofficial carers, identifying it early on to prevent suicidal ideation/action. This is important in that the ability to identify and support individuals considering dying by suicide to date has been under-researched and under-represented within academic literature. Also by taking part in this study you have contributed to the growing body of knowledge concerning this important step forward in providing active and timely support where it is desperately needed. You are reminded, however, that you still have the right to withdraw at this point. Should you decide to do so, you will not have to give any reason and collected data will not be used and will be destroyed.

You will be aware that this study has received ethics approval from the UWTSD Research Ethics Committee and if you have any questions or concerns about your participation in this study, you can contact Dr Beverly Cole by telephone on x2031 or by email at beverly.cole@uwtsd.ac.uk

This study focuses on issues which can invoke emotionally sensitive reflection, and sometimes the process of reflection can prove to be disturbing. If answering any of these questions led you to feel distress and if you would like to speak to someone about your thoughts, arrangements can be made for you to be provided with a list of helpful organisations so that you can talk about any aspects of the research which has caused you distress. Should this be the case, you will need to contact the researcher within seven days of the date of this form.

If you would like to learn more about >>>>>>>> you will find some excellent Information Sheets on the .... Website, or within the following material:-

Appendix III – Table II Pre-Death

Pre-Death **Cancer Victim's Attitude**
Denial
The beginning of the reality hitting. PC1 - P12 *"we had an appointment in [Redacted], with the palliative care nurse and it just brought it home really, these people saying it out loud that it's the end of your life and which way do you want to go, and he was like, "Oh! Oh!" you know, saying it out loud, it's a different thing to thinking it, you know. When someone else says it out loud, it's real, this is happening you know! It's not gonna go away you know. So it was quite hard for us both to attend those, you know."*
Anger
Kübler-Ross Five Stage Grief Model - Anger. PT1 -P2 *"And that's what always stuck with me. Was the anger. And that's with her as well. That's what she struggled with. He was angry at his diagnosis. He was angry at everything."*
Bargaining
What attachment style is prevalent? PT2-P6 *"somebody who's got a relatively secure attachment is going to grieve still and find it very painful because that secure attachment they've had to the person has been taken out of their control. But they're going to be able to regulate their own emotions around it. It doesn't mean they're not aware that it's painful for them and that they've got a big loss there.* *But somebody who's very insecure especially somebody who's going to fear rejection of any kind is going to find loss excruciating and that bargaining process in particular is going to be excruciating because it's what if, there's going to be all the guilt stuff in there too and was it my fault, could I have done things differently and also if they have an insecure attachment that means they don't hold accountability very well."*
Depression
Cancer Victim dying from suicide. PT2 - P11 *"it can be that somebody knows they're going to die and doesn't want to die painfully from cancer, and so they'll end their life"*
Acceptance
Husband's decision to die. PC2 - P3 *"The nurses told me that he'd taken his oxygen mask off."*
Husband decided to go out on his own terms. PC2 - P2 *"[Redacted], I think, had had time to get used to the idea that he wasn't going to live. And therefore, he stopped the chemotherapy "*
Feelings of Inadequacy/Guilt

Husband supporting her, giving her value PC1 - P4 *"I sort of underestimated that aspect you know, just me being there was enough. I just felt useless, you know. I thought I'm not doing anything, you know. He tried to say that just you being here is enough,"*
No knowledge of what was to come. PC2 - P2 *"not having gone through this before, you know, you put yourself in the hands of the experts. And so I felt quite useless really"*
Putting her needs first - guilt. PC2 - P2 *"The hospital offered me to ... it was ... in the later stages, but did I want to stay? ... it was just so painful being with him. I just really selfishly needed to take some time away so I would come home."*
Fear
Anticipatory Grief. PC2 - P4 *"From when we got told that the chemo wasn't working. I think for me it's that, you know, anticipatory grief"*
Emotions experienced near the end, all connected with grief. PC2 - P5 *"There was grief. There was anger, there was upset. I was scared"*

Appendix IV – Table III Medical Profession

Personal Therapy
Personal Experience
Therapeutic Alliance
Impact on Therapist

Personal Experience
Further support from another Cancer Specialist Gp. PC1 - P22 *"I heard about [Redacted] ... they've got counsellors working upstairs and ... you can get 6 or 8 appointments, ... Sometimes I'd think Oh I'm not going this week, I can't be bothered, or what's the point you know? And then Come on, just go and like I said, I'd come out and I'd always feel that tiny bit better. Only a tiny bit, but I'd always feel it you know, feeling more positive coming out of there than going in."*
Reasons for personal therapy. PT1 - P11 *"she was quite keen to understand a bit more about how therapy works in that way. Because of her children going through it"*
Often times the cancer isn't the 'supposed' reason for attendance in therapy. PT2 - P2 *"the cancer comes up. And it often surprises me that that's not something that comes to the fore, that it's something that's pushed ...And that it takes a little bit of discussion before the details of that will come forward."*
Societal dictations impact people's abilities to grieve. PT2-P5 *"It's not okay to be angry. In particular when a whole family unit have had that same loss. And there can be a lot of falling out. Quite often if it's a matriarch that's passed away, there can be a lot of falling out within the family."*
The main carer can often not be an adult. PT2-P9 *"Sometimes it's a single parent with a child caring for them towards the end; a teenage child. Designated carer"*
Tribal needs as children/teenager impacted by grief. PT2-P9 *"I don't think we do enough to support children at school when they've had a loss. If it's a brother or sister or a parent, the other children being told how to help somebody who's had a loss like that, so often they can feel isolated at a time when they're meant to be, especially the teenagers, ...integrating with their peers more than their family; they're in that transitional tribal bit, around 14 onwards they can feel totally isolated which sets up a pattern of them not feeling confident with making new relationships, and that can have a huge impact. Their group of origin, their family have been scattered and had a loss and they feel isolated within that group"*
Therapeutic Alliance
Being introduced and creating the therapeutic alliance. PC1 - P23/24 *"It's uncomfortable the first time because you're opening up to a complete stranger, you know. But once you get, you know, through the first one, it's ok then, going forward you're OK."*

The value of the Therapeutic Alliance. PT1 - P8 *"it's the therapeutic alliance, the therapeutic relationship, that's what really matters and we were able to form one, where there was trust and a safety and a comfort where she could speak and she could talk openly and that was accepted and that was the really important thing, that she was able to talk about these things that she hadn't spoken about with anyone else."*
Impact on the Therapist
Lessons for the therapist. PT1 - P7 *"thinking about death and thinking about what can happen and all of these things actually then gives you a different perspective. You come to an acceptance of it, and then you can see ... you want to live more fulfilled in the moment when you live like that and you think like that. So it changes your perception, I would say. And people like her have been instrumental in changing my thinking about it."*
Triggering potentials and what is done. PT2-P4 *"INT: (15:22) So any of these losses, has it ever triggered anything in yourself?* *PT2: (15:28) Oh yeah definitely. Definitely because I've had personal losses and so yeah it does bring up an awareness for me ... and if there's anything new there then that's something I'll take to therapy because there are different layers to it... Afterwards I'll go to therapy myself if there's something that comes up. If it doesn't feel like ...new ...just ...I'm aware of that sense of feeling being revisited then I'll give myself a bit of time afterwards [for reflection]... I might write in my own journal and I'll be a bit gentle with myself for the rest of that day or two."*

Appendix V – Table IV Those Left Behind

Those Left Behind
Attachment
Isolation
Suicidal Ideation

Attachment
Opening up is vulnerable. [Avoidant style attachment?] PC1 - P29 *"I was talking to [Sister-in-Law] and she was saying have you got anybody to talk to when you get really, really … have you got just someone you can talk to and I said I have, but I don't. I just won't; I can't. I've got this barrier that stops me opening up because I'm frightened. I'm frightened of revealing a vulnerability or a weakness and I think, well if I keep it to myself, nobody will know. So I find it very difficult to be very open with people."*
Avoiding being triggered, trying to keep herself safe. Avoidant style? PC2 - P14 *"And in terms of coping with those triggers? I do find that I can … I try and not put me in a situation where I know I might be triggered. I avoid those situations because that helps me cope."*
Feelings of abandonment (grief and/or anxious attachment) by/to [Redacted] PC2 - P18 *"it's very much a case of we're here and you know where we are, if you need us, whereas for me, I would feel better, if they reached out to me, you know, and,* *INT: So proactive contact.* *PC2: yeah. And just kept that contact with you so that you didn't feel as though, I hate to say the word abandoned because I don't. You know, I can't speak highly enough of Saint Gemma's, but it's very much that 18 months is the deadline. The cut off point. And that's it. from beyond.* *INT: So you do feel abandoned?* *PC2:   To a certain extent, yeah"*
Putting her needs first. PC2 - P2 *"The hospital offered me to … it was ... in the later stages, but did I want to stay? ... it was just so painful being with him. I just really selfishly needed to take some time away so I would come home."*
Isolation
Loss on loss. PC1-P19. *"I couldn't quite erm, see into the next day, you know? It was erm, very, very difficult. Very. Going in the empty house. It's bad enough when my son used to fly back and my husband was there, but you know, I know it sounds dramatic but I used to be ?in a form of grief when my son would fly back home, you know, but my husband would be there to comfort me and support me through it, but then I, both of them are gone."*
Feelings of isolation within friends and family. PC1 - P21 *"you can speak to family members, you know, friends, and they say "well I don't know how you're feeling" and you say, "no, you don't know how I'm feeling"*

Lonely despite friends. PC2-P12 *"although friends are great, they'll sit and listen to me, but they don't know, you know. Thankfully they've not been through this"*
There is no grief experienced like that of losing your spouse. PC2 - P10 *"I'd lost three family members before, but losing my brother and then my mom and then my dad, yes, you grieve, but this grief for my husband, it's like nothing I've ever experienced."*
Nobody to talk with about her exerience. PT1 - P6 *"So she didn't have a lot of people she could talk to. There was the odd mum at the school. But again, she felt like after 18 months, that she shouldn't be talking to them about how she was struggling with loss. So. Difficult. Yes, quite isolated . I would say. In terms of support"*
Family members feeling isolated within the family. PT2 - P3/4 *"a couple of people who were very young, they were children when their parent passed away through cancer and found themselves very isolated because the other parent was grieving or the other parent moved on very quickly and the other siblings were grieving in their way and so that meant that they didn't know quite what to do with their grief."*
Suicidal Ideation
Planning Suicide. PC1-P36 *"No ... well... loose plans, thinking well what would be the best way, would it be tablets or would it be this? Or would it be that? I have sort of thought .... Different things ... then I go to the practical side then and I think that it's not a very nice thing to do ... to my son"*
Counsellors from [Redacted] provide a 'plan' to fill in in case suicidal ideation gets out of control. PC1 - P32 *"you get to the point where you feel there's no hope anymore, and I had to write down a little plan to help you"*
Waiting room in a station scenario. PC2 - P19 *"what I'm leaving behind will be for the benefit of others. And it's like I'm in this waiting room, waiting to go . And that's when I'll see him"*
Red Flags of Suicidal Ideation. PT2-P10 *"when there's one suicide, I'm always watching out for whether they're going to be the next one because quite often a suicide in a family with a young person can lead to another one quite often."*
A way for a therapist to deal with suicidal ideation. PT2-P12 *"I always talk about suicide in graphic detail with clients who are talking about suicide, as in how difficult it is to actually do it."*
What's left with the therapist if the client still feels suicidal. PT2-P13 *"I can remember one client who I've still felt concern for, when they didn't finish therapy; they just stopped coming. And I've no idea what happened to them"*

Appendix VI – Table V Personal Therapy

Personal Therapy
Personal Experience
Therapeutic Alliance
Impact on Therapist

Personal Experience
Further support from another Cancer Specialist Gp. PC1 - P22 *"I heard about [Redacted] ... they've got counsellors working upstairs and ... you can get 6 or 8 appointments, ... Sometimes I'd think Oh I'm not going this week, I can't be bothered, or what's the point you know? And then Come on, just go and like I said, I'd come out and I'd always feel that tiny bit better. Only a tiny bit, but I'd always feel it you know, feeling more positive coming out of there than going in."*
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Appendix VII - Sample Example of Transcription

Interview 1 Transcription

Interviewer: (INT)
Participant: (PC1)
File: MAH00277
Duration: 01:00:07
Date: 18/02/2025
Typist ID: Deborah Wilson

Summary:
This is a transcript of an interview with a bereaved wife who lost her husband to cancer; the story of what happened from diagnosis to include support provided, reactions to her loss, suicidal ideation and coping mechanisms. It will highlight areas in the system which require both attention and improvement.

AUDIO TRANSCRIPT

EXPERIENTIAL STATEMENTS	EXPLORATORY NOTING	NOTES
	INT: First of all, I think I've already said, thank you so much, I really appreciate this. PC1: If I can help in any way, you know, my son and his partner, they write papers and different things, I know how challenging it can be to get people to help and if I can do a tiny bit to help, then you know … INT: This is not a tiny bit, this is a big bit, so I really value it. INT: OK, so did you get a chance to have a look at the different topics? PC1: I did look at them yeah INT: So, what I will say is I will probably write some salient points down, so if my head is down and I'm writing, I'm not being ignorant PC1: I understand	

Ruling out cancer for peace of mind straight away. Showing stoic attitude, not really believing the worst PC1 heavy reliance on husband's ability to deal with whatever life throws their way Private med insurance and WFH enabled husband to crack on normally, ? ignoring symptoms or being strong for PC1?	INT: Is that alright? PC1: Yeah, yeah INT: So. As well, I would like to mention that, you are not alone in this PC1: mmm INT: Definitely not. So, would you like to tell me, in your own words, what happened PC1: Well, my husband had cancer. First of all, he had sort of, like IBS type symptoms and they were just a bit niggly, and sort of he'd manage his way around it, you know, watching certain foods and what triggered it etcetera, but to cut a long story short, he thought, "oh, I'll just go for tests, just to rule anything out and put it behind me" so of course he went for tests and it showed he had cancer, which was, the last thing (INT: yeah), you know he wanted that ruled out, not ruled in, and of course it was bowel cancer, stage 4, and erm, but he was a very, very positive person, completely, you know. He said right, we are where we are, what are we going to do about it and **I was the one in pieces** you know, and he's the strong one and you'd think it'd be the other way around, ya know, and, well anyway, he had lots and lots of treatment and different things, he carried on working and he didn't take time off at all, you know, he just worked through it all. Luckily he had private medical insurance with his work, so he was able to have	Straight to the point about cancer. Cancer not immediate; tested to rule out but ended up ruling in. Pragmatic. Stoic. Husband strong. She was in pieces. Lots of different treatments. Carried on working, no time off. Private medical insurance. Chemo at home Worked from home Stoic Nurses in to set all up and continued working