

Learning lessons from five student paramedics within their exposure to suicide: a critical narrative study

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“We all Wear Green”.

Learning Lessons from Five Student Paramedics Within Their Exposure to Suicide

A Critical Narrative Study

A Thesis submitted in partial fulfilment of the Professional Doctorate in
Health and Wellbeing at the University of Wolverhampton

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Abstract

Background

A suicide loss leaves behind a ripple effect of exposure and sense-making. Postvention research and practice has in part focused on professional/occupational exposure. However, it appears to have largely neglected paramedic science and emerging professional/occupational contexts for students who are studying a Higher Education course in allied health professions.

Methodology

The study design is methodologically grounded in the narrative method. The stories of five student paramedics who self-identified as experiencing exposure to suicide in their emerging professional/occupational context were collected. Positioned as socially co-constructed, and emerging in a post-structuralist world, this narrative inquiry then becomes a critical narrative study. A collocation of sense-making emerges within the discussions and places the students' narrations side-by-side with the wider discourse and discursive practices which surround and construct professional/occupational suicide exposure, which are then analysed through a Foucauldian lens.

Findings

Having engaged in a critical interpretive synthesis of the background literature, this thesis has exposed how professional/occupational suicide exposure research is constructed as a problem. Expanding this body of knowledge, the student paramedics' experiences and sense-making are presented within this study against an emergent plot line of voyage and return, travelling through themes of anticipation, initial fascination, frustration, nightmare, and return, and offer a form of oral history and co-constructed sense-making. These themes are merged and held against a narrative plot line and depicts a metaphor of multiple journeys. The concluding chapter offers an evocative and poetic representation of this metaphor, which has the capacity to bridge concepts, and to extend imagination into recognising new possibilities that emerge from the lessons our student paramedics offer.

Possibilities

Other avenues of research as well as paramedic science pedagogic possibilities emerge from this study, such as a decision to focus on allied health professional students studying in a Higher Education and placement learning context when exploring suicide exposure. Narrative as a way of knowing, would see us move away from a research and pedagogic approach that simply imparts knowledge of an accepted culture to the next generation of professionals. More so, a student paramedics education should offer sufficient time, space, and place to critically evaluate, to develop better knowledge of themselves and their contexts so that they can participate in that professional/occupational space to transform it. The augmented theoretical

and conceptual model that is constructed within this critical narrative study, could be adopted within any study focus or topic of inquiry.

Key words – Postvention, Professional/Occupational suicide exposure, Student Paramedics, Pedagogy, Narrative Inquiry, Critical Narrative Study, Poststructuralism, Foucault.

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Foreword: Navigating this thesis

I have presented this thesis in what may be considered a traditional format, with introductory, literature review, methodology and method chapters, as well as findings, discussions, and conclusions. It will be presented through my voice

given the subjective narrative beginnings, which I also offer as a personal justification for this study. My subjectivity has also proved to be a useful resource to make sense of and co-construct the retold stories. I have used part of my own personal history to inform this study, which is presented as a source of data and is subjected to analysis. Furthermore, the re-told stories have been filtered through my lens and experiences. Presenting this thesis in first person throughout, I hope offers an invitation for the reader to get up close and hear the stories of the student paramedics', and of my own, journeys of voyage and return.

List of abbreviations

AACE	Association of Ambulance Chief Executives
ASMR	Age-Standardised Mortality Rates
BERA	British Educational Research Association
CIS	Critical Interpretive Synthesis
DH	Department of Health
ECG	Electro Cardio Gramm
HCPC	Health and Care Professions Council
HE	Higher Education
HEE	Health Education England
HEI(s)	Higher Education Institution(s)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
UK	United Kingdom

Chapter One: Introduction

Introduction

The introduction chapter places this study within a wider background of the topic of interest, which builds on the personal, social, and practical justifications for this piece of work. The reader will gain an overview of the contemporary United Kingdom (UK) and global context of suicide. The statistical prevalence of suicide and its complexity will be briefly explored. Each suicide leaves a ripple of exposure, and this lays a foundation from which we can explore professional/occupational exposure to suicide, and thereafter, the specific experience of student paramedics in this area. This contextualisation of professional/occupational exposure will consider student paramedics in both their emerging professional/occupational and Higher Education (HE) contexts as they make sense of professionally/occupationally situated exposures to suicide. This chapter will present the purpose, scope, and aims of the study and will conclude with an overview of the thesis and its conceptual framework.

1.1 Personal Justification: The Narrative Beginnings

‘What does his risk assessment say?’

Storm clouds of panic spilled out that bright summer morning, and I stood there frozen to the spot. I was an 18-year-old student nurse who had only ever heard about suicide in the parameters of someone our family knew, who opted to end it all. I had now come face to face with it. I felt like I was floating away, desperately trying to claw my way back into the immediacy of what needed to be done. A tug of war played out and I was trying to make sense of what I had just witnessed, and what I was now witnessing in the response to finding one of the patients suspended with a ligature. My internal scream was willing these

nurses, whom I so admired, to just stop and to see the futility of now checking his paperwork. I felt myself becoming frustrated by them, trying to extrapolate how he had scored on a risk scale the last time these details were captured, because right now HE IS DEAD. He had been known to mental health services for most of his adult life and his identity, hopes, and talent seemed dulled by his diagnosis and the medicine prescribed to manage it. He had longed for recovery and to move on with his life, away from the inpatient setting that didn't seem to want to let him go.

On the bus ride home, I could finally begin to say goodbye to him. My internal dialogue began to piece together that final day, and I thought maybe after all of this, in some way he has moved on from where he did not want to be. He has won, resisting, and wriggling loose from the grip of an institution, that didn't want to let him go. Immediate guilt set in at this thought because this seemed to be in complete parallel to what our hopes for him were. It punched me in the face, and awoke the emerging professional in me, taking my thoughts back into the profession I had been given an opportunity to join, and that I was training to become. I asked myself if the nurses I am learning from are thinking as I am now? I never had the chance to explore that question with them. This is because I was worried it may expose me as someone not up to the job. I feared that they would see me as mis-aligned to the aims of psychiatry, there as an agent of the cause, but not fully signed up to it.

I have not had any difficulty in pinpointing where the interest in the topic for this study has emerged from (Ravitch and Riggan, 2012), given both my personal and professional exposure to suicide. Indeed, these narrative beginnings have shaped my entire career and the direction in which it has travelled as a clinical and educational practitioner, and researcher.

1.2 Context of this Study: The Ripple Effect of Suicide

Every person who dies by suicide leaves behind suicide loss survivors. Gutin, McGann and Jordan, (2011) posit one definition of a suicide loss survivor as

‘Someone who experiences high levels of self-perceived, psychological, physical and/or social distress after the suicide, regardless of the social relationship with the person’ (p. 7).

In the decades since Shneidman first highlighted the needs of those left behind following a suicide, postvention is a concept that has gained some momentum. Its aim is to facilitate ‘recovery’ amongst those ‘impacted’ by a suicide, and to prevent adverse outcomes. Expanding on the definition above, the use of a common language is presented within the ripple effect of a suicide, (Cerel *et al.*, (2014). Here, people would be considered as being ‘exposed to’, and ‘affected by the suicide’. Following which they become ‘suicide-bereaved short-term’ and ‘suicide-bereaved long-term’.

This defining ripple creates a space to conceive that suicide exposure and loss survivorship are the reserve of friends and family members alone, and who have been the focus of postvention consideration (Bartik *et al.*, 2013; Andriessen, 2014). It can also include those who have responded to the death such as the police, fire, and ambulance services, as well as those who may have delivered care to the person who has died (Gutin, McGann and Jordan, 2011). Self-perceptions of closeness are allegedly crucial to understanding the perceived impact of the death. Furthermore, perceptions of greater closeness and impact are purported to relate to higher incidences of mental health difficulties (Cerel *et al.*, 2017). This highlights the importance of better understanding the differential experiences and sense-making of suicide on specific sub-groups (Andriessen *et al.*, 2017). See Appendix 1 for further details about Professor Julie Cerel’s work and her influence on my own study endeavour.

A 2019 Health Education England (HEE) report highlighted a theme of bereavement by exposure, and that every clinician carries with them a *lifetime* of upset, trauma, and experiences of exposure to death, and dying (Pearson, 2019). It guides us to consider that professionals working in healthcare have vastly different emotional needs to those working in other sectors (See Appendix 2). However, although this report focuses on NHS staff and learners' wellbeing, the principle of bereavement by exposure assumes applicability to those established in their career and those who have had multiple experiences of professional bereavement exposure. It is also assumed that bereavement is the best frame to describe their sense-making and does not make any reference to different causes of death and their associated bereavement or sense-making.

This has prompted me to ask the question, what does the literature say about professional/occupational exposure to suicide? The Critical Interpretive Synthesis (CIS) of available research between 2005 and 2022 (presented in chapter two) highlights where paramedic professional/occupational exposure has been seldomly explored. Where paramedics are considered, it is with little specificity (Rothes *et al.*, 2020), and directly in only one article (Nelson *et al.*, 2020). Trainee/student experience and sense-making across any professional/occupational exposure has only been tentatively explored in two articles (Gaffney *et al.*, 2009; Darden and Rutter, 2011). Therefore, this study is unique in that it has engaged in hearing, co-constructing, and re-storying student paramedics experiences and sense-making of responding to suicide.

1.2.1 Paramedic Science Education in Higher Education

The student paramedics' experiences within this study are situated within paramedic science education as UK based Higher Education (HE) students, studying within a situated regional context in the Black Country within the West Midlands. Ambulance services and ambulance work have travelled a journey from being a blue-collar occupation mainly involving manual work and the transportation of patients, to now being a clinically advanced profession

comprising of highly skilled and trained colleagues (McCann, 2022). Their journey of professionalization (McCann and Granter, 2019) sees paramedics, ambulance paramedics, and technicians alike trained and educated in the UK to a single national level. The student paramedic narrators within this study, are occupying a space which see's many paramedics now educated to degree level within a university setting.

At the time of writing this chapter there are 37 UK based universities who are offering Paramedic Science Degrees. Higher Education has an almost a one-thousand-year history which has based some of their sense of purpose in developing the characters of the students studying with them. In the last few decades this sense of mission has allegedly declined (Seldon and Martin, 2017; Dickens, 2020). In its place, a more contemporary challenge has been set where universities are tasked with making the mental health and wellbeing of their students a strategic priority. This is because there was found to be too much variation in how well-equipped universities are to meet the increasing mental health need of students, and disclosures of mental health difficulties (Thorley, 2017). This has led to a call for action called *Step Change* (Universities UK, (UUK), 2017), the campaign acknowledges the increasing number of students dying by suicide and the duty of care that universities owe their students. It also highlights the need to adopt a whole-population approach to student mental health and asks universities to reconfigure themselves as health-promoting and supportive environments, aided by mental health literacy training for staff. Further guidance has emerged in the form of Suicide Safer Universities which sets out the need for suicide prevention to span a spectrum of prevention, intervention, and postvention to prevent suicide in this context (UUK and Papyrus, 2018), with an additional set of guidance published in December 2022 focusing on postvention specifically, (UUK and Papyrus, 2022).

1.3 Social and Policy Background of Suicide Prevention

1.3.1 Definitions of suicide and prevalence

Suicide is a complex issue for which no single cause or reason exists and is believed to emerge from an interaction of biological, genetic, psychological, social, cultural, and environmental factors (WHO, 1999). Within the period of these narrative beginnings outlined at the start of this introduction chapter (Caine, 2010; Kim, 2016; Dubnewick *et al.*, 2018). The Age-Standardised Mortality Rates (ASMR) for suicides in the UK were in steady decline between 1981 and 2007, with 14.7 deaths by suicide per 100,000 in 1981 compared to 10.0 deaths per 100,000 in 2007. After this point the trend reversed as a rise in verdicts of suicide among men increased (Office for National Statistics [ONS], 2016). In 2020 there were 5,224 suicides registered in England and Wales, equivalent to an age-standardised mortality rate of 10.0 deaths per 100,000 people, which at a statistical level, is significantly lower than the 2019 rate of 11.0 deaths per 100,000. The decrease is likely to be driven by a reduction in male suicides at the start of the coronavirus (COVID 19) pandemic, and delays in death registrations because of the pandemic (ONS, 2020). In a global context it is a phenomenon that accounted for 1.4% of all deaths worldwide making it the 18th leading cause of death in 2016 (WHO, 2018).

1.3.2 Societal Reactions to suicide

Suicide has been known in all cultures, throughout history, (Pridmore, Ahmadi and Evenhuis, 2006) and over the centuries attitudes and beliefs have shifted. It has moved from being considered an individual act with John Evelyn once noting England as being the land of suicide in 1694 (Darely, 2006). Through to Durkheim's suggestion of societal and political influences, and causation (Durkheim, 1897). Now suicide is a potential cause of death calling for the attention of public health, which requires intervention from a second party to prevent it. Some would argue that this latter strategic involvement in suicide prevention constitutes the ultimate deprivation of personal freedom (Szasz,

1977). It may also conveniently obscure our view from trying to understand the social context of suicidal behaviour itself, which is critical to informing suicide prevention strategies (Dougan *et al.*, 2015). People living and dying by the realities and consequences of social policies (Mills, 2017) infused with imposed factors such as austerity, equates to sustained trauma and wounding. A minute's silence was held on the 30th of March 2017, during a meeting in the UK Parliament about cuts to welfare sanctions (Mills, 2018). This was held to remember all those who died as a result of the welfare cuts and austerity measures that have become part of the UK policy landscape since the 2007-08 financial crisis. In 2013, suicides reached a 13 year high in the UK, with population level data linking this increase to austerity policies (Barr *et al.*, 2015). Staying blinkered to these factors would see us engage in a connivance, solely focusing on an individual as a set of problems and failings to be fixed, which in turn generates more suffering (Springer, 2016).

Perhaps prompted by the proposed economic 'burden' of suicide in the UK which is estimated to be in the region of £1.67 m for each suicide (McDaid and Kennelly, 2009), it appears a truism to think and say that the monetising of life has seen suicide become a governmental concern in the UK. The most recent cross-Government National Suicide Prevention Strategy for England 2012 (Department of Health (DH), 2012) charges Local Government with a coordination of planning partnerships to prevent suicides. Updated in 2017, it now expands to include another five key areas such as self-harm prevention, and better targeting of those considered to be within high-risk groups such as men (DH, 2017). Further targets were added with recommendations from the Government-commissioned Independent Mental Health (MH) Taskforce. It set out National Health Service (NHS) England's Five Year Forward View for Mental Health, which mandates NHS services to contribute to a 10% reduction in local suicide rates through local system partnership (Farmer and Dyer, 2016). Most local authority areas have responded to these calls and have established suicide prevention plans and multi-agency partnerships to deliver them (DH, 2012). Much of the activity emerging from these collaborations focus on

reducing suicide via policy that derails individual behaviour. However, survivors of suicide attempts have been vocal in highlighting the problems with some of the help seeking narratives set out within such campaigns, because they often fail to consider structural and relational barriers when doing so (Maopolski, 2018).

1.3.3 An emerging critical lens and approach to suicide prevalence and prevention practices, and knowledge development.

What is visible and defined as neutral, evidence-based, and common knowledge about suicide and suicide exposure, is as a result of an elaborate somatechnic machinery aimed at the regulation of knowledge. This has resulted in the preservation of an image of scientificity and its position of authority of the field, dominated by epidemiological efforts in the main, (Tack, 2022). The term 'somatechnics' indicates an approach to corporeality which considers it as already bound up with a variety of technologies, techniques, and technics. Why this is significant, is because it enables an examination of the lived experiences engendered within a given context, and the effects that technologies, technés and techniques have on embodiment, subjectivity, and sociality, (Lodder, 2016).

Suicide is arguably deeply embedded in particular social, political, ethical, and historical contexts. Therefore, they are rarely amenable to cause–effect reasoning, certain understanding, or technical solutions. In short, suicide is a complex problem that is always on the move, (White, *et al.*, 2015). So far within this introduction chapter, I have presented and communicated suicide prevalence and prevention practices in such a way which could be argued as upholding a static construct of the issue. Arguably, I may inadvertently be adding to the regimen of social practices within suicide prevention education and communication aimed at advancing suicide literacy, that restrict certain testimonial and hermeneutical knowledge construction (Fitzpatrick, 2020). At some level, it might be easier for me to accept the conception of suicide as a public health crisis and hand over suicide to the language of such institutions

(Gan, 2023). With this said, I have begun an attempt to resist the pull to construct suicide as primarily a question of individual mental health and have guided the reader to consider suicide in a context of psycho-political analysis (Marsh, 2020). This would encourage us to make attempts to better understand the complex social and political contexts of suicide, which may open up more possibilities for us all. Therefore, I would caution the reader of this study, to be minded of some of the normative traps it may fall in to in the use of terms and the presentation of concepts we are more familiar with and feel more real. My professional and strategic practice is underpinned with a desire to democratise suicide prevention. I am aware that suicide prevention seeks to guide and manage citizens' conduct through the application of practical knowledge. Whilst initial intentions are no doubt sound, they are not of course value-free. My aims have involved a set of moral and political commitments that shape the ways suicide within my geographical and practice context is understood and responded to. Therefore, I have had to go on an intellectual journey of deconversion from a possible assumption that by simply imparting taken for granted knowledge to wider community groups, that it somehow achieves this aim. This study aims to take readers, and myself further, hoping to cultivate critical dialogue and new ways of thinking. Thereby giving space to so far unheard voices within a professional / occupational suicide exposure space and daring ourselves to listen to them in a different way.

1.4 Purpose and Aims of the Study

This study aims to hear the voice of student paramedics, and to listen for their sense-making related to their experiences of responding to suicide in their emerging professional/occupational contexts. In hearing, co-exploring, co-constructing, and re-telling those stories, I aim to engage in a critical storied narrative analysis. This study will present the re-told narratives and sense-making of five undergraduate student paramedics who are studying in a UK HE context. They have self-identified to have had exposure to suicide and suicide attempts from their emerging professional/occupational context. The aim of the study then shifts, to view the student paramedics stories through a more explicit

post structural lens. A collocation of plotlines is then held against the wider literature which sees student paramedics belonging to an unheard group. I would go further to suggest that students from any emerging professional/occupational background are far removed from the research conscience, which emerges from a belief that professional/occupational exposure to suicide is an experience worthy of exploration. In co-exploring, co-creating, and critically analysing the narratives, this critical narrative study hopes to foster possibilities for future professional/occupational postvention research, and pedagogic enhancement within the teaching and learning of student paramedics.

1.5 The Study Questions

The study questions that I will explore are:

- What are the stories that are re-told by student paramedics who have experience of direct exposure to suicide?
- What sense and meanings have student paramedics applied to these experiences?
- What are the similarities and contradictions that arise from the collective narratives of the whole study?
- What possibilities emerge from the study that might expand professional/occupational postvention knowledge and practice, as well as paramedic science education pedagogic practice?

1.6 Overview of the Chapters

Chapter Two presents a critical interpretive synthesis of a body of literature that informs professional/occupational exposure and sense-making in response to suicide. The iterative process, working with a sampling frame of primary research studies explores conceptualisations of dominance that emerge in both professional voice and how it is heard. This organic and exploratory process offers a new space for student paramedic context to be explored. **Chapter Three** explores the positionality of the study which supports an epistemology

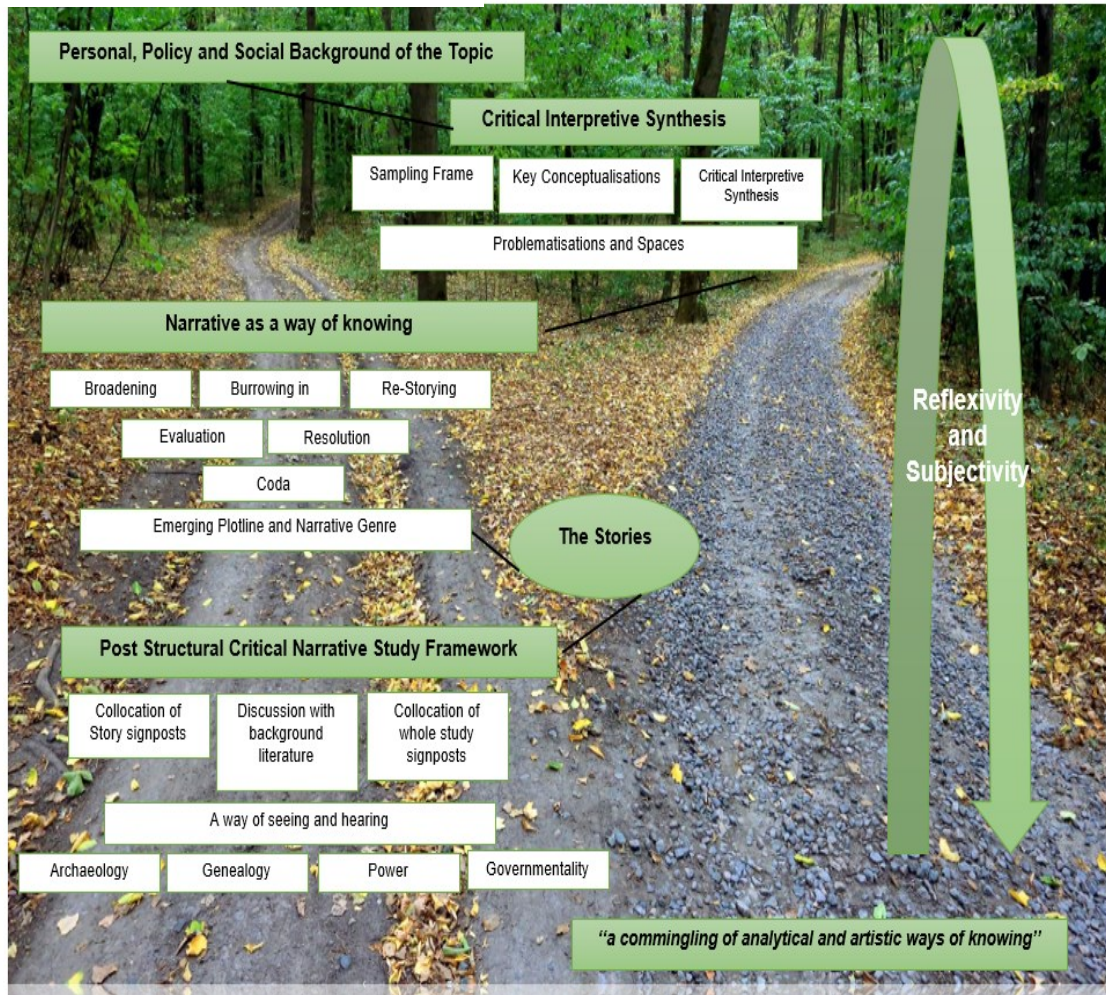
that utilises multiple ways of knowing, aligned to an exploration of nodes for narrative analysis. An augmentation of theoretical narrative analysis signposts is presented. The complexity and fluidity of ethical considerations for this study is discussed along with principles of trustworthiness. **Chapter Four** presents the co-constructed stories of five paramedic students' journeys of voyage and return in their emerging sense-making of suicide exposure. Further analysis of those plotlines involves engaging in a double reading which is aided by a Foucauldian lens. This chapter explores a collocation of sense-making through lenses of governmentality, genealogy, archaeology, and power. **Chapter Five** picks up the continuing metaphor of travelling across the whole thesis, arising from the student paramedics stories of voyage and return. A map of experiences is presented which offers a poetic and evocative artefact. It is hoped to aid the navigation through this concluding chapter locating the landmarks of the studies contribution to knowledge, and future possibilities.

1.7 The Conceptual Framework of this Study

The conceptual framework for this study represents a synthesis of the background literature, which emerged from the personal, policy and social background of the topic of interest. Engaging in a Critical Interpretive Synthesis has seen me attuned to exploring taken for granted ideas, meta narratives of dominance, problematisations and spaces. Narrative inquiry is considered as the broad banner under which the methodology and the conceptual framework emerged for data analysis. I have situated this study as a way of knowing professional/occupational exposure to suicide (Hatch and Wisniewski 1995), but there was a need to adopt an analytical style which moves beyond the *'novelty, and celebrity of narrative itself'* (Atkinson and Delmont, 2006, p. 166). It is here I show how using the storied signposts of anticipation, initial fascination, frustration, nightmare, and return, offer windows through which they can be viewed through a more explicit Foucauldian poststructuralist lens. In adopting the lenses of archaeology, genealogy, governmentality, and power, this has brought the 'little things' to the surface that embody complexity and fragmentation of professional/occupational suicide exposure (Rowan and

Shore, 2009). I have therefore offered a different way to see and hear the narrative threads within the whole thesis, which may offer a way to rethink professional/occupational exposure to suicide.

Diagram 1: Conceptual Framework of the Study



Chapter Two: A Critical Interpretive Synthesis of Professional/ Occupational Exposure to Suicide.

Introduction

This literature review chapter contextualises this study within the ripple of suicide exposure (Cerel *et al.*, (2014). Here, people would be considered as being 'exposed to', and 'affected by the suicide'. A justification for the use of the Critical Interpretive Synthesis (CIS) approach by Dixon-Woods *et al.*, (2006) will be presented and exposes a process that has been iterative and organic. It concludes with a critical synthesis of the themes within the body of literature. This creates a space where I can conceptualise the methodology and professional/occupational focus that shapes this study.

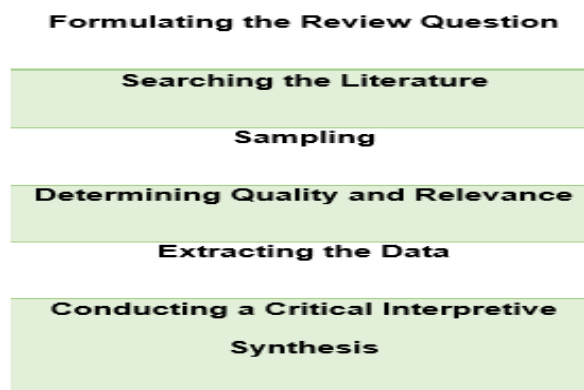
2.1 Literature Review Framework

When synthesising research that is of mixed epistemological and methodological genre, there are choices for critique, analysis, and synthesis that I must make explicit (Pluye and Hong, 2014). The CIS approach (Dixon-Woods *et al.*, 2006) includes an iterative method that includes six phases. This approach best aligns to my own post structural philosophical position, and to the aims of this review.

The aims of this review do not rest with asserting definitive outcomes, more so, it will try to uncover assumptions such as social structure and taken for granted ideas, and truth claims. This is achieved by engaging in a dialect with the body of evidence. I have explored the ways in which the literature constructs its problems and the assumptions on which it rests. This suits the less specific aim

of my literature review question (see 2.2 for a justification), which has allowed me to develop a critique, and generate theoretical conceptualisations that justify my study and my contribution to knowledge (Dixon-Woods *et al.*, 2006).

Table 1: Six stage framework adapted from Dixon-Woods *et al.*, (2006)



2.2 Formulating the Review Question

I developed a tentative question at the outset of the review, offering a compass rather than an anchor (Eakin and Mykhalovskiy, 2003; Greenhalgh and Peacock, 2005). The question was: what does the literature say about suicide exposure within a professional/occupational context?

Guiding objectives emerged as the process of searching, sampling, and synthesis evolved, they were:

- To show the professional/occupational groups exposed to suicide within the literature, and to explore signposts of nuance.
- To explore the position from which the papers have appeared, how the topic of suicide exposure is perceived and how it is evolving.
- To review the methodological alignment, contributions, and limitations of the existing research.
- To consider implications for future research.

These guiding objectives allowed me to move beyond pooling and assembling data which have secured and well-defined variables (Noblit and Hare, 1988). I

engaged in a process involving both inductive and interpretative approaches, offering an aggregation of theory grounded within the papers (Dixon-Woods *et al.*, 2006).

2.3 Searching the Literature

Due to the interpretive aims of this review, it was tempting to limit the scope of the synthesis to interpretive research only, as in the case of Thomas *et al.*, (2004). Here, they have engaged in research collecting and analysing non-numerical data to understand concepts, opinions, or experiences. I have avoided the temptation to exclude quantitative studies which have looked to gauge, measure, and quantify experiences against a backdrop of making predictions, testing causal relationships, and generalising results to wider populations. This was despite my aim not being to test 'what works' or to find the 'efficacy' or 'impact' of something.

In systematic reviews, the aim is to engage in an objective exercise. This literature review might be viewed as the antithesis of this approach because in systematic reviews the idea of a non-comprehensive search strategy and sample is suggested to introduce selection bias. The idea that I can suspend my values, interests, and power in the pursuit of knowledge gained at a distance, which can then be replicated by others, is simply not possible (Devetak, 2005; Dixon-Woods *et al.*, 2006). This is as applicable at the search stages of the critical interpretive synthesis. This is not without critique, as it is suggested that clear accounts of a search strategy should allow reproduction (Depraetere *et al.*, 2021). Exhausting a sample of literature was not the primary aim in this review. I was concerned with finding sufficient cases to identify patterns (Harris, 2011). Therefore, I cannot expect the synthesis of the literature to be repeated or that it will say the same things to other researchers.

With the aim of gaining an adequate sampling frame (Dixon-Woods *et al.*, 2006), I combined search strategies including, data base searches (Google

Scholar, EBSCO host including Medline, APA Psych Info, Education Research Complete, Humanities International Complete, Psychology and Behavioural Science Collection, Soc Index and Cinahl, and PubMed), reference chaining, and searching websites to identify relevant literature between January and March 2019 and repeated the process every three months until December 2022 to capture any new papers.

Search terms.

Searches were conducted using different search terms, namely, Professional and Occupational, Boolean operators and MeSH terms, as well as “suicide, grief, bereavement, exposure, client suicide, patient suicide” and Boolean Operators.

Eligibility criteria.

The inclusion criteria comprised of peer-reviewed research published in English in the last seventeen years (from January 2005 to December 2022) that examined the prevalence and experiences of exposure to suicide among occupational or professional groups. Non-primary research articles (discussions, editorials, protocol papers, reviews, and theoretical papers) were excluded.

Not many papers were found (Data base search $n=29$) and it was clear that a lot of them had no relevance ($n= 25$). I could not access one paper (Leaune, Olié and Vaiva, 2021) that was relevant resulting in a total of three primary research papers available (Gaffney *et al.*, 2009; Cerel, *et al.*, 2019; Sanford, *et al.*, 2021). Hand searching the reference list within these papers yielded more results. I also engaged in citation chasing within similar literature reviews that have been conducted in recent years ($n=2$), Lyra *et al.*, (2021) and Causer *et al.*, (2019), which yielded a total of 22 papers which I could access fully. Using the PubMed similar articles function also revealed two further papers that were relevant (Davidsen, 2011; Kim, 2019) and I was sent one paper that was relevant to my review by one of the primary authors, as they felt it would be

relevant to my work (Causser *et al.*, 2021). My sampling frame eventually consisted of 28 studies that were pertinent to this review.

2.4 Sampling and Extracting the Data

I felt the process of refining my sample may be achieved through exploring and exhausting concepts. I used purposive sampling to select papers within the sampling frame of the literature review. Using Benoot, Hannes and Bilsen, (2016) worked example of adopting purposeful sampling as a guide for the stages of my sampling technique. Purposeful sampling techniques rest on the power of selecting information rich cases, which offer insights and understanding rather than empirical generalisations (Patton 2002). I then engaged in the process of intensity sampling until I reached a point where the concepts and categories within the papers were exhausted, and no new concepts were derived from reading any further (Thompson, 1999). Thereafter, I began to engage in a process of maximum variation sampling. This sample was derived by identifying key dimensions of variations within the papers, and then finding cases that vary from each other as much as possible. I commenced with a standpoint that different study characteristics may highlight different aspects of the exploration of professional exposure to suicide, and as such, a picture of the phenomenon could be sketched out by taking a step back from them (Suri, 2011).

The concepts derived from the intensity sampling set out the key dimensions that served as a basis for selecting additional papers. These papers varied from each other, e.g., theoretical underpinning. Maximum variation sampling aided me to develop preliminary lines-of-argument, and I then further engaged with the sample by adopting disconfirming case sampling. This latter stage gave me a selection of articles that did not fit the emerging patterns that I had found so far. They were a source of opposing interpretations, which spoke differently to the dominant ways of knowing and offered a means of placing some boundary around what I had so far found (Suri, 2011).

I did not exclude any papers and therefore did not reduce my sampling frame. However, the process was useful and supported my aim of theoretical synthesis. In summary, my main interest is not in seeking a single answer, rather, I aimed to explore the complexity of different conceptualisations (Palinkas *et al.*, 2019). Engaging with the papers in this way, informed by wider reading, allowed me to begin generating some synthesised arguments (Dixon-Woods *et al.*, 2005). It is important to highlight that I explored concepts with the aim to maximise the range rather than to accumulate multiple mentions of similar concepts. The overarching concepts are presented in the table below and can be found in more detail in Appendix 3.

Table 2: Conceptualisations appearing from engaging with the sampling frame

Counting Exposure
Responding to Suicide
Experiencing the suicide
Practice Impact
Emotion Impact
Medicalised framing of responses
Existential sense making
Contextual Sense Making
Suicide as a cause of death
How to go about finding out about all of this?
Getting to know you – who are the authors?
How are those who have died, framed?

I re-visited each paper with the view to explore the data as it was presented, organising this with a template that I designed to enable me to ensure I could capture the study characteristics and results. This included the titles, the year of publication, the place of the study, methods of the research, professional groups identified as exposed to suicide, and the findings of the study (See Appendix 4).

2.5 Critical Interpretative Synthesis

2.5.1 Process

This synthesis brought together a topically connected group of studies that included a range of professional/occupational groups and suicide exposure experience. In contrast to systematic reviews, this review has been concerned with inductive and interpretative approaches with the aim of hearing what the literature says once immersed in it. I concede that there was an element of aggregation because I knew I was going to focus on professional/occupational exposure to suicide. Treating the literature as a whole body calling for critical scrutiny, the 'pull to synthesis' has broadened my gaze to consider principles such as the literature' tradition, the meta-narrative employed to describe the phenomena which may have guided the field in a particular direction. More detail related to the process of CIS can be found in Appendix 5.

Table 3: Critical Interpretive Synthesis Compass (Dixon-Woods et al., 2006).

An inspection of the papers, building up and identifying recurring themes, developing a critique
Generation of themes that assist me to explain professional exposure to suicide and how it is being described in the literature.
Comparison of the theoretical structures being developed against the data in the papers,
Specifying the categories of my analysis and the relationships between them
A focus on epistemological and normative assumptions

2.5.2 Dominant Professional Voice and Space

The frequency of suicide exposure within an overarching mental health professional's context has been investigated in Sanders *et al.*, (2005); Ting *et al.*, (2006); Bohan and Doyle, (2008); Gaffney *et al.*, (2009); Draper *et al.*, (2014); Dransart *et al.*, (2015); Murphy *et al.*, 2019; Sanford *et al.*, (2021); Van der Hallen, (2022). Exposure to suicide within Psychology, Therapist and Psychiatrist context was found in Tillman (2006); Clark (2009); Landers, O'Brien and Phelan (2010); Darden and Rutter (2011); Kelleher and Campbell (2011); Wurst *et al.* (2013); Erlich *et al.* (2017); Gibbons *et al.* (2019). Within an Irish based study (Gafney *et al.*, 2009), the researchers explored the 'impact' of suicide on front line staff. In anticipation of this presenting a differing group of professionals exposed to suicide in a non-mental health saturated context, in the review of background literature they highlighted that professional context exposure research tended to be aligned to mental health nurses, psychotherapists, psychologists, and psychiatrists. Of the 83 survey respondents, professional groups included nurses, social work, therapy-based professionals, and emergency medicine. Their initial findings revealed that the groups most exposed to suicide were Psychiatry and Emergency Medicine. Within the Emergency Medicine group, death by suicide was highlighted to be one of the many causes of traumatic death they come in to contact with, recommending that further exploration of this 'impact' should be considered. What I found most remarkable was that this Emergency Medicine professional group was only included when they had learnt of the survey and asked to be considered!

Lesser represented groups within the body of literature include police / law enforcement officers (Cerel *et al.*, 2019), schoolteachers (Kim, 2019), counsellors (Christianson and Overall, 2009), university-based staff (Causar *et al.*, 2021) as well as paramedics (Nelson *et al.*, 2020). Inputting a variation of terms, I engaged in another google scholar and data base search to ascertain if I had missed any papers that would fit in to the scope of this review. There were study titles that indicated an exploration of suicidal ideation amongst some of

these groups, but they didn't explore their professional/occupational exposure in a response, experience, or sense-making capacity.

Nelson *et al.*, (2020) study illuminates paramedics as a professional group having established that little is known of their perspectives of suicide exposure. The participants within this study report that in relation to the many other NHS professions, they can feel demoralized, forgotten, and neither valued nor respected by colleagues from other disciplines. I would go further that they appear to have been forgotten in the scope of suicide postvention up until this study. Participants reported the experience of job-related strain including exposure to suicide, and to suicidal ideation of colleagues. They described suppressing their distress despite a significant emotional impact. They outlined the complexity of their experiences, from exposure to the scene and responding to those bereaved. This is akin to Hom *et al.*, (2018) and Kimbrel *et al.*, (2016) who explore firefighter exposure to suicide, and Rothes *et al.*, (2020) in pre-hospital professional context where staff reported long-term, salient memories of these events. Death scenes emerged in Wang *et al.*, (2016, p. 357) where a nurse describes '*terror of the death scene made me all of a quiver*'. For paramedics, there is a reported lack of acknowledgment in the workplace that suicides may be traumatic, and no guidance existed for staff on how to cope (Nelson *et al.*, 2020).

Table 4: A list of professionals identified in the literature.

Professional / Occupational Group	Reference
Mental Health Nurse	Bohan and Doyle, (2008)
General Practitioner	Davidson (2010); Saini et al., (2016);
Firefighter	Kimbrel et al., (2016); Hom et al., (2018)
School Counsellor	Christianson and Everall (2009)
Therapist	Tillman (2006); Clark (2009);
Clinical Psychologist	Darden and Rutter (2011) Wurst et al., (2013)
Psychiatrist	Landers, O'Brien and Phelan (2010); Kelleher and Campbell (2011); Wurst, et al., (2013); Erlich et al., (2017); Gibbons et al., (2019)
Law Enforcement	Cerel et al., (2019)
Mental Health Professionals – nonspecific in their description or framing	Gaffney et al., (2009); Gulfi et al., 2010; Draper et al., (2014); Dransart et al., (2015); Murphy et al., (2019); Sanford et al., (2021); Van der Hallen (2022);
Paramedics / Ambulance Staff	Nelson et al., (2020)
Front Line Professionals – these were framed as mental health professionals, with the inclusion of emergency department staff when asked to be included	Gaffney et al., (2009)
School Teachers	Kim, (2019)
Nurses in a General Hospital Setting	Matandela and Matlakala (2016); Wang et al., (2016)
Pre-Hospital Professionals - their occupations? there were four physicians, eight nurses, and two prehospital technicians.	Roths et al., (2020)
Mental Health Social Workers	Sanders et al., (2005); Ting et al., (2006)
Higher Education Professionals – inc. executive staff, student facing, professional services and academic staff	Causer et al., (2021)

2.5.3 Some responses may be easier to say and hear.

My analysis of the literature highlights that there is constructed distain towards those who have died by suicide, as a collective, describing their decision as selfish. This sense-making may be due to the pain they leave behind, possibly

assuming by default, that this was their intention to punish. This resonates with a respondent in Sanders *et al.*, (2005, p. 205) who stated, '*those poor children who lost their mother*' in Gaffney *et al.*, (2009, p. 647), '*how will their relative's cope?*'. There are studies within the body of literature, which frame their inquiry within the attribution of a patient suicide to be an 'occupational hazard' (Roths *et al.*, 2020; Sanford *et al.*, 2021), and adverse effects have then been reported by their health professional participants. These range from professional doubt, self-blame, and fear of legal consequences (Bohan and Doyle, 2008; Darden and Rutter, 2011; Gibbons *et al.*, 2019; Murphy *et al.*, 2019), emotional turmoil and stress reactions (Draper *et al.*, 2014), and severe distress (Wurst *et al.*, 2013; Dransart *et al.*, 2015). With, Sanford, *et al.*, (2021) interestingly highlighting that bereavement focused outcomes, where the loss of an attachment relationship is the focus, does not capture the full range of experiences in an occupational exposure.

The position from which these research questions have been asked, and the professional dutiful position from which they have been answered, in addition to the framing of the questionnaires and surveys they used, might draw our attention to other questions. Such as, has the research process looked to define the appropriate objects of their attention? Have they framed the responses and engaged participants in a process of further adding to this 'appropriate' definition? As such, upholding discourses that are easier to hear. In Darden and Rutter (2011) they asked how clinical psychologists have coped and what hindered their coping, commencing from a standpoint that there should be something to cope with. In Draper *et al.*, (2014) suicide deaths are reported to have a greater impact than sudden deaths upon the life of Health Care Professionals (HCPs), reporting that clinical inexperience and availability of support influences impact on professional practice and personal life. This study employed statistical and interpretive methods, however within their semi-structured interviews they asked questions such as 'what was the impact of the death?', this may communicate that there should be an impact.

In contrast, there is an alliance in the 'world of' suicide loss survivorship that acknowledges the journey of shock, despair, and disorientation, but then of personal, and post traumatic growth, with a restoration of meaning. Some studies that I have reviewed, tentatively proposed this within themes of *professional growth* in a group of social workers (Sanders *et al.*, 2005) and of psychiatrists in Erlich *et al.*, (2017). A theme emerged for schoolteachers of '*staying in the game*' in Christianson and Everall (2009), of absolving responsibility in Sanders *et al.*, (2005) for example, '*he wasn't my client*', with some consultant psychiatrists reflecting on the next steps in the form of recommendations to learn lessons, (Landers, O'Brien, and Phelan, 2010). However, they are responses that are still framed within a professional obligatory plot line of having to possess responsibility and the need to learn lessons in the first place.

Some of the study participants reported 'no impact' on their lives (Sanders *et al.*, 2005; Ting *et al.*, 2006; Landers *et al.*, 2010; Darden and Rutter, 2011), and a theme of nothingness emerged in Sanders *et al.*, (2005). In the same study, one social worker reported that the experience was *an 'excellent training experience'* and was thankful that it had occurred! Another social worker said:

'It may be strange to say this, but I am glad the man did what he did. It was the one thing in my career that has taught me more about who I am as a person than anything else'. (p. 207)

Clinical psychologists reported to be ambivalent when asked to acknowledge any personal impact in Darden and Rutter, (2011).

There is a dominant narrative that appears and from that voice, a similar malady plays out that sets a prognosis that professional/occupational exposure to suicide will impact on professional and personal life. Indeed, the aim of postvention which is a frame in which many of these studies sit, is to facilitate recovery amongst those impacted by a suicide and to prevent adverse outcomes including suicidal behaviour (Andriessen, 2009). This may serve as a

means of presenting collective ways of experiencing suicide exposure in a professional/occupational context, resulting in responses that have been exposed with elements of restraint and professional obligation. Therefore, they may contribute to a collective moral duty and consciousness by dulling the narratives that may be more difficult to say and hear, but are discursively there, nonetheless.

2.5.4 Post Suicide Sense-making, Aligned to a Pathological Gentrification of Distress

The studies who infer a need to measure the impact of suicide or test a hypothesis that post-event reaction is negative, and can then be understood through psychiatric, psychological, or suicidal symptomology framing (Wurst *et al.*, 2013; Kimbrel *et al.*, 2016; Hom *et al.*, 2018; Cerel *et al.*, 2019) make some broad epistemological assumptions from their very inception. They do not discuss or position these in comparison to others, for example post traumatic growth or a narrative approach to knowing the experiences. As such, they do not create a space to consider the contrary to their hypothesis. In Cerel *et al.*, (2019), 14% of their law enforcement officer sample (n=813) identified moderate to severe depressive symptoms, 9.1% *probable* posttraumatic stress, 6.4% suicide ideation, and 14.2% moderate to severe anxiety. In Hom *et al.*, (2018), firefighters completed self-report measures assessing their experiences with suicide exposure, history of suicidality, current psychiatric symptoms, and suicide risk, with Kimbrel *et al.*, (2016) also reporting that 12% of their sample reported positive screens for significant suicide risk.

They may be contributing to the history of the order and identity that is being imposed on professional/occupational exposure to suicide (Mc Nay, 1994). I also ponder how the participants of these studies have any positive status when they are being measured against an abstract diagnostic principle that works from a vantage point of 'what is wrong', instead of 'what is happening'. This foundation was pre-determined before the participants even consented to be

part of the study. Indeed, the only apparent scope to suggest something different would be to opt not to respond, which may communicate as much in its silence.

In Causer *et al.*, (2019), they highlight that those HE professional participants who purposefully sought help after the suicide exposure appeared to be open to talking explicitly about the discomfiting emotional and psychological aspects of the event. This was in comparison to those who reported that they did not seek help 'appearing' more reluctant in interviews to discuss emotional aspects of the event. They then align this to evidence which suggests that these (HE) professionals may be using avoidance strategies as a means of evading engagement with threatening feelings (Arble and Arnetz, 2017). They concede that such avoidance may be protective but go on to alert the reader to the possibility that this strategy may result in negative consequences, including increased psychological difficulties.

The literature may risk presenting diagnostic '*styles of thought*' (Rose, 2000; Marsh, 2010, p. 31), emerging from diagnostic ways of seeing and saying, and heard through the filters of diagnostic styles of listening (Anderson, 1997), therefore fostering diagnostic '*sensibilities and sensitivities*' (Shotter, 2010, p. v). The participants in these studies may have had little choice but to have their experiences and distress seen in any other way as a set of features that represent illness, difficulties, and problems. We must also consider the possible consequences of medicalizing many forms of human distress, because in doing so, we risk blurring the disease-illness divide, offering subcategories and lowering the thresholds for diagnosis. This in turn paves the way for the introduction of many new psychiatric 'disorders' (Thangadurai and Jacob, 2014). Laing (2016) offers further insight when discussing the gentrification of cities but also of emotions. Here, emotional distress is fast becoming a socially constructed medicalised term, typified by labels referring to anxiety and depression set against a backdrop that they are because of the brain not

working as it should. This is a process that could be described as language of fantasy emerging in a world that grants it constant visibility (Mc Knay, 1994).

2.5.5 Demand for Assimilation by Design

Academic and scientific communities which validate and legitimize knowledge claims may unwittingly contribute to systems of oppression (Mertens, 2005). Consideration should therefore be given to domination, exclusion, privilege, and marginalisation within the research process (Ceci *et al.*, 2002). The studies reviewed that ask questions about an experience, and/ or experience frequency, employed a measure to 'measure it' (Landers, O'Brien and Phelan, 2010; Kelleher and Campbell, 2011; Dransart *et al.*, 2015; Kimbrel *et al.*, 2016; Erlich *et al.*, 2017; Hom *et al.*, 2018; Cerel, *et al.*, 2019; Gibbons *et al.*, 2019; Murphy *et al.*, 2019; Van der Hallen, 2022) against a deficit framing of post event response, also commence from a baseline assumption that there is a response to be given that will fit into that structure. I reflect on what choice the participants had if the framing or context of their distress, experiences, stories, values, and beliefs did not lend so easily to the rigidity of the methodological design. Was there any scope within the research for them to say 'no this isn't how it is' or, if they were aware of the possible tensions that existed in how their experiences were being measured and tested?

By no means do I dismiss the participant's experiences as expressed within the studies reviewed. However, there is a possibility that for some participants they may have felt relieved for the person that had died. Or they may feel emotionally and professionally punished by the person. Or they might not have quite figured out how they feel about the experience yet. How willing or able would they be to say this within a research process and professional context, that has also not offered enough space and permission to do so, and was only interested in measuring symptoms of Post-Traumatic Stress Disorder? Do the participants have to abide by the rules of the current discourse and gaze to then be heard in this contemporary understanding of professional exposure to

suicide? Do they have to perform to the literal narrative which in some cases is endorsed by the bio-medical model, and that of the informed researcher? Here the researcher performs the role of interlocutor, and the participant adopts the role of confessor (Roberts, 2005). For example, in Landers, O'Brien and Phelan, (2010) one strand of their questioning asked what effect the suicide had on the consultant, both personally and professionally, and then what coping strategies they used in its aftermath. In Kim, (2019) the overarching aim of the research was to explore the bereavement experiences of teachers and the challenges they face in coping with student suicide.

However, in Wang *et al.*, (2016) a theme of bitterness towards the person who had died emerged from respondents who had discussed the sense they had made of the exposure, they did so within a semi-structured interview framing. There is a thread in Darden and Rutter, (2011) where a participant responded '*I don't know if I know, I am sure, how could it not, but not in obvious ways to me, in subtle ways I am sure*' when asked of personal impact. However, in contrast Rothes *et al.*, (2020) asked participants to think about the suicide attempts they had attended in their service within a prehospital setting so far. They also asked that among them, can they select one that has particularly affected them or that has been more significant for them. They went further in asking participants to describe the situation and their own experience in as much detail as possible. In Sanders *et al.*, (2005) they asked participants to describe how they felt in the seven days immediately following a client suicide, and to describe how they feel now when they think about the client suicide, highlighting the need to consider the temporality of experience. Experiences can be accumulative building blocks contributing to someone's sense-making, which also exposes the risk of presenting any data snapshots as fact.

2.6 Themes of Discussion

2.6.1 Underpinning, Uncontested Latent Themes

A theme underpinning the literature is constructed under a banner of postvention, and that suicide is a cause of death that is to be prevented. I want to guide the reader to consider the inconceivability at this point in our history and political milieu, that a search on pro-choice professional/occupational alignment would elicit many results. Considering the epistemic authority that sanctions such research, with discourses that are entangled in different power struggles among the realms of law, medicine, and morality. They are in turn imposed up on by intelligibility and meaning on human subjects (Borg, 2020), knowledge production is therefore political (Scotland, 2012).

The first basic tenet of choice theory is that we can only control our own behaviour, and that we cannot control the behaviour of others. If we consider suicide as behaviour, suicide prevention programs and the research that informs their evidence base aim to reduce, and prevent/control this behaviour (Glasser, 1998; 2000). However, in some of the studies reviewed, one professional's sense-making and ability to cope was underpinned by their belief that they did not have control of their patient '*She did what she felt she had to do*' (Sanders *et al.*, 2005, p. 208). Akin to this sense-making was the theme of acceptance emerging in, Ting *et al.*, (2006). Narrative as a way of knowing, would see us move away from a research and pedagogic approach that simply imparts knowledge of an accepted culture to the next generation of professionals (Florence, 1998). This poses a dilemma for debate where we might achieve a more pleural ground and space in professional/occupation postvention research. Here we may hear professionals valuing someone's existential right and choice, and therefore do not resent or punish them in their death. At the same time, they can occupy a space that does not accept the inevitability of suicide which may in turn reject those seeking help, nor neglect to consider a need to learn possible lessons through our value of people's lives, and loss.

2.6.2 A Desire to Avoid Assimilation by Design with Due Regard to Temporality

Power and knowledge '*directly imply one another*' (Foucault, 1979, p. 27), therefore when designing my study, I am aware that if we live in a decentred universe with no firm foundations or higher authority, some metanarratives appear to dominate over others. It is this latter point I am interested in partially addressing by adopting a differing stance. My study will aim to hear some of the unheard voices and in doing so it will resist the pull to collapse the possible complexity of their experiences into one single aspect. Thus, adopting an exclusively positivist stance that aims to measure and frame experiences using scales and questionnaires, does not allow for an exploration of how people experience responding to those who have died by suicide. Nor does it lend easily to consider that this sense-making is co-constructed and is ripe for change.

2.6.3 Broadening and Fine Tuning of Future Research Gaze

My study aims to broaden our gaze beyond the scope of professions/occupations included in the current peer reviewed literature. It will look beyond the saturation of the mental health professional context and acknowledge that many suicides that occur in the UK are outside of this scope of practice. Furthermore, few of the studies reviewed in this thesis capture experience of responding to suicide specifically, within the initial moments of the attempt/suicide. Though death scene themes appear in Kimbrel *et al.*, (2016), Hom *et al.*, (2018) and Nelson *et al.*, (2020). Exploration of the literature shows less focus on those within the emergency services, Law Enforcement (Cerel *et al.*, 2019), and more specifically paramedics (Nelson *et al.*, 2020).

If Darden and Rutter (2011) highlight that the research into psychologists' exposure to suicide is negligible in the literature, it is positively scant for paramedics with only one paper retrievable from Nelson *et al.*, (2020) that has explored this context with any degree of specificity. There is also an appeal to

focus on such exposure in more quantity and depth (Maple, Poštuvan and McDonnell, 2019). Indeed, this should be important to the premise and aims of postvention, given that emergency services staff were twice as likely to identify problems at work as the main cause of their mental health problems when compared with the general workforce (Mind, 2019). This is underpinned by an increasing concern about the rate of paramedic suicide (Mars *et al.*, 2020). In addition, it is highlighted that paramedics are an occupational group who respond to suicide often without enough training or support (Association of Ambulance Chief Executives (AACE), (2021).

2.6.4 Silent Student Voice

It remains that student paramedics are a group that have not been explicitly sought out in postvention research. As with the iterative nature of this review, I have exhausted google scholar and data base searches for such an emerging professional/occupational focus. Within the body of the literature reviewed, the experiences of trainees from other professional groups such as trainee psychologists and psychiatrists, and those individuals who were much further on in their career was also less apparent. In Gaffney *et al.*, (2009) and Darden and Rutter, (2011) they depict the student/ trainee status of some of their participants, and reflections on experiences from their trainee 'days'. However, within the abstract of these studies this was not illuminated. Furthermore, there is an apparent exclusion within the Health Education England Review mentioned in the introductory chapter of this thesis, in relation to students and their exposure to bereavement. This also resonates with the narrative beginnings of this study. Therefore, given the exclusion of both paramedics and students overall, this study will focus on student paramedics.

2.6.5 Wider discourses and discursive practices within paramedic science education.

On their journey to professionalization, paramedics within the UK are now registered professionals with their titles protected in law (Aronson, 2017). They

are regulated by The Health Professions Council (HCPC), formerly known as Professions Supplemental to Medicine (CPSM). Their practice had undergone re-evaluation by an Audit Commission in 1998, which shifted their focus to becoming practitioners who can triage, assess, treat, and manage less serious conditions on the road, in contrast to simply conveying patients to hospital, (Kilner, 2004). It is fair to say that such changes have seen them converge with a process of academisation (Givati, Markham, and Street, 2018), which has required reform to the training standards Paramedics needed to engage with.

Paramedics have shifted from apprenticeship style training to training and education that needed to be delivered in universities (Brooks *et al.*, 2015). This shift was bolstered further by a strategic review of the NHS Ambulance Service led by the Department of Health in 2005. The subsequent report entitled the Bradley report, critically, put emphasis on the need to better utilise these practitioners' skills to support an overarching aim of reducing cost and meeting efficiency targets of the NHS. In many ways this mirrors the journey and mobility of other allied health professionals such as nurses and pharmacists and has invited critique that has led to them being referred to as 'noctors, phoctors and mocktors' (Nabi, 2015) in response to their upskilling and utilisation in an environment where the short fall in qualified medics has not been addressed.

It has been argued that universities who are the predominant providers of paramedic education, are caught between two opposing discourses of professionalisation and socialization (Givati, Markham, and Street, 2018). Professionalisation would see them offer a platform for their students to become socialised and become professionals through the eloquence of their education and training. This is achieved with 50% of their programme occurring within on the job placement-based learning. This comes into direct conflict with the role of university socialisation serving as a conduit for managerial/organisational strategies of professionalism which appear to undermine this aim (Givati, Markham, & Street, 2018). At the same time, it is argued that whilst placement learning has begun to reflect the pace of change for paramedic's interface, the taught components now may not always match the experience of paramedic

educators if they have not maintained their own clinical practice (O'Meara, Furness, and Gleeson, 2017).

Despite what appears to be a complex field, that I view as straddling positions of being deeply embedded with a history dating back to the crusades (Eaton, 2023), and yet evolving and emerging as one of the most rapidly developing professions in the UK, ambulance work has received very little attention from sociology, despite also being considered one of the most dangerous professions, (Maguire *et al.*, 2018). It is argued that when exploration is attempted, it is largely situated in the context of other health professions (Wagner *et al.*, 2020). Described as autonomous registrants who are pluripotent by design and generalist through their experiences (Eaton, 2023), paramedic education and its unique identity formation is shaped by societal expectations and cultural perceptions (Nancarrow and Borthwick, 2005) and requires a combination of 'doing, knowing, being and becoming' (Ewing and Smith, 2003). These intricacies are all ripe for exploration within this study alongside how they may shape the accounts of suicide exposure.

2.6.6 Creating a Space for Stories

Within the CIS sample, one of the papers I kept revisiting was that of Clark (2009) who engaged in a narrative analysis of silenced therapists' stories. It was powerful, moving, and was the only study where I felt I was permitted entry into the author's life for a moment. I would add here, that as I progressed with making sense of the body of literature, I noted that even those studies that first presented themselves to me as cold and distanced, because they were engraved with statistical prevalence and measures, still gave me some threads of stories, context, and sense-making.

There are arguments that statistical evidence captures interest promising more persuasiveness than narrative evidence (Baesler and Burgoon, 1994; Chaiken and Mahewswarn, 1994; Allen and Preiss, 1997; Ah Yun and Massi, 2000;

Green and Broock, 2002). Others suggested that narrative signals are stronger (Kazoleas, 1993; Morgan *et al.*, 2002). Though persuasiveness is not the most pressing tenant guiding my study, I have thought about the readers in this field. What variety do they have? How much of the existing body of literature serves to construct an identity to the experience of professional/occupational exposure to suicide through its mere method? Viewing my study as a contribution to the existing body of knowledge, an apparent space has been created. Here I can settle and try to add to its personal-ness (Beasler, 1997) by enriching it with experiences told through stories, co-constructed through narratives, and then analysed in a narrative way.

I am, however, cognisant that I may have fallen into a trap of attending to the policies and practices of paramedics within the previous sub chapter, when the first principle of seeking stories should attend to the lives of the story tellers (Caine *et al.*, 2018). With this said, I hope to extend the co-construction of our understanding of paramedic's daily conditions and their exposure to suicide with that context, whilst also taking in to account any power dynamics that may serve to constrain the autonomy of this study's participants. I will also listen for signposts on how they compose their lives, responses to suicide exposure and professional identity formation given the initial exploration in the section immediately prior to this. To do so, I must acknowledge my own professional background, I am not a paramedic and now a nurse within an academic context. Therefore, any inquiry I undertake must attend to my insider outsider researcher status and what I may represent to the participants in this study, and how this shapes their accounts.

2.6.7 Creating a Space for Self

In one of the papers reviewed within this CIS (Darden and Rutter, 2011) none of the research team had any previous professional exposure to suicide. I considered if their choice to highlight this was an attempt to hint at their 'objectivity'. In the methodological approach that emerges from this literature review, I would argue that there is space for the 'inquirer' to bring themselves to

the story. The process of inquiry could be aided by honesty, self-criticality, and vulnerability that is born through professional exposure to suicide. Above all, any research I go on to engage in commences from a starting point that does not set a hypothesis of the experience of interest, resisting the pull to shape them through grand narratives. Therefore, I will attempt a resistance of forcing the narratives gained in to a pathological or deficit framework by the study design, an ensure my own part in co-constructing them becomes an avenue for exploration also.

Summary

This Critical Interpretive Synthesis has explored a body of literature which shares commonality in wanting to find out about exposure to suicide in a professional/occupational context. Synthesised themes have emerged from a vantage point of viewing the literature as a whole entity. I have been guided, but not anchored, by my literature review question which has been disinterested in ascertaining 'what works'. I have provided a sweeping critique of the ways in which the literature in professional/occupational exposure to suicide is explored and represented. However, I hope that I have exposed some of the epistemological and normative assumptions on which it currently sits.

Dixon-Woods *et al.*, (2006) highlight that a critique of the Critical Interpretive Synthesis approach may emerge from judgement of an undisciplined reviewer who may construct their theories and then round up the evidence to support them. Indeed, I have felt liberated in rejecting a pre-determined sequenced approach to this review, and I have enjoyed the iterative, interactive, dynamic, and recursive way I have engaged with the papers. The approach has commanded continual reflexivity; therefore, I believe this adds a layer of discursiveness to this review which may increase its transparency. With this said, my conversations may have been limited by the number of papers in this review. My date range was set within a perimeter between 2005 and 2022 and there were papers within this date range that I could not access due to requiring

payment. A limitation of this review may be its refusal to engage in any quality assurance processes, and to then eliminate papers which were methodologically troublesome. A further limitation may be that I have failed to exclude one paper which isn't published in a peer reviewed journal. Picking up this last point and applying this boundary may have led me to miss Clark, (2009) which though I make no demonstrable or repeated mention of within the literature review itself, it is one study which has been instrumental in guiding the direction for my own study.

This review has remained faithful to its guiding question and emerging outputs that did not anchor me as the inquirer. They have allowed me to explore principles of dominance that emerge in both professional voice and how it is heard. This iterative, organic, and exploratory process now offers a differing lens for a student paramedic context to be explored. This lens aims to commence from a starting point that will resist the temptation to frame experiences at the outset of the research endeavour.

Chapter Three: Methodology

Introduction

In this chapter I aim to make my study positioning more explicit. I will therefore expose and subsequently align my study paradigm, which is pivotal to its methodological approach (Wilson and Stutchbury, 2009; Robinson and Kuteyi, 2010). This extends to the means for data collection and knowledge generation (Howell, 2013). The chapter will present the reader with a step-by-step account of how I came to the decisions about theoretical and practical data collection and analysis, which then goes on to shape the findings and discussions within the subsequent chapter.

3.1 Philosophical Positioning

I have resisted previous tendencies to pitch positions against one another, acknowledging that critique only exists in relation to something other than itself (Foucault, 1997). I have been guided by a commitment to explore the binding relations between power, truth, and the subject, and how others and indeed I may '*subjugate ourselves within everyday practices*' (Foucault, 1997, p. 386). Therefore, I commenced this study admitting that any one of us is rooted within commitments to versions of, and ways of knowing our world (Usher, Bryant, and Johnstone, 1997). I am also one of the main instruments for generating and analysing the stories within this study (Leibing and McLean, 2007; McLean, 2007).

My study aims to hear experiences of unheard voices within the student paramedic community, and thus increase our cultural awareness of their exposure to suicide within a wider postvention context. It can be conceived that their lives and mine are a unified narrative embedded in a multiplicity of other narratives (MacIntyre, 1985; Raggatt, 2006). The narratives co-explored and

created within this study have offered a platform to make sense of complex meanings of experiences. These experiences are enlightened by a poststructuralist lens and are discursively constructed non-linear performative developments and representations of the sense-making associated with exposure to suicide.

It could be argued that there are strong constructivist threads within the phenomenon of narrative inquiry, as there are socially enacted learning bonds that are created (Vygotsky, 1978; Denzin and Lincoln, 1994; Neimeyer and Raskin, 2001). However, I would argue that my study is rooted in a social constructionist perspective, revealing itself in a post-structuralist world. Social constructionism could be viewed as a perspective which believes that much of human life exists as it does, due to social and interpersonal influences (Gergen, 1985; Hrubys, 2001). There may well be an underpinning cause or correlation within any culture, but we must resist describing them as universal and certain (Owen, 1995; Stam, 1998). When reviewing the body of literature which aims to explore professional/occupational exposure to suicide, I have been drawn to those lines of tension such as the claims or aims of universalism. I have explored modes of objectification, power, and meta-narratives which may lead us to comfort ourselves with illusions of objectivity, and a pursuit of one truth (Gould 1992; Remenyi, 2005). Indeed, the social constructionism perspective highlights that there is no true or false, right, or wrong, there are only stories about what is perceived as true, false, right, or wrong.

As an extension to critical theory, post-structuralism when used as a critique of structuralism, has some important theoretical components. Poststructuralism asks us to re-consider the interconnection and the role of discourse, viewing subjectivity in relation to language and power (Connolly, 1991; Bleiker and Chou, 2010; Merlingen, 2013; Kouri and White, 2014). Critical theory and poststructuralism alike allow us to adopt degrees of skepticism towards accepted ways of thinking as rational and neutral (Kellner, 1989; Alvesson and Sköldbberg, 2000; Poster, 2019). Particularly as they are rooted in positivist

understandings of the world (Marsh, 1995; Smith, 1996; Steinmetz, 2005). Indeed, knowledge that claims to be neutral or positions itself as a part of self-evident assumptions, should be questioned and examined for those very reasons (Knight and Jack, 1992). In my poststructuralist view of the world there can be no objective or final truth (Morin, 2007). I am guided by the respectful rejection of universalism and consensus formation, together with narratives of rationality and normative justification (Hanssen, 2004).

Any number of truths cannot be separated from the procedures of their production, and conceptualisations of 'power' can be seen as a representative phenomenon rather than a concrete, material entity. Foucault's work exposes the link between power and knowledge and unsettles the positivist foundations that many theories have rested their political methodology upon (Foucault 1978, 2004). Therefore, the suspension of values and power relations in the pursuit of knowledge is simply not possible (Fiumar, 1990; Smith, 1990; Devetak, 2005). I concede that all knowledge of reality comes with a brand of culture, and this cannot be separated from what any specific group of people would call knowledge. Such knowledge is shaped in accordance with traditions, interests, needs, and indeed biases (Edkins and Pin-Fat, 2005; Galbin, 2014).

Foucault is said to have acknowledged the abundance of levels of analysis and challenge to the traditional approaches to intellectual history, such as the history of ideas, or literature, or ideas, or philosophy of history. However, they still take for granted the unity of their objects: for example, a tradition, identity, a scientific theory or set of theories (Harlan, 1989). Whilst there is something tempting about exploring and presenting an identification of cross-cultural regularities in narrative form that recur with a higher frequency than is consistent with chance (Hogan, 2003), I will resist any temptation to sanitize my study by appealing to facts and linear trajectories (Franzosi, 1998; Plummer, 2001). My narrative approach aims to emphasize particularism and cultural difference.

3.2 Embracing the Space Between: My Insider and Outsider Researcher Status

Within the previous chapter, I cautioned the need of tending to my positionality and what I may represent to the participants of this study. I have been considerate of my insider and outsider researcher position within this study, to include what I represent to others and what they represent to me, and how my social identity influences the research (Einstein, 2012). I anticipated that this would be a dynamic that may occur paradoxically throughout the entire study (Maykut and Morehouse, 1994; Merriam *et al.*, 2001; Flores, 2018), and beyond (Day, 2012), and will *shift 'over time and place'* (Naples, 2003, p. 198). However, I have attempted some demarcation at points to pre-empt some of the possible assumptions that may emerge from the two positions of insider, and outsider researcher.

Relations of power can be viewed as the immediate effects of divisions and inequalities that occur in social relationships and interactions. Shifting from structural conceptions of power alone, it is important to emphasise the idea that these power relations do not merely accompany discrepancies in other relationships. Instead, they can play a directly productive role (Guedon, 1977; Blix, 2015) in '*objectifying and subjectivating people*' (Neal, 2009, p. 163). To that end, our attention is drawn to the '*panopticon*' which refers to an experimental laboratory of power in which behavior could be modified (Foucault, 1977, p. 201). I acknowledge my insider researcher status as a staff member of the university in which the student paramedics study (Costly, Elliott and Gibbs, 2010a: 2010b). I also needed to be aware of the subject I was researching (Lee, 1993; Plummer, 2001; Dickson-Swift *et al.*, 2008; Lee and Lee, 2012), because it may have been difficult for them to think and talk about their exposure to suicide and the associated sense-making. I also have some practice, academic, and online presence, and positioning within the subject area, and these may conflict with some of their experiences and philosophical viewpoints. However, my poststructuralist position would indicate that no one is able to be an

objective expert on someone else's experience and I made this position clear at the recruitment stage, and throughout the data collection.

As a member of a group being studied, it is neither necessary nor sufficient in being able to explore a way of knowing the experience of that group. Knowing implies being able to identify, describe, and explain experiences that are co-constructed (Fay, 1996). Despite this, as an outsider to the student paramedics emerging professional/occupational group and student status, I found myself studying members of a profession/occupation to which I do not belong. I could not commence this study assuming that I would be permitted entry into their lives, and in the emergence of their developing professional identities. I made some attempt to mitigate the possible barriers of not being a member of their student or professional group within the design of my data collection and recruitment of study participants, which I discuss later in this chapter.

I believed I also owed some regard to gain a better understanding of paramedic professional/occupational context given mine is nursing (Morawski, 1998; Asselin, 2003; Hamdan, 2009). Therefore, I engaged in a 12-hour observer shift with paramedics in the hope to add to my sense-making of their cultural context. I hoped to gain an exposure to the language of the profession, as well as an experiential base which I could draw from within the story telling sessions (Asselin, 2003). I am aware that my knowledge so far, though not anchored, has found a home within my positionality (Mullings, 1999; Jacobson and Mustafa, 2019). I must therefore have an appreciation for the fluidity of the participant's experiences and indeed my own (Naples, 2003; Day, 2012). Being a member of their group may not grant automatic similarity, therefore anticipating that there may be an analytical benefit in exploring how we are different and how we are the same, I am able to embrace the space between these two positions (Adler and Adler, 1987).

3.3 Reflexivity and Subjectivity

When considering bias within research, it can be viewed as any tendency which

undermines the aim of unprejudiced consideration of its question (Poses and Levitt, 2000; Abreu, 2001; Ratner, 2002). I would argue that bias can't be excluded from the research process, irrelevant of paradigm. This is because as human beings we are limited, making it impossible to achieve an objective or absolute truth (Popper, 1959; 1972; 1986).

There is something to be said about using bias as an explicit resource, as reflexivity can be used to inform learning and transformation, and in doing so we develop an ability to notice our responses to the world, other people, and events. When using these signposts, we can inform our sense-making (Etherington, 2004). Achieving this critical standpoint has left me to look at my own professional practice at a distance, rather than just from inside (Bauman, 1991), I have then used those signposts to inform my learning. Therefore, I have tried to resist the pull to settle and ignore any renewed pull to critique within this study, recognising that this has previously stifled my intellectual and reflexive capabilities.

With regard to the topic of interest, it is argued that it is advantageous to understand this reality by knowing it from within (Smith, 1990), and then contemplating experience from within that situation (Bolton, 2010; Johns, 2009). As Foucault said, *'for one or another reason I had the occasion to feel and live those things'* (Martin, 1988, p. 11). I have therefore been guided within this study by my willingness to listen to my own feelings and use my experiences as a resource (Alvesson and Skoldberg, 2009). To make this principle clearer, I have included an account of my own experiences of exposure to death by suicide as a source of data. Reflexivity not only implies the ability to reflect inward, but *'outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share.'* (Sandelowski and Barroso, 2002, p. 222)

Reflexivity is further enhanced in the form of journal logging, voice recordings, and written reflexive accounts. In doing so, I bridge a dialogue with my sense-

making to the stories of the student narrators. I acknowledged that my own story nor theirs, is one that is lived, but is instead living. Importantly, grounded in a phenomenological position, the idea of lived experience can appeal to experience being praised as the best possible source of knowledge, giving the impression of foundationalism (Bevir, 2009). Experience has not been assumed within this study, it has needed explanation, raising questions about its constructed nature and how subjects within the study are positioned as being different in the first place (Scott, 1992). With all this said, whilst acknowledging that subjectivity is central to interpretation of social meaning instead of a pursuit to measure it (Holden and Lynch, 2004), I have been minded not to be carried into the reflexive light at the risk of my voice shadowing the student participants (Finley and Knowles, 1995; Finley, 2007).

3.4 Epistemological Design

Narrative is present in an almost infinite diversity of forms, all humans have their narratives, *'it is simply there, like life itself'* (Barthes 1977, p. 79). Narrative has offered a space for the voice of student paramedics within this study, who are situated as emerging professionals exposed to suicide. The study has not 'given them voice', more so, it has sought to hear it. This phrase can be traced back to a formal acquisition of research that appeals to voice (Moore and Muller, 1999), but we need to consider the critique of assumptions in relation to voice speaking truth (Jackson and Mazzei, 2009). Drawing on a post structural critique of voice, a negotiation of power relations between myself and the student narrators has shaped the pursuit of a shared meanings in this study (Foucault, 1979). This permits both me as co-narrator, and the readers of this work to think and engage with the stories provided by the student paramedics, and to bring our own experiences to bear within the text. This might make way for new or renewed perspectives and can be envisioned as a dialogue of discovery of the self and the other (Sarris, 1993).

Narrative inquiry explores experiences that are expressed through narration

(Clandinin *et al.*, 2010). In this study, I have strived to attend to the ways in which the narratives are constructed, their proposed purpose and intended appeal, as well as the cultural discourses that they draw upon (Trahar, 2009). As identified in the literature review, I intend to resist the temptation to gauge, generalise, and frame the narratives with a measure. Exploring professional/occupational exposure to suicide from accepted and normalised ways, may block out possibilities to challenge pre-given meanings of experience. For example, asking the pre-determined question 'how did you cope?', as we observed within some of the literature synthesised within chapter two (Darden and Rutter, 2011; Draper *et al.*, 2014), assumes there was something to cope with and views the experience through a deficit lens.

There are three dimensions to narrative inquiry (Clandinin and Connelly, 2000): 1) space as temporality, 2) sociality, and 3) place. Temporality considers that people and indeed events have a past, present and a future. In this study, it considers the narrators stories, as in process and always in transition (Naples, 2003; Connelly and Clandinin, 2006; Day, 2012). Sociality is concerned with the student paramedic's' personal conditions such as their hopes, their reactions and reported moral dispositions situated within the social conditions. This includes the environment and surrounding people, and therefore informs the individual context. I am aware that I cannot subtract myself from that relationship either (Connelly and Clandinin, 2006). Finally place, encourages me to focus on where the storying is taking place, and the possibilities alongside the boundaries that this may pose.

There are possible issues with narrative inquiry, including conflicts that occur both in its position, how stories are heard its hearing and representation of stories. There is a call for narrative scholarship that details actual dilemmas of practice, with better guiding principles (Josselson, 2007). I have also been aware of the social spaces in which the research knowledge was being produced, with a consideration that it can only be made sense of if this additional lens is applied. I needed to be aware of inequalities of the relationships, and I considered this with the choice of location where the stories

were told, aiming for a location that was confidential and convenient for the participants. I asked for their preferences about where to conduct the research and acted on them. I wore casual attire with the aim to reduce any formality in how I appeared, this transpired to be in parallel to the students who all opted to remain in their paramedic uniforms. I was aware of a possible line of tension that I have control over the representation of those stories and that there is a risk of potential for exploitation (Borland 2001; Plummer 2001). Therefore, in writing up and moving the narratives from the private to the public space, I needed to ensure anonymity, and be aware of the broader impact and unintentional consequences of the study. This included the consideration of who owns the information and other characters invited into the stories (Plummer, 2001; Tolich, 2010). I made attempts to address this by giving pseudo-names to the student paramedics and omitted to include any names or details they discussed which I felt would risk identification of other people or specific patient cases.

In summation, this study has been enlightened by the narrations of student paramedics concerning their experiences of exposure to suicide, and their role and that of others within this exposure (Zellermayer, 1997). Their lives, and indeed mine, have been considered as a narrative, consisting of rich threads of interwoven stories, that are there to be performed and heard. As I set off on this study journey my aim to co-construct narratives offered me a compass, which has orientated me throughout the whole experience. Hence, the narrative approach has been both the phenomenon and the method (Connelly and Clandinin, 1990).

3.5 Recruitment, Sampling and Study Participants

The students were recruited from level five modules within a Paramedic Science bachelor's degree course. The inclusion criteria for selection were that the participants have self-identified to have had a professional/occupational encounter(s) with death by suicide or suicide attempt(s), forming the basis of an

exclusion criterion that their encounter could not have solely been born of any other context, such as personal or other professional/ occupational experience. I recruited students by first making their module leaders aware of my study, having met with the course team and the students with the purpose of discussing my study and its aims (Fontana and Frey, 2005; Glesne, 2011). Five student paramedics went on to share their stories.

Purposeful, homogeneous, and convenience sampling were utilized to select participants that met the specified criteria. Purposeful sampling involved the process of selecting participants from a known group that maybe rich with data for this study (Merriam, 1998; Patton, 2002) due to the angle of the experience they may have (Thorne, 2008). The homogenous nature of this sampling refers to selecting participants with similar characteristics, so that I can understand a common experience through the comparison of their student paramedic status (Glesne, 2011). I acknowledge that the convenient nature of the sampling and selecting participants that are close at hand (Thorne, 2008; Sedgwick, 2013), placed me in a position of privilege.

All five student paramedics remained engaged in the study which included discussions around emerging sense-making beyond the initial one-to-one storytelling. They were in the first half of their second year of study, and some of their reported demographic details can be found in the table below.

Table 5: Self-reported demographic details of the study participants

Participant Pseudonym	Self-Reported Age and Gender	Ethnicity
Lucy	19 Female	White British
Matt	19 Male	White British
Hope	20 Female	White British
Cameron	20 Male	White British
Jodie	27 Female	Mixed heritage – African Caribbean and White British

There may be a criticism pointed towards this participant sample, in that it is both small, and that it is not representative. However, my study position would avoid a ‘one size fits all’ design and assumption (Barbour, 2001). I also ascribe to the sentiment that less is more in the context of narrative inquiry (deMarrais, 2004; Petty, Thompson, and Stew, 2012; Guetterman, 2015). Large sample sizes are not required as it is not the aim of this study to generalize data to the population of student paramedics, rather the aim of this work is to explore individuals’ narratives and consider transferable possibilities (Vishnevsky and Beanlands, 2004). Participants in research should of course reflect the diversity of our culture and conditions, considering race, ethnicity, gender, age. However, race, gender, or age did not play a specific role in advancing the study aims (Clarke and Braun, 2013), for example, as a variable to be controlled and then compared.

3.6 Data Collection Methods and Procedure

3.6.1 Data Sources and Procedures

In the recruitment and sampling of study participants I have intended to nurture a narrator and listener relationship (Chase, 1996) by regarding participants as

collaborators (Altork, 1998). This section attempts to expose the reader to the considerations and techniques employed to gain access to the students' experiences. Intricacies concerning data sources and procedures were considered well before the student paramedics were approached. I did not want to simply view the data/story collection as a means to an end. I conducted a pilot of the study method with two colleagues from the paramedic academic team who have been exposed to death by suicide. It enhanced my confidence in the method and offered an opportunity to consider mitigating any elements that did not work well (see Appendix 6).

To better ensure I could cross verify narrative threads and sense-making, within this study I used multiple methods to gather and analyze narratives from multiple sources, (Creswell, 1998; Bhattacharya, 2008). In this study, the sources of data that have been compared are story boarding sessions, one to one story telling interviews, my own essay of experiences with suicide exposure, and reflexive journal logging. Comparing sources, I aimed to improve my comprehension by highlighting important details, and in doing so it made the abstract more concrete in my thinking.

Through engaging the student paramedics in story board development, I sought to capture their constructed cultural context by asking them to depict some of their experiences so far, the drivers for joining the paramedic science course which included their hopes for the future. The students attended the story boarding session as a group, and it lasted approximately three and a half hours including discussions surrounding them once they were completed. The whole session to include the discussions were recorded, transcribed, and thus provided another source of data. Such an approach has been argued to bring relief, as the use of our hands, and other senses, may offer ways of solving and re-visioning experiences that are difficult through descriptive language (McNiff, 2008). In addition to the creation of the visual product, participative activities such as story boarding, demarcates '*reflective time to construct knowledge*', the opportunity to enter a '*playful*' mode, with the purpose of '*information not distraction*' (Gauntlett, 2007, p. 185). It was hoped that making an artefact which

the narrators could look at, think about, adapt, and talk around, would level up the playing field and mitigate the possible power I had over their responses, (Gauntlett and Holzwarth, 2006). The story boards were photographed and can be found in chapter four. In the vein of giving back, I invited the student paramedics to take their story boards home with them.

The student paramedics were then invited back to take part in a one-to-one story telling session. If at this stage or prior to the second session the student paramedics did not opt to continue, their data would not be used in the analysis, however this did not occur. The sessions lasted between one and a half hours to three hours. These second sessions focused specifically on their experience of responding to a call whereby someone had died by suicide or tried to end their own life and was supported in story telling form on a one-to-one basis. I kept my own journal notes and reflections, offering another source of data, which supported the analysis. Though the sessions were conversational in nature, I was aware that I had a study focus and aim, and that the story needed to follow some form of order. To support this focus, aim, and reflexive discussions, as well as offering me nudges within the conversation, I created a prompt sheet which can be found in Appendix 7.

An essay of my own experiences offered another source of data, which also offers a personal justification for this research. This account was facilitated through my analysis of artefacts relating to the experience, and adopted principles set out by Tolich (2010) to include consent and internal confidentiality. This essay adds to the reflexive nature of this study, and over time, consideration was also paid to the risks related to over identification and over rapport building. This guided the conversations that I had with the participants (Glesne, 1999; Abbe and Brandon, 2014; Hoolachan, 2019). At the same time, I did not want to hide behind the disguise of professional distancing, recognising the difficulty in maintaining an imagined dichotomy of insider outsider status, and instead I honoured the '*consequences of acting with genuineness*' (Glesne, 1999, p. 105).

3.7 Data Analysis

3.7.1 Co-Created Narrative and Interpretation

The study emphasis within the storied stage has been on co-construction of meaning, and in part owes a due regard for the representation of the stories told. The design of the study encourages the participants not to be passive agents. Immersing in/ listening to/reading the conversations, I took in what was being said and compared it with their personal understandings, resisting any temptations to fill in any gaps with 'grand narratives'. Instead, I inquired about how pieces of the stories make sense together. To enhance this, I invited the student narrators back to follow up sessions to extend the co-construction of meaning (Guillemin and Gillam, 2004). Both the students and I were complicit in the production of narrative through dialogic communication (Blaikie, 2007), therefore alignment could only be achieved in ensuring we remained in dialogue within the more explicit story analysis stages.

I progressed the narrations, by engaging in a debriefing session that took place a month after the completion of the one-to-one storytelling. For some of the students this was face to face (n=3) and others this was conducted via teams and phone call (n=2) based on the availability and preferences of those students. Given the COVID-19 pandemic gained such rapid momentum in the weeks after this stage of the study, I felt the need to extend this period to six months after the one-to-one storytelling sessions, and I contacted the students once monthly via email and phone call. The sessions lasted between 30 minutes and one hour and had two functions: firstly, I explored the wellbeing of the student participants, and enquired if the study had negatively impacted on them. Secondly, I conducted a check with them and ensured that they agreed with my transcription which had been sent to them via email. This offered an opportunity for them to make sense of them with me, and to ensure they were a fair representation of their narrations and gave them scope to add further layers of understanding.

Engaging in four narrated readings in collaboration with the student narrators, I read for the self of the narrator, read for content, read with attention to the study question and focus, and, read for relations of power and culture (Arvay *et al.*, 1999; Arvay, 2002; 2003). I achieved this in dialect with the students during our follow up sessions, which I explicitly expressed that they had no obligation to attend if they did not want to. This is because they may have preferred to use their time doing other activities, the timing may not have been right, or, they may have preferred not to go over the experiences they shared which may have been painful. Despite this, all of the students continued to engage, and the process was as much about meaning making as it was about mining for more information (Holstein and Gubrium, 1995). Within these follow up conversations that focused on the transcribed story telling sessions, I ensured I took the time to *'really listen'* (Anderson and Jack, 1991, pp. 179-192). Though I did use prompts that had us focus on intricacies such as any power dynamics, they were aware of and sense-making in relation to suicide exposure, I tried to ensure I remained responsive to the idiosyncrasies of each conversation, aiming to be *'interviewee-oriented'* rather than *'instrument-oriented'* (Reinharz, 1992, p. 38). It could be argued that without this collaboration, the stories would rely solely on my interpretation and would pose a line of tension that conflicts with some of my own underpinning philosophy. Additionally, I found these prompts useful when revisiting the narratives on my own and this is discussed in more detail within the analysis chapters.

3.7.2 Narrative Analysis

I initially considered thematic analysis at the proposal stages of this study. It had been put forward as a method for organizing data rather than a methodology, offering the promise of not being aligned to a particular epistemological or theoretical perspective (Braun and Clarke 2006; Clarke and Braun, 2013). However, as sense-making occurred, trying to adopt a thematic analysis lens was pulling me to a simplicity of reduction. It was also removing me from the individual narratives and their complexity (Chatman, 1978; Bal, 1997). I became more receptive to the idea that narrative is not a method, more

so, it offers a loose frame of reference (Heikkinen, Huttunen and Syrjälä, 2007).

Exploring ideas for analysis (Phillips, 1994) led me to abandon the idea of having a preconceived way of analyzing the narratives and to take advantage of the idea of surprise and curiosity. I approached the narratives as discourse, interactional conversations, storytelling, and the sharing of experiences (Williams and Cheepen, 1998). The nature of this study did not end abruptly as soon as the stories were spoken verbally. This methodological decision to explore ideas for analysis is also aligned to my ontology, as I recognised that there are potential dangers in the techniques, we employ with preciseness to resolve or conceive problems. This approach has emerged within this study from personal experience of '*deconversion*', where I have embraced a loss of certainty (Rajchman, 1991, p. 141).

Meaning making occurred throughout the study, rather than being a separate activity carried out after data collection (Gehart and McCollum, 2007), and I had accounted for this despite the method for analysis. Further familiarization with the stories occurred throughout the process of transcribing the story telling, as well as reading and re-reading the transcripts to enable familiarity with the entire body of the narratives. The transcription stage of the study might be tempting to skim over, viewed as a necessary and laborious task to tick off as done.

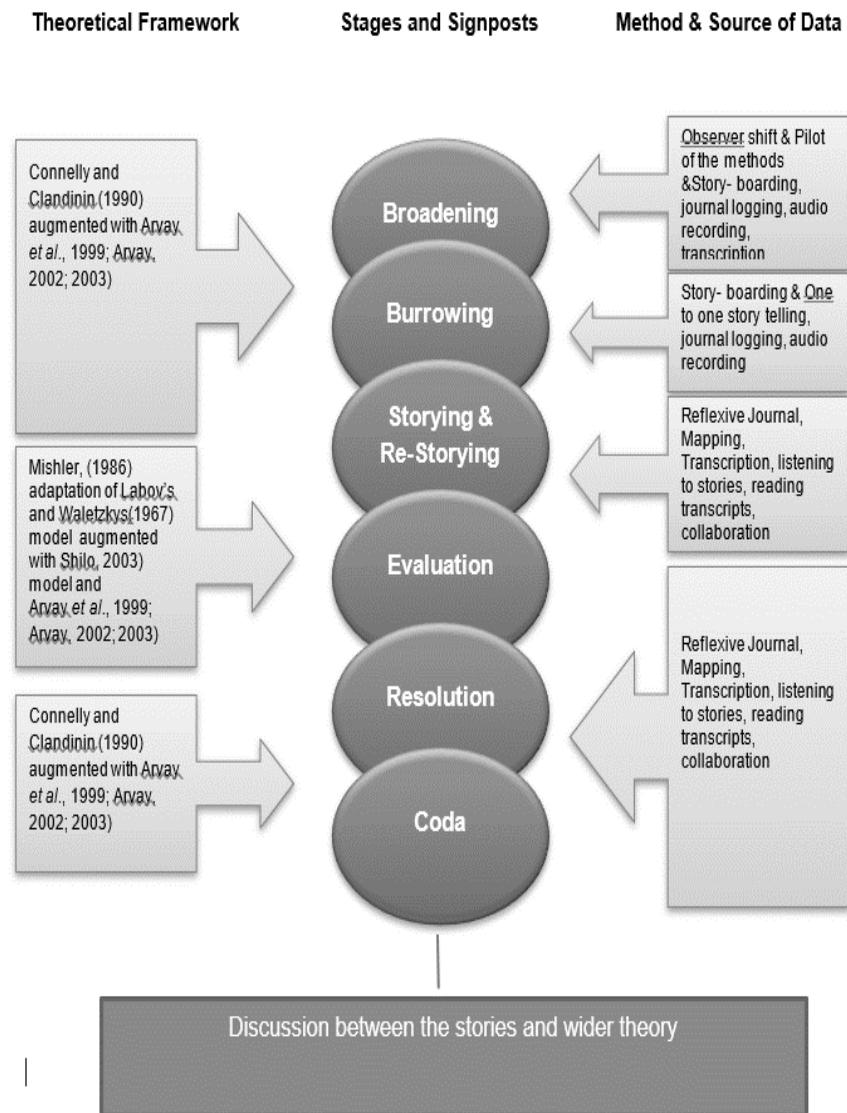
Transcription is however laden with theory and is itself an interpretive process (Lapadat and Lindsay, 1999), it is prone to being partial, and selective (Riessman, 1993). I was aware that I could not yield exact reproduction of speech (Arvey, 2002), therefore, I was considerate of the need to transcribe the audio recordings myself, which was enhanced with my own journal logging and note taking within the story telling sessions. I re-listened and added to my transcriptions including details of the narrator's pauses, sighs, laughter, and silence. I thought these may signal important signposts within the story telling and co-constructed sense-making in relation to suicide exposure within their emerging paramedic cultural context. Being "*attentive to the intersubjective, relational, embedded spaces in which lives are lived out*" (Clandinin, 2013, p. 24), I was aware that such a culture may be made up of people who do not

always follow the status quo. Those people may not take up the types of narratives that they are 'meant to', and these pauses or silences may cue an emergence of narratives that are different (Cranny-Francis, 1994; Simon, 1996). Some of these narrative silences may have also been interwoven with secrets or lies, (Rich, 1995). I was also cognizant of the fact that the student paramedic narrators' stories were being told amid other nested stories (Clandinin, 2013), such as intergenerational, cultural temporal stories, institutional and personal stories. Some of the silences may have also been a way for the student paramedic narrators to communicate the unsayable, possibly related to an experience that triggered discomfort (Rogers, 2006).

Bold font and upper-case text were added when there was a particular emphasis in the tone, emotionality, or volume of speech. During the story telling and subsequent stages of analysis, I paid particular attention to plotlines that travelled over time and place through an individual's narrative account (Clandinin, 2013). For example, I explored threads that spanned the past, present, and future tenses of their lives, exploring content as indicators of what happens within the narratives, as well as the form in relation to how something happens (Bleakley, 2005).

To aid the reader through the next stages of narrative analysis, a diagrammatic representation of the theoretical frameworks, stages and signposts, the method of data collection and analysis is offered below.

Diagram 2: Theoretical frameworks, stages and signposts, the method of data collection and analysis



I adopted the Connelly and Clandinin (1990) Broadening, Burrowing and Storying framework and augmented this with the last three stages of Mishler (1986) adaptation of Labov's and Waletzky's (1967) model, adding Evaluation, Resolution and Coda of the story. The coda of the story, came from a desire to bring the reader and narrator back to the present, extrapolating principles of what the students said they had learned from the experiences they had shared.

At the broadening stage of the analysis, I looked for and explored the broader context of the stories to include a spoken description of the storyteller, performances of their character, their values, as well as their context, including

knowledge of their professional culture (Connelly and Clandinin, 1990) to add to what I thought I knew of and about the story tellers (Mishler, 1986). Engaging in the observer shift and the pilot of the study aided this and broadened my gaze. This situated the student paramedics within a wider emerging professional/occupational context in which they are being socialised. This enabled me to situate the students as subjects who have been shaped as a 'construct of social languages or epistemes' (Foucault, 1977 a pp. 13-38), and as a product of regimes of power/knowledge and the will to power (Foucault, 1977 a). An example can be found in Appendix 8.

Burrowing in explored the individual experiences of responding to a call whereby someone attempted or has died by suicide. I focused on the student paramedics reported observations and sense-making of those specific exposure experiences, listening for turning points in the narratives to include their reported feelings. I refocused to explore any tensions they had encountered as it was told from their standpoint, to include how and why they have influenced their living experience. An example can be found in Appendix 9. I could then look upon the stories being told, in one of two ways. I could take at face value what the students were saying is true, or I could view their accounts with a little more scepticism and suspicion (Josselson, 2004; Ricoeur, 1970, 1991, 2007). Torn between not wanting to undermine any trust I was gaining, and not wanting to miss an opportunity to explore the stories in another way, I adopted a lens that considered contradictions, and the possibility that the stories being spoken may be masking other narratives (Josselson, 2004) (see Appendix 10).

Storying and re-storying involved organising the stories into a form that flowed, given the narratives often jumped and didn't follow an order that may be easily understood. Bringing the stories to coherent life, narrative inquirers may implement narrative smoothing (Spence, 1986), focusing on the interesting rather than being faithful to the original account. I had to manage the tendency to find strands of the plot that fitted my immediate understanding, and therefore I had to consider that the stories might want to tell me something different

(Munro, 2007). Narrative analysis treats stories as knowledge which constitutes the '*social realities of the narrator*' (Etherington, 2004, p. 81), and conveys a sense-making of that person's experience in its messiness and texture, by using the actual words spoken. To this end, the presentation of the stories includes some of my part in that conversation, to be transparent about the relational nature of the study, and the ways in which these stories are shaped through dialogue and co-construction.

Evaluation came through exploring the emotionality of the narrative, explaining why the story is worth telling (Ozyıldırım, 2009). This focused on the retelling of the student narrators emotional state, the 'How did you feel during the experience?' and moving them beyond minimal narrative. This is an important signpost in the analysis, as it can offer an illumination of what the story may mean (Labov, 1972). Despite the importance related to the evaluation in narrative (Labov, 1972), I was at odds with the suggested formality, indeed there is little agreement in the literature on narrative analysis, especially with respect to the types of evaluation to be analysed and how (Shiro, 2003). I adopted some guiding principles presented by Shiro, (2003), that focused on the linguistic features utilised by the narrators, to represent feelings and thoughts as a way of approaching the narrative. Here I focused on the statements, practices, and institutional structures discussed, that share and give us hints at common constructed values (Hare-Mustin, 1994).

I have far from engaged in a discourse analysis of the stories, nor do I believe any reported values have any depth. With this said, I wanted to focus attention to some specificity of the actual words spoken, in the hope they would be helpful in recognising the performed realisations that corresponded to each evaluative thread (Ozyıldırım, 2009). The signpost expressed anything that is reportedly perceived through the senses, to include the reported physical state and internally felt experiences, with the aim of moving beyond a mere description of their emotions. Intention focuses on the student paramedic's intention of doing something, referring to an action which is interpreted as a

relation between characters, rather than action itself. An example can be found in Appendix 11. The Resolution Stage of the narrative analysis involves ‘what finally happened? Or ‘what did you learn?’ It intends to offer the reader a conclusion and ending of sorts, albeit temporary (See Appendix 12). This leads to the coda clauses offering a summation of the narrative overall, given the storytelling is retrospective in nature, the reader will be brought to the present. The coda clauses include what the student paramedics hopes for the future (Ozyildirim, 2009).

When reading the stories to identify the paramedic students’ co-constructed sense of self, I asked questions of each of the student paramedic’s narrations (Arvay *et al.*, 1999; Arvay, 2002; 2003). These questions included, ‘What role are they assuming at this point?’ ‘What meaning are they attempting to convey to me and how are they feeling?’ ‘Where are they located in this story?’ ‘As the main character in this story, what do they want to portray to the wider audience?’ ‘What parts of themselves are they sharing?’ (Arvay, 2002). Focusing in on the study question, I paid particular attention to questions such as: ‘What are the student paramedics saying about the lead up, intervention and outcomes when they responded to a suicide (completed or attempted), and who played a role in influencing their sense making?’, ‘What sense have they made of this both at the time and now, is it ripe for change?’ ‘What do they not say and instead imply?’

Revisiting the transcripts, recordings, and drafts of the co-constructed plot lines, I paid closer attention to relations of culture and power. I opted not to do so through the lens of gender, race or social class, more so as situated student paramedics engaging in placement-based learning, responding to suicide or attempted suicide and who were being assessed by a qualified paramedic mentor. However, I aimed to move beyond a simplistic notion of a social relation that situates two agents in a hierarchy of dominant and dominated (Scott, 2001). More so, the pull to a Foucauldian lens had me explore normalizing power (Foucault, 1988), which is a power dynamic which manifests as a form of disciplinary power through internalization of an idealized norm of conduct

through our socialization. I asked questions of the narrations such as 'Are the narrators aware of any political or cultural influences on their experiences and sense making?' 'What cultural stories are invoked in the text and what sense of that am I making?' 'Are they aware of any imbalances of power and how they are possibly silenced?', 'In responding the way they did, what role are they assuming, and for who's benefit?' (Arvay, 2002).

3.7.3 Theoretical Analysis

With no desire to test hypothesis, a further layer of analysis has occurred throughout the re-storying (Conle, 2000) which aims to add another layer of discussion (Pace, 2012), and a dynamic within the sense-making (Clandinin *et al*, 2007). This theoretical linkage was a difficult balance to achieve (Ellis and Bochner, 2000), because on one hand I did not want to leave stories stranded by not exploring them against some social and theoretical context (Goodson, 1995). On the other hand, I needed to manage the risk of disrupting and dominating the flow of the stories, which is why not every juncture is met with theoretical linkage.

3.7.4 A collocation of Sense-Making

Each of the stories depict the students' paramedics individual signposts which are organized into the stages of anticipation, initial fascination, frustration, nightmare, and return based on a co-constructed plot line discussed in chapter four. The discussions following each of these stages pull me away from looking at the student paramedics individually and addresses the third study question that I posit in chapter one. That is, what are the similarities and contradictions that arise from the collective narratives of the whole study?

Moving away from viewing the students' narrations individually with the aim to achieve a collocation of sense-making. I have drawn on a distinction that does not seek out linguistic similarities per se. More so, I lift the signposts of

anticipation, initial fascination, frustration, nightmare, and return which emerge within our student paramedics stories. I use them as windows through which I view and draw up on the consistent and inconsistent features of the signposts across the whole thesis. Therefore, the process of collocation moves beyond pooling or assembling the re-occurring plotlines to draw out similarities. It calls for the analysis of data to explore contradictions, taken for granted assumptions and wider discursive practices.

A more explicit post structural analysis, lending on a Foucauldian way of observing the co-constructed narrations has been adopted. To do so, I appreciated the past and present sociocultural, environmental, and political influences upon the professionals meaning making and storying of themselves, others, and the wider world. This has seen me focus on what might be viewed as the insignificant details within the texts and stories. I have traced '*grey meticulous details*' (Foucault, 1986, p. 76) framed as discontinuities, recurrences and play whereas other research may look for continuous development, progress, and gravitas.

3.7.5 The Pull to Foucault

Later in his career, Foucault reflected on his life's project and announced that he had been concerned with western culture and its truth games within the social sciences such as, medicine, psychiatry, and the penal system. His project had been to '*unsettle, historicise, and analyse how they shape knowledge and techniques that enable us to know ourselves*' (Foucault, 1988 a, pp. 16–49). There is resonance with this statement throughout this study, as I have tended to some of the taken for granted assumptions and grand narratives that appear to have shaped the field of professional postvention, and those who have been a focus of its attention. Foucault outlined that the subject is a '*construct of social languages or epistemes*' (Foucault, 1977a, pp. 13-38), and acknowledged that the subject was a product of regimes of power/knowledge and the will to power

(Foucault, 1977 a). The pull to Foucault was a choice I made as it allowed me to move beyond face value representation within the discussion stage of each story signpost. I engaged in a re-reading of the student narrators' stories which challenged the collocated narrations and wider literature. I have used this strategy in my study to problematise practices and discourses that constitute professional/occupational exposure to suicide. I have done this by exploring who they may benefit and what they may fail to mention. In doing so, I have not aimed to present notions of truth because any story depends on the degree of repression of internal tensions to produce a stable effect of homogeneity and continuity (Devetak, 2013). A multitude of fragile things can be changed, connected through circumstances more than with necessities (Foucault, 1988 c). I have often returned to Foucault at times in my life when I needed to be reminded of who I was, who I am and what I might become, taking his works up as spiritual exercises of self-cultivation (May, 2005; McWhorter, 2005). Therefore, this subjective pull to Foucault aids me in avoiding a specific method to engaging in this double reading, and instead offers a way of seeing and hearing the discourses (May, 2005; Numer *et al.*, 2017).

A Foucauldian understanding views discourse as a group of statements or actions that constitutes a set of understandings about a topic that takes place at a given historical moment (Foucault, 1991 b; Nelson 2008). The discourses within a postvention, professional/occupational sense-making context, operate to make things knowable by shaping and locating its commonly understood objects. They offer a productive operation (Lemert and Gillan, 1982), and coagulate '*regimes of truth*' (Nelson, 2008, p. 15). This means that I will not use the language of certainty within my study, but instead present ideas in ways that are more tentative, circular, and multiple (Borland, 1991; Hyden, 1994). Employing a way of seeing and hearing the narratives that allow for 'thick' or 'rich descriptions' (Denzin, 1989; Plummer, 2001; White and Denborough, 1998), I accept that research is a muddled, piratical affair, and I will '*do no service to anyone pretending otherwise*' (Stubbs, 1983, p. 246).

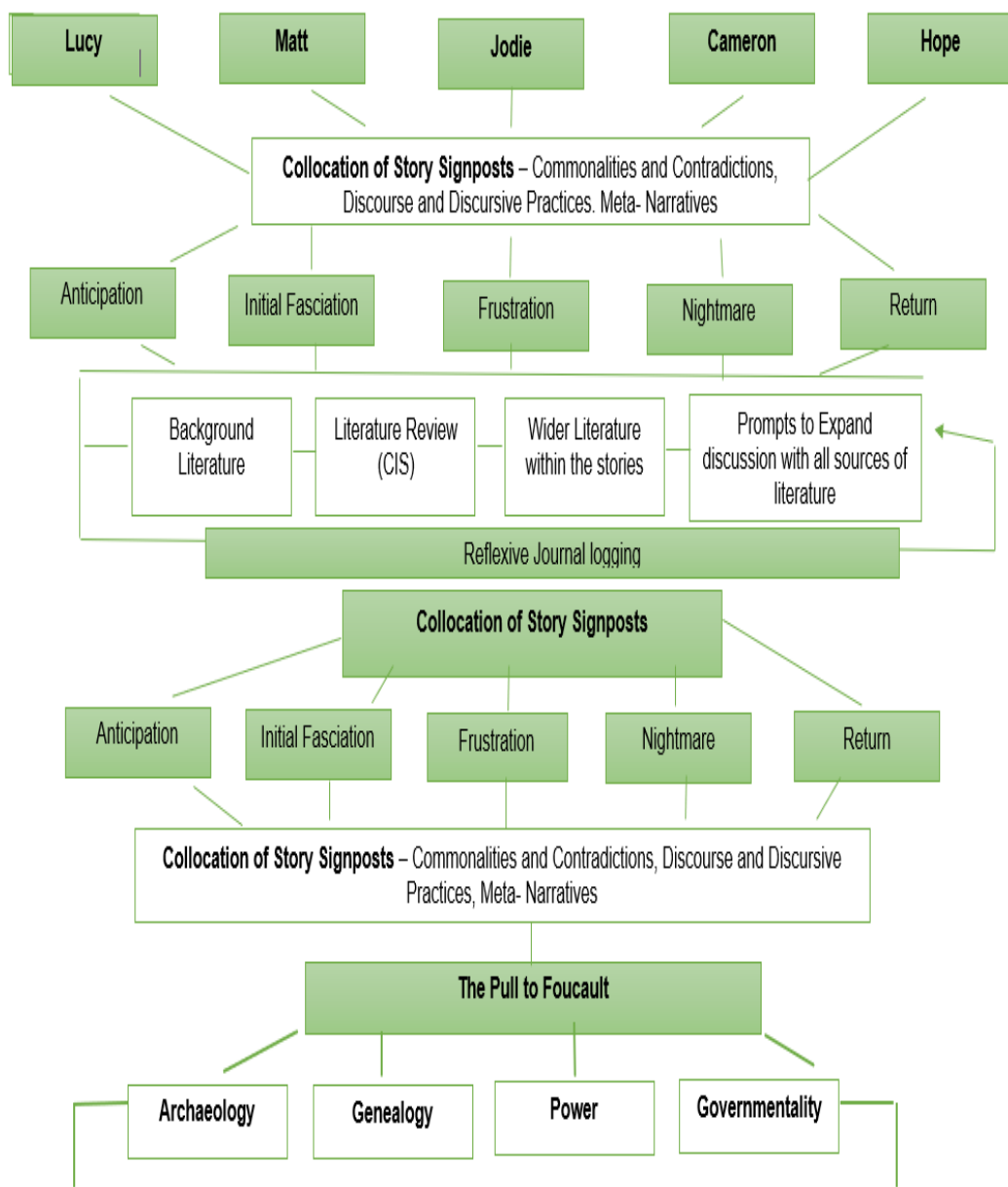
Foucault's lenses have been posited as a toolkit and offer resources for thinking in times of continual change (Rowan and Shore, 2009). I use the story signposts, viewing them as events within a series. This additional layer of analysis may only go part way to demonstrate the spirit of Foucault's ways of seeing, but I aim to go further than simply name checking and I will try to do his work justice (Soyland and Kendall, 1997; Kendall and Wickham, 1998). Some of Foucault's key conceptualisations and lenses that I have adopted are presented within the glossary of terms, they are, Archaeology, Governmentality, Genealogy and Power. They have informed the exploration and shaping of the collocation of narrative threads and sense-making presented in chapter four, which has explored principles such as plot points and figurative speech.

3.7.6 Critical Narrative Study Journey

My use of a Foucauldian way of looking up on the narratives is not a '*closed methodological framework*'; instead, it has offered a '*map charting genealogical trails*' (Tamboukou, 2008, p. 103). However, the approaches I have taken within this study, might be viewed as straddling two contradictory positions. The approaches I initially took to analyzing the stories, had me broaden, burrow in, and evaluate them. I was drawn to focus on discourses of emotionality, resolution, and realization, as well as the coda clauses. This might be viewed as having fallen into a trap of imposing '*frameworks, categories, or ideas on the data instead of unravelling multiple meanings*' (Savin-Baden, 2004, p. 370). With this said, the first approach involving an augmentation of narrative analysis lenses, enabled me to offer a space within this study for the student paramedics stories to breathe, and for me as a co-narrator to ensure the first of my two study questions were explored, and therefore organising the data into some semblance of coherence for the reader. In re-storying the student paramedics narratives and sense-making of suicide exposure, I have attempted to preserve the complexity of their individualities, which also emerges from my positionality that would eschew the objectification of people. Therefore, I have found some form of order, but this order exists the process of never-ending change. The pull to Foucault I refer to above then allowed me to engage in a double reading, and

instead offers a way of seeing and hearing the collective discourses across the whole thesis (May, 2005; Numer *et al.*, 2017). Given that I envisage this double reading as abridging the narrative signposts that emerged in the student paramedics stories, to the wider discourses and discursive practices where professional/occupational exposure to suicide plays out, they are far more connected and equivalent than they might first appear.

Diagram 3: A Critical Narrative Study Journey



3.8 Trustworthiness

This study emerges from and operates within a non-positivistic paradigm, as such the principle of Doxa is something to consider, because it may be received uncomfortably in its difference to the well-established Doxa (Bourdieu, 1990). Taking in this study, I invite the reader to reflect on the familiarity and connection they may experience when reading research that offers immediate understanding, and their possible approval of trustworthiness. However, I have asked if the field of suicide exposure knowledge, should permit a range of epistemological approaches to successfully co-exist, and avoid getting tangled in distracting debates (Lawson, 1995). Striking this balance creates spaces, and it is within these spaces where a further place is created, and that is, to honour 'little stories' like these (Palmer, 1993). To disregard these stories, would possibly lead to ignoring a key part of how we make meaning and are able to live in society where suicide occurs.

Narrative inquiry does however need to acknowledge its lack of acceptability and trustworthiness across both positivist, and interpretive research positions (Loh, 2013), I am also aware of the scholarly expectations of this study, and that rigour and trustworthiness can also be viewed as an augmentation of responsibility to the study participants and offers guiding principles characterised by interpersonal communication and subjectivity (Lannamann, 1991; Moss, 2004; Stige, Malterud and Midtgarden, 2009).

Criteria for trustworthiness will continually evolve, never achieving agreed perfection or completion (Lincoln and Guba, 1985). Consequently, credibility and internal validity were considered in the triangulation of the narrative data sources. These were further enhanced by extending the conversation and sense-making with the student paramedic narrators, and with peer debriefing whereby I discussed the stories with my supervisory team. I engaged in revisiting the narratives in visual and auditory form, and continued to make reflexive journal logs and meaning making notes throughout. I have presented a section of the data audit, which supports dependability principles (Lincoln and

Guba, 1985) (see Appendix 13) to include information about how it was collected and how it was kept. Confirmability of the study might suggest a removed relationship with the stories. However, I will present the reader with the stories, evaluation, resolution, and coda, and, where any collocation of meanings and possibilities are discussed, they will be supported by quoted narratives.

3.9 Ethical Considerations

Ethical tensions are part of the everyday practice of ‘doing’ research (Guillemin and Gillam, 2004), often divided into the procedural and the practical. This is in addition to the principles that are important to ethical approval committees, such as those who have granted permission for this study (see Appendix 14), which saw me follow guidelines set out in the British Educational Research Association (BERA), (2018) document. The practical ethical considerations were not as obvious to me before I commenced the study, for example: revelations that came about within the narrations, and the powerlessness of the participant to alter the repurposing of stories for academic use (Muncey, 2010; Tilley and Woodthorpe, 2011). These were narrated throughout; therefore, I did not consider ethical issues as dealt with once and for all after ethical approval was granted (Clandinin and Connelly, 2000). The following section will focus on the anticipated procedural ethical considerations.

3.9.1 Confidentiality and Consent

Confidentiality for participants and those they may invite into the story as characters, was maintained by adhering to information governance in line with the General Data Protection Regulation (GDPR) and University policies on handling sensitive data. In writing up and moving the narratives from the private to the public space, anonymity and an awareness of the broader impact and unintentional consequences of the study was a constant feature of my sense-making (Plummer, 2001; Ellis, 2007).

Consent was initially gained with a specifically designed form for this study using guidance from the Ethics Committee (See Appendix 15). My role within the study was clearly outlined to potential participants to avoid any deception and exploitation. I provided information prior to gaining consent, as well as informing them of their right to withdraw consent at any stage of the research process, which was also monitored throughout the data collection stages (Beauchamp and Childress, 2001; Dunn and Jeste, 2001; Flory and Emanuel, 2004; Appelbaum, Lidz, and Klitzman, 2009; Hardicre, 2014).

3.9.2 Participant Welfare

Reflecting on participant welfare, I had to acknowledge that I was entering their life and then asking them to tell their story for the 'benefit' of my study (Fisher and Fyrberg, 1994; Gibson, 2001; Gibson, 2003). After our time together they would continue to live and make sense of their stories. I was aware that by asking people to recall and re-tell their experiences, I could trigger distress related to that event. If within a session I believed an individual was becoming overwhelmed, I planned to ask their permission to continue and invite permission for them to stop if they wish. For this purpose, I created a sheet of self-care and signposting for services as well as resources to offer to them after the session. I met with the participants one month after the story collection, which in part offered an opportunity to check in on their wellbeing, which as noted was extended to one per month for six months after the one-to-one story telling sessions.

3.9.3 Ethics of Self

I could not be completely detached when approaching the stories, my study position does not command this, and my world view says this isn't possible. As someone who has been personally and professionally exposed to suicide, I have observed and consumed the tangible lines of tension and the complexity of reactions. I was hopeful that these experiences would serve to add richness

to the narrative that is available to analyse. However, this does not come without risk and with reference to self-care (Ellis, 2007; Chatham-Carpenter, 2010). I have ensured that I have owed a due regard to my own wellbeing throughout, with supervision arrangements, diary planning, and a pre-considered plan for if any distress experienced became overwhelming to manage.

Summary

This chapter has explored the positionality of the study and instead of relying on one approach to knowing, my post structuralist lens supports an epistemology which utilises multiple ways of knowing. An exploration of ways to engage in analysis has resulted in an augmentation of narrative analysis signposts. I have combined the framing of more than one scholar in the field of narrative inquiry, guided by my ontological position. This tells me that no system of essential categories can capture people's lives in all their complexity, and has permitted my interest in stories, more than in universally applicable generalisations. The complexity and fluidity of ethical considerations for this study has been put forward along with the continued ownership of my subjectivity and reflexivity. I have discussed principles aligned to trustworthiness and transferability. I now invite the reader to explore and make sense of the stories presented in the next chapter which will address my study questions: what are the stories that are re-told by student paramedics who have experience of direct exposure to suicide? And what sense and meanings have student paramedics applied to these experiences?

Chapter Four: Findings and Discussion

4.1 Pen Portraits of the Student Paramedic Narrators

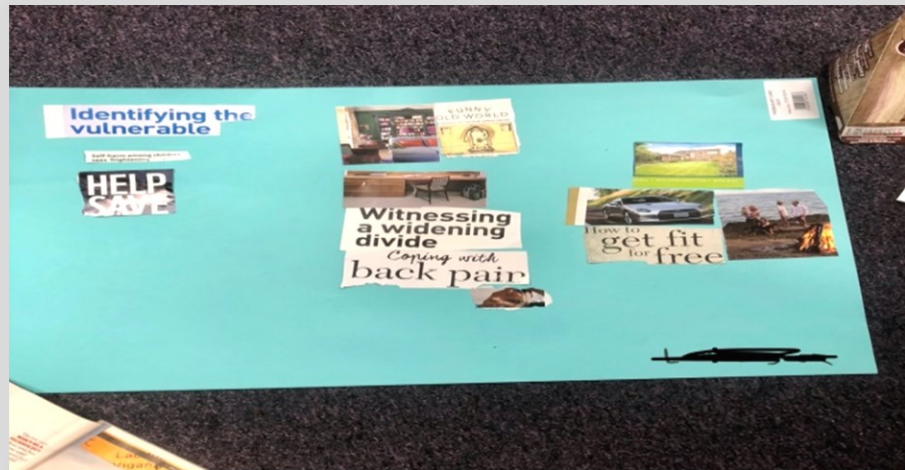
This following section augments aspects of the broadening stages of the narrative inquiry, as well as my own reflections which capture my impressions of the student paramedic narrators, alongside the coda of the stories. Here I also reflect the point at which the narratives end to include their hopes for the future. This is not to say that I believed that the paramedic students' identities could be found in their personal narratives. More so, their narratives went some way to mediate their identities through their stories of particular life events. (Lieblich, Tuval-Mashiach, and Zilber, 1998).

It is argued that '*we constantly construct and reconstruct a self to meet the needs of the situations we encounter, and we do so with the guidance of our memories of the past and our hopes and fears of the future*' (Bruner, 2003, p. 210). Matt, Lucy, Jodie, Cameron, and Hope have all co-constructed signposts of personal growth and identity development. This evolution of formation, cultivation, and education (Davey, 2006) sees its roots branch out in the narrative genre of Bildungsroman (Kim, 2016). This concept positions the students as having entered their course with ambition and dreams, but they have all experienced some form of challenge so far in their journey. Nonetheless, they have gone on to construct their own conviction and confidence. The concept of Bildung has us forge and co-construct the self to become somebody and goes beyond gaining skills and knowledge (Biesta, 2002; 2009).

In the sections below I will introduce the five student paramedics who shared their experiences as part of this study.

4.1.1 Matt

Image 1: Matt's Storyboard



Matt looks and speaks much older than his years. Matt is not at a loss for words, he is confident and forthright. I find myself shifting in my initial impressions, reflecting if his confident tendency was a means of trying to convey that he was up to the job he was doing. He radiates intellect and commitment to the course and his end goal of becoming a paramedic guides the whole story that unfolds.

There is a glimmer of a future academic, teacher and mentor in Matt. He is at ease sharing his stories and easily forges links between the academic and the non-academic. Matt sets out a goal of resilience and mental toughness, sculpted through his professional exposure. Paramedic science would appear to be gaining a true comrade, where he has weighed up the other helping professions, and hasn't been drawn to their anchored geography of a hospital or clinic.

4.1.2 Lucy

Image 2: Lucy's Storyboard



Lucy arrived to our one-to one story telling session appearing flustered, it was freezing outside, and she had just run to make it to our planned session because she had been delayed in the skills lab. Lucy has a background that has seen her parents push her and her older brother to take any opportunity they can. She expresses a loving gratitude related to their encouragement, as it is now serving her well. However, Lucy is developing a growing distain for being considered a 'baby' in her emerging professional context.

Lucy really brought into focus how we help the helpers in our society, and wherever there is tragedy, chaos and unkindness, there are people helping. This needs to be considered against a context of their constructed professional identities, and indeed their own sense and meaning making of each job they attend. Lucy would have us consider that what makes a job stand out occurs from a variety of sources and modes, to include internal and collective sense-making which is not static or predictable. Lucy has ambition, and she performs an endearing reflexivity and commitment to her own personal growth. If Lucy and those in her age group who are studying at university are considered akin to a snowflake, then paramedic practice needs to prepare for an avalanche!

4.1.3 Jodie

Image 3: Jodie's Storyboard



Jodie entered the room apologetically. She is late and had to cancel our first planned one-to-one session due to her mother being ill. Jodie depends on her mother for the care of her son when she is at work and university. She is quietly spoken. I recall Jodie really struggled in the story-boarding session and articulated that she couldn't collapse signposts in her life in to one single aspect of a word or a picture.

As I left Jodie that day, I reflected on just how many roles she is navigating. She is a mom, provider, paramedic student, and higher education student, an ex-army professional and daughter. She performs them with a calm pragmatism. I don't underestimate that this may be disguising her paddling frantically underneath the surface at times. She has fears, life experiences and a story to tell. She knows what she wants but doesn't dwell too heavily on dreamy ambitions. She wants to survive, to earn money, she wants a nice home and to provide a future for her child. Her son is pivotal in her story, no doubt he too is navigating his mother's career ambitions and the demands her roles dictate. She pines for the day she graduates so that he can see what it has all been for.

4.1.4 Cameron

Image 4: Cameron's Storyboard



Cameron awaited an invitation to speak and tell his story. He is very quietly spoken and quivers sometimes when he speaks. We were sat in a good-sized classroom within the university's campus, it had no natural light. But this seemed to create a sense of security and safety, given the collaborative need within the storyboarding and one to one story telling.

Cameron wants to build on his experience as a paramedic for a few years and then consider developing a specialism such as substance misuse. Cameron is excited that he hasn't quite figured out his path yet. His career and where he is drawn to, may tell people everything they need to know about those turning points in his life and the ones that are yet to be.

4.1.5 Hope

Image 5: Hope's Storyboard



Hope has a slight advantage on me in height given the disproportionate standard paramedic student issue, steel toe capped boots she is wearing, which she complains are heavier than her backpack. Hope comes across as bubbly, permeating ambition, and has a revived sense of self confidence and hopes for her future. She wants to earn money and gain freedom to travel the world.

Hope's visually petite frame certainly does not reflect the growing strength and confidence she radiates. She has big ambitions, she is forthright, and offers the sense she is making of experiences so far with conviction and an unapologetic tone. Her life took a turn and is going in a differing direction to that she had settled for at the beginning of the course. Her horizons have been expanded and she is excited about the future.

4.2 Co-constructed Plotline

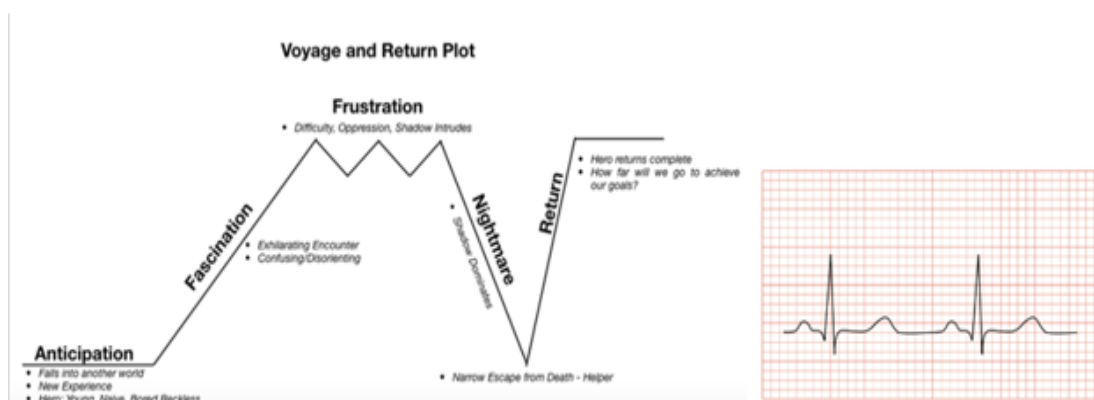
The co-creation of the narratives elicited an overarching theme of journey and being on the road. Matt depicted in his story board the words 'CRAZY, MAD WORLD'. He had anticipated that he would be exposed to a different world, but nothing could have prepared him for what he has seen and been exposed to. As he expressed this, his peers and fellow story tellers nodded in agreement with smiles. This non-verbal response hinted at a unique and shared insight that I might be invited in to. Here my outsider status became tangible. Narratives are often used to *'explain to outsiders what practices, places, or symbols mean to the people who hold them'* (Young, 1997, p. 72). As the session progressed, the narratives flowed, and I considered the shaping of the collective narratives and how they may fall into a plotline.

Hoping to avoid imposing a fixed plot at the outset, I had to foreground this stage of the study by promising to only hear the stories and with the permission to allow the plotlines to be heard (Bakhtin, 1981). The co-constructed plotline emerged as voyage and return which sees the protagonist go to a strange land, or in the case of this study, discussed in the paragraph immediately above, a 'mad, crazy world', and face adversity on their way home. The stories will therefore be presented across the stages of anticipation, initial fascination, frustration, nightmare, return, which are sub themes of the journey of voyage and return. Interestingly, this plot is represented in the literature in picture form, which could be seen as a mountainous landscape, or an Electro Cardio Gramm (ECG) reading. During my observer shift with paramedics, I felt compelled to make sense of the paramedic's apparent collective professional and intellectual fascination with ECG readings.

Box 1: Segment from my journal logging- Observer shift

“Up on our return to their canteen during the stand down period, in amongst the walls filled with NHS bulletins and training updates was a pin board. This is not any old pin board, in stark contrast to the others, it is a pin board that reminds me of my primary school classroom and which teachers no doubt painstakingly prepared during the half term breaks, with bright boarders and a stapled backing, and lots of artefacts that depicted a theme of significant interest. On this board are reams up on reams of ECG readings, carefully pinned up one by one with the challenge “guess the diagnosis “. Throughout the shift, ECG readings, a visual representation of the beating heart continued to be forensically examined by my colleagues long after the patient had been conveyed to hospital and they had forgot their name; different crews who they would meet in passing would join in this process and offer their interpretations. They are bloody obsessed with ECG readings”/

Image 6: Voyage and Return- ECG



4.3 Anticipation and Initial Fascination

Within the stages of Anticipation, each of the student paramedic narrators expose details about their home life and personal background, to include some of their motivations for joining the paramedic science course. These were important signposts in the story telling sessions in relation to suicide exposure, as they may offer clues as to how that particular narrative serves to make sense of, or draw continuity to the self (McAdams, 1988;1993). Here the student narrators offered a past, present, and anticipated future by using important aspects of their life (McAdams, 1988). Thereafter, within the Initial Fascination

stages of the story plotlines, as readers we are exposed to some of their initial sense-making within their placement-based learning spaces.

4.3.1 Matt- Anticipation: Becoming a Dad has Changed Everything

When he had hit his teenage years, the pull to paramedic science was becoming stronger. Drawn to helping others, he also liked the thought that no one day will be the same.

Matt- 'I can't imagine working in a hospital, I like the freedom of being on the road'.

Matt constructed the view of a straightforward life, he didn't speak of his own childhood much, other than supporting friends who self-harmed. He became a father at the age of 19 during the first year of his paramedic science course. Matt dotes on his little girl, during the time we spent together she featured heavily in his reflections. His face lit up and beamed when he talked of her. His hopes now seem to centre on her, and he describes her in part as the making of the man he wants to be. Matt epitomises a forceful challenge to notions such as those set out in studies that aim to explore 'risk factors' and 'precursors' for adolescent parenthood, presenting an idealistic identity and timing to such a rite of passage (Fagot *et al.*, 1998).

4.3.2 Matt- Initial Fascination: Mad World

Matt reflects that nothing could have quite prepared him for the mad world he encounters, its barbarity and its beauty can be felt in the space of one 12-hour shift.

Matt- 'people are not mad, the world is, I have seen some horrific things, I have seen a lot of death, I mean I must have seen at least 50 dead bodies so far'.

He tells me this fact as he laughs, it's as if the sudden realisation has just hit him, that death is such a common feature of his life now. It feels bizarre given we are sat in a mock classroom for primary education students, where paintings are drying, rows of safety scissors are lined up, and the sense of innocence that these formative experiences once held.

4.3.3 Lucy- Anticipation: I am not a Snowflake.

Lucy outlined a growing frustration at how others perceive her route into paramedic science education.

Lucy- 'coming straight out of school and sixth form, and my choice to go down the degree route and not the internal training route, I am constantly told I am too young. It makes me feel that others think I am not up to the job and ready to take on the responsibility'.

Me- 'you haven't been called a snowflake have you'.

Lucy- 'Oh yes, of course! It's insulting'

We reflected on some of the intricacies of her placement-based learning on the road, and the competencies she must achieve and perform. We both reflected that for Lucy to pass the course, there must be people out there who are in need or who are suffering.

4.3.4 Lucy - Initial Fascination: A Refusal to Call Death What It Is

We reflected on if there are any jobs so far that stand out to her.

Lucy- 'my first job, not because of what it was, it was pretty straight forward, but I felt out of my depth and like a burden, my mentor possibly didn't help'.

Me- 'so what would you have done differently?'

Lucy- *'I don't know, I just felt chucked in the deep end. There are some really good mentors though, and I want to be like them'.*

There are some similarities within the role of the student mentor for paramedics to that of the nursing student mentor (Lane, 2014). However, where should the guiding principles of better mentorship emerge from? Educational standards, scholarly pondering, or from the students themselves?

As Lucy continued to talk about the jobs that stand out, her reflections about her sense-making demonstrate pragmatism and desire for the reality of situations to be acknowledged.

Lucy- *'Arrests are always difficult, not necessarily just because of the person but their family, you feel bad that you know this person isn't coming back, and you can see their fear, you know it is going to be realised'.*

Me- *'that must be awful'.*

Lucy- *'yeah but one job, it was clear she was dead, she had gone, and the doctor kept telling the family 'She isn't doing very well at the moment'. I felt like saying 'you are a liar, we should not get their hopes up, because soon, they will hear us call the death'.*

Paramedics can absorb how to communicate death notifications by observing others and by trial and error (Douglas *et al.*, 2013). This transcends paramedic science and is applicable to accident and emergency hospital contexts (Campos *et al.*, 2020). Lucy's frustration highlights this sense-making through observing others and the possible need to offer space and time for professionals as they navigate this part of their role, and their symbolism for bereaved family members.

4.3.5 Jodie- Anticipation: I am a Mom.

Jodie's life has included an army career which she hadn't revealed to her peers before. She is a single mother to a young son who she hopes witnesses how to

overcome adversity, to hold ambition and work toward goals. Jodie seemed to bring our discussion to the focus of the study as soon as we commenced our conversation and I felt myself pulling her back slightly in a desire to get to know her better.

4.3.6 Jodie- Initial Fascination and Imagined Nightmare: The Jobs I Dread

We spent some time asking Jodie to reflect if there are any jobs so far that she dreads, or that stand out.

Jodie- 'well I thought I dreaded a child cardiac arrest, until I was called to a child cardiac arrest.'

Jodie narrated her response as one of suppressing her anxiety in exchange for the amplification of confidence.

Jodie- 'my training kicked in, I got in there and got on with it'.

Jodie- 'I am dreading a hanging, [and she physically shudders] I just don't want it to happen- I cannot imagine how it looks, I just know it won't look good, it isn't right'.

Jodie went on to highlight that she has lost a family member to suicide in this way. Suicide loss is constructed in wider literature to be complicated and different; each death may be distinct, and such distinctions may be dependent on the age and life experiences of those exposed (Cerel, Jordan and Duberstein, 2008; Cerel and Sanford, 2018). Such sense-making may be compounded by social processes surrounding those exposed and the impact suicide has on family systems. Jodie's student life should therefore not be seen as separate from the specific roles she assumes before or during her studies (MacIntyre, 1985).

Jodie- 'there are horror stories of children doing it, I have been to suicide attempts and suspected suicides and there are some that stand out'.

Me- 'what makes them stand out?'

Jodie- *'not what you necessarily think would make them stand out, sometimes it's the family or their connection with my life. I have had a young woman, she was really unwell, and she had taken an overdose, her family were just at their wits end with her, it seemed they were fed up with her as she had done this before'*.

Jodie constructed a theme that what made this job stand out so much was that she was so young, and her family's reaction to what she had done.

4.3.7 Cameron- Anticipation: Winning the Lottery of Adoptions

Cameron had worked in a well know fast food restaurant in the years before his paramedic science degree. He had climbed the ranks to supervisor and then manager and reflected on the good stead that this had put him in for this course. He constructed in his own sense-making, that he didn't have the best start in life.

Cameron- *'I was taken in to foster care aged six months and adopted by the December of that year, because my biological parents had issues'*.

Cameron speaks of his biological parents with an understanding and kindness. He reflects what a kick in the teeth it can prove to be when he hears his paramedic mentors and peers talking about people with similar difficulties, especially when they are lacking compassion and humanity.

Cameron- *'I keep my mouth shut for now, I am a student'*.

Cameron reflects that he *'won the lottery'* of adoptions-

Cameron- *'they [adoptive parents] have never failed in letting me know how special my adoption day was for them, never stopped me from trying to find out about my biological parents'*.

Cameron is emerging from his adolescent years where his developmental task, in part, has been to establish an identity and a life path of his own. He is constructing a narrative identity (McAdams, 1985), which may partly be as a function of societal expectations regarding his place in the world. However,

some aspects of his parents' lifestyle and choices haunt him, particularly through the images cast of people like them through our society and in turn how they are discussed amongst his paramedic peers.

4.3.8 Cameron- Initial Fascination: Managing a Balancing Act

Cameron- *'I am having a mare at the moment, I am overwhelmed with assignments and managing the balance of placement'*.

He reflects on just how much toll the course is taking on his body.

Cameron- *'my back aches, my sleep is messed up and I am worried that one day I will become clinically obese'*.

Interactions between critical incidents and workplace culture are constructed to have an overwhelming impact on the well-being of ambulance personnel. These include day-to-day managerial responses, the impact of shift work, poorly managed rosters, and long working hours with little time between shifts for recovery (Lawn *et al.*, 2020). Cameron questions whether his emerging professional identity is really recognised and valued.

Cameron- *'student nurses are set to have their bursaries returned to them, aren't they? What about us?'* (This was said with a slight elevation of assertion in his voice, and one I had not observed until this point)

4.3.9 Hope- Anticipation: I Chose Me

Hope had a future planned with her childhood sweetheart, they have since split, and she now finds herself single and looking to a new horizon.

Hope- *'I had lost the person I thought I would start my life with, I felt like packing it all in as I had lost all interest. He began to get on at me about the hours the course demanded, and that I was distant, and it wasn't what he wanted anymore. So, I had a decision to make, and I chose myself and my ambition to do a job where I can save lives'*.

4.3.10 Hope- Initial Fascination: Missing Pieces of the Jigsaw

Me- *'In your storyboarding you all seemed to share a common language and understanding around 'jobs'. There are big jobs, good jobs, and bad jobs, right? And I gleaned that they can all kind of mean the same thing?'*

Hope- *'yeah (laughing)- '*

Me- *'so what makes a job stand out?'*

Hope reflected that everyone would remember their first cardiac arrest. She outlined that she had built herself up to this and then when that call came through her adrenaline kicked in.

Hope- *'My first arrest died, but it isn't uncommon, I think I have only ever had two ROSC's'.*

Me- *'ROSC?'*

Hope – *'Return of spontaneous circulation, it is weird, dead strange, the one big job I remember, it was in a busy public place and his heart had stopped, everyone turned up- helicopter, police, doctors, it was chaos, it was so cool to watch'.*

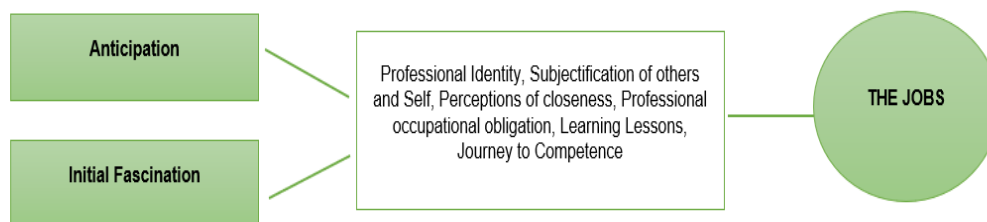
You can almost see Hope flicking through the filing cabinet of memories that she has lodged away; it is like she is no longer with me in the room.

We reflected on the fact she doesn't always know the outcome of a job and Hope constructed a resolute sense-making related to this which was aligned to her emerging professional identity and her way of coping.

Yeah- *'it's what we do, dip in, dip out and there are missing pieces of the jig saw for us, maybe it's good I don't remember every job, or find out the outcome, I can hold on to an imagined hope when I don't know the outcome'.*

4.4 Discussion- The Jobs

Diagram 4: A collocation of sense-making across the anticipation and initial fascination stages



All experiences of suicide exposure within this study are situated within a professional/occupational context. For the student paramedics in this study, a strong thread of their emerging professional identity was constructed within the stories they narrated. An essentialist approach to exploring these constructs might be viewed as *“trapping people inside personalities and identities that are restrictive”* (Burr, 2015, p. 7), and yet there are no ‘essences’ inside people that make them what they are (Burr, 2015, p. 6). The non-essentialist position of this study might instead assert that they cannot really narrate their sense of self, nor their identity in ways that are easily definable. More so, our student narrators navigate *‘dilemmatic spaces’* (Bamberg, 2011, p. 17) where they have been able to position a sense of who they are and how they wish to come across, whilst at the same time turning themselves in to subjects through operations mediated through their professional education, training, and their upbringing.

This can in part be traced in the discourses that are used within the relational sense-making towards those who have died by suicide. For example, in the background literature they are a patient (Bohan and Doyle, 2008; Gaffney *et al.*, 2009; Davidsen, 2010; Landers, O’Brien and Phelan, 2010; Kelleher and Campbell, 2011; Wurst *et al.*, 2013; Draper *et al.*, 2014; Dransart *et al.*, 2015; Gulfi *et al.*, 2015; Matandela and Matlakala, 2016; Saini *et al.*, 2016; Wang *et al.*, 2016; Erlich *et al.*, 2017; Gibbons *et al.*, 2019; Rothes *et al.*, 2020). Or

viewed as a client in Sanders *et al.*, 2005; Tillman, 2006; Ting *et al.*, 2006; Clark, 2009; Murphy *et al.*, 2019; Van der Hallen, 2022), or as a 'service user' 'person I assessed', or 'consumer' in Sanford *et al.*, (2021), and a student in Christianson and Overall, 2009; Kim, 2019; Causer *et al.*, 2021).

The studies focusing on firefighters (Kimbrel *et al.*, 2016; Hom *et al.*, 2018), police/law enforcement officers (Cerel *et al.*, 2019) and paramedics (Nelson *et al.*, 2020) share the likelihood that exposure to the death scene would likely be their first encounter with the person who has died. The discourse constructs a more distanced approach to their professional/occupational exposure. In Nelson *et al.*, (2020) suicide exposure is framed as a work-related stressor, in Cerel *et al.*, (2018) a suicide scene and a suicide death in Kimbrel *et al.*, (2016). In Hom *et al.*, (2018). Within the student paramedics sense-making, exposure to suicide sits within a construct of the jobs. This discourse first emerged within the pilot of the study with paramedic science academic colleagues. It was further entrenched within the observer shift with paramedics on the road. I was able to unpick this theme further in the storyboarding sessions and the one-to-one storytelling, and that good jobs, bad jobs can hold the same meaning. For our student narrators, suicide by default would seemingly not fit in to a category of 'good, job, bad job', they are another potential cause of medical emergency or death which they have to attend, in amongst others.

If we view these professional signposts through a lens of governmentality which construct technologies, techniques of power and self. We may observe that regardless of professional/occupational contexts, we need these professionals/emerging professionals to learn to 'deal with' suicide, therefore they have to emerge into a way of dealing with it. Indeed, this is the primary aim of postvention itself, to recognise and manage suicide exposure and to achieve personal growth and strength, not succumbing to the same fate. Postvention aims to create professionals who can handle, understand, and express the emotional traumas. I expose a critique of professional/occupational exposure research within chapter two, and how it may shape collective understanding via

the method it adopts. Via such methodological design, and the framing of the research itself, discursive practices within discourse may be performed by these professionals. They may wish to '*transform themselves*' to behave in a manner that enables them to achieve the desired professional/occupational identity, that is presented in the discourse of the methodological approach (Foucault, 1972, p. 183). Therefore, I would argue that the very situatedness of the inquiries and sense-making that build our knowledge of professional/occupational exposure to suicide, fertilise the soil from which these professional/occupational sense-making individualities grow.

Whether through research or occupational performances, the professionals also govern themselves. They may control and manage their actions for the benefit of the state, their professional bodies, and for the benefit of themselves to become and uphold their professional status. This learning takes place within situated contexts of either a university or placement, where competencies are being assessed for our student paramedics. As such, there is power over responses, and responses to power and sense-making related to suicide and death exposure. For example.

Cameron- *'I keep my mouth shut for now, I am a student.'*

Lucy- *'my mentor possibly didn't help, there are some really good mentors though, and I want to be like them'.*

As an insider researcher, and a member of staff at the University in which these students' study, I cannot remove myself from the consideration that these student paramedic narrators may have mediated their responses for my benefit within the collective and one-to-one story telling. Indeed, the practice of telling the truth about oneself is to rely upon and appeal to the presence of the other person who listens (Gros, Ewald, and Fontana, 2011). Within the narrative beginnings of this study, I did not have the opportunity to discuss my own sense-making with the nurses I so admired, fearful that this would expose me as not up to the job. This was akin to schoolteachers in Erlich *et al.*, (2017)

where a theme of 'staying in the game' was constructed as a part of their sense-making. Indeed, in one narrative thread in Clark (2009), the author reflected on how others needed her to be for them to cope.

For society to construct and tap into any of the professional categorisations presented in this study, people must suffer and die on that journey to competence. Indeed, our student paramedics narrations of good jobs, bad jobs, wasn't in relation to their outcomes being good or bad, more so, the learning they had taken from them, and the complexity involved. Suicide may or may not feature as a job that they go on to commit to memory, given there were few lessons be to take from it. A theme of learning lessons also emerges in Landers, O'Brien, and Phelan, (2010) and in Sanders *et al.*, (2005), one social worker was quoted that the death was an '*excellent training experience*' and was thankful that it had occurred! Another social worker said, '*It may be strange to say this, but I am glad the man did what he did. It was the one thing in my career that has taught me more about who I am as a person than anything else*' (p. 207). Maybe this isn't so strange at all, indeed I reflected on this with Lucy that for her to pass the course, there must be people out there who are in need or who are suffering.

4.5 Frustration and Nightmare

Within the frustration signposts of our student paramedic narrators' stories, this is where they begin to express some discomfort and the world starts to feel that bit more oppressive and sinister. This paves the way for the nightmare stages of the plotlines, where they are met with darker imaginings or realisations.

4.5.1 Matt- Frustration and Nightmare: Too Young, and Too Close to Home

There are jobs that Matt dreads and jobs he has attended that have shaken him to the core. He recalls a '*sick sepsis kid*',

Matt- *'she was gravely ill Clare; the ground was swallowing me as I looked at her and then thought of my daughter'*.

For the most part, emergency workers are reported to learn to deal with such events and take them in their stride. Certain circumstances can disturb this script of coping, when this occurs, paramedics can report increased symptoms of traumatic stress, opting to manage this on a practical level, for example, spending time with friends and finding humour (Regehr, Goldberg and Hughes, 2002).

'I dread a teen committing suicide, not someone my age, but a teen, I cannot fathom or get my head around a young person so full of life and opportunity, opting to die, where there is hope of things getting better there is a chance '

I was drawn to the word committed, it is said that how we talk of suicide is important, and we should try to use language that does not stigmatise or criminalise (Nielsen, 2016). It might be argued that in policing people's language, we may close conversation altogether (Dickens and Guy, 2021), also creating an illusionary comfort blanket that we are 'doing our bit' by using the correct term but does nothing to address the reasons why people feel so desperate in the first place.

Matt- *'one job I attended; the man was dead, dead'*.

Me – *'dead, dead?'*

Matt- *'Yeah, he had been dead for a very long time (nods and raises his eyebrows) – he was out of rigors put it that way, he had been dead and hadn't been found for a few weeks, that was a suicide'*.

Me- *'how did you know it was a suicide? And what sense did you make of it at that point?'*

Matt- *'There was a note by the side of him, I didn't read it, I opted not to read it and drug paraphernalia was around his body'*.

Matt apologetically informed me that had he been *'fresher'*, he may have made sense about this experience differently. The jobs that hit him hardest are those that they attend where they work on someone to revive them, and the attempts are in vain.

Matt- *'Whatever the reason is why they stopped breathing and their heart stopped beating, if they are retrievable when I get to them, I then work on them and it didn't work, this saddens me'*.

Suicide notes are the attention of research focus as they allegedly allow us to unlock the unknowns of suicidal phenomena (Shneidman, 1973; Galasinski, 2017). Yet the reasoning of the suicide didn't seem to be the focus of Matt's sense-making. The hope of survival seemed to be the common thread, rather than why the patient is clinging on to life. Matt has developed his own rituals and coping mechanisms. For example, he recalls the first dead body he saw. She too had been dead for some time and the heating was on in the home. The smell hit his stomach instantly and he had to leave and vomit.

Matt- *'I opened the window, the front and the back door'*.

Me- *'because of the smell?'*

Matt- laughing- *'yeah, but it's also to set their soul free, it's a silly thing, but it's my little ritual to every death I attend in the home'*.

Matt reflected that there is something quite resolute about these rituals and the fact someone has passed in the assumed comfort of their own bed, lying flat, eyes closed and calm.

Matt- *'it is how death is meant to be and if this is how you die, you were possibly at peace'*.

Matt also talks a lot about mental health, I asked Matt if he had seen many suicides and suicide attempts, he replied with an assertive,

Matt- *'oh yes'- I have also seen Schizophrenia, Bipolar, Depression and Mania.'*

He seemed to be *'collecting experiences'* with a commitment to know more about how he could help, and to add to the catalogue of stories he would go on to tell, but I pondered if it could be masking something else. Was Matt singling out these experiences because they were unpredictable, which then exacerbated his fear and anxiety as in Lawrence's 2015 study focusing on the emotional control of paramedics (Lawrence, 2015). Matt had a lot to say about the state of mental health services and the frustration he feels when someone just needs somewhere safe and are distressed, but that they don't quite meet a threshold to get it, and yet they (the paramedic services) are called back each time they hit their breaking point.

Me- *'with reference to means of suicide Matt, you seem to have seen a lot, have you seen any hangings?'*

Matt instantly and assertively replies *'NO, and I don't want to, there was a call where it was actually handed over as a hanging, and my stomach dropped, fortunately it turned out to be a hoax'*.

Me- *'a hoax'*

Matt- *'better a hoax than it be real, I really do not like even how I imagine that will look, what I have been told and I hope I don't get one'*.

4.5.2 Lucy- Frustration and Nightmare: He Couldn't Be Saved

Lucy began to outline that she has jobs she dreads. She then opts to next discuss a job she had a few weeks ago, where it was called in as a hanging. She reflects that she was anxious walking in, and about what she would be faced with:

Lucy- *'here I am 18 and most of my mates are out partying tonight, but I am about to see something that I dread seeing, a hanging body'*.

It transpired that the man had tied a ligature around his neck that was still in place when Lucy and colleagues arrived, but he was seated, distressed, and

intoxicated. He had struggled to comprehend his life and future after his relationship breakdown.

Lucy- *'I went to an overdose recently and this job stands out, we got to the job and his parents were just arriving, he was upstairs on the bed'*

Me- *'What did you notice'*.

Lucy- *'he had taken an overdose and had a note at the side of him'*.

Me- *'did you read it?'*

Lucy- *'yeah, there was loads in there, he apologised to his parents'*.

Lucy found herself talking to his parents who seemed angry with him. From Lucy's perspective, they were seeking answers from her as to why he would do this. People who attempt suicide can be seen as attention-seeking, selfish, incompetent, weak, or immoral by their family members and this can impede help-seeking (Oexle *et al.*, 2018). As Lucy relayed her experience of hearing their distress, I re-constructed their verbalizations as rhetorical pleas for clarity and understanding of what was unfolding before them. Lucy's sense-making of this job was compounded by a series of chance encounters.

Lucy- *'we got him to hospital and he survived, but it transpired that he killed himself two weeks later Clare, by chance I saw the mentor I was working with and by chance someone had remembered him from A and E, and by chance remembered he had brought him in before, and by chance they cared for him again, this time however it was too late and nothing could be done to save him'*

Lucy then hinted to a contingent trajectory in relation to her view of suicide as a topic itself, admitting she can portray a more apathetic view of death and dying itself at this point in time because she has never lost anyone close to her.

Lucy- *'I know it is terrible, but it will not help anyone, me standing there crying with them. It isn't my grief [says with an increased volume]- but this may change if ever I have experiences where we share a similar grief'*.

4.5.3 Jodie- Frustration and Nightmare: Ghosts from the Past and the Present

Jodie moved us on to another story involving an ex-squaddie and he stuck out given the symmetry of her own army career. She noted that how and when you leave the army can leave you feeling lost.

Jodie- 'he tried to end his life; he couldn't cope and tried to drive his car at speed into a wall'.

Jodie did not verbalise her sense of this experience, but I gathered this was playing out privately in her thinking, we sat with the silence of the next three or four minutes.

Jodie came back in the room and moved my attention to the experience of what she described as a traumatic cardiac arrest. However, it was uncertain if it was accidental or a suicide. All they knew was that he had fallen from a height.

Jodie- 'it was a mess Clare, his skull was gone, and yet his face was perfect, I wasn't doing the breathing end of things, but I remember looking up to his face as I was trying to set up a drip'.

The death was called quite soon in as it was apparent there was nothing that could be done for him. Again, Jodie filed this experience away and opted to take the thread of our discussions to making sense of those jobs she dreads.

Jodie- 'I have also realised I don't do well with dead, dead people'

Me- 'Dead, dead people'

Jodie- 'Yeah, one fella we attended he had been dead a while, sat in his armchair, I remember my mentor telling me to pull myself together before the family arrived'.

4.5.4 Cameron- Frustration: The Need to Call Mom

Cameron reflected that there were some jobs he dreaded at the start of the course.

Cameron- *'Kiddies and hangings were my fears'.*

Cameron's fears tie into previously reported risk factors for psychological injuries associated with emergency worker incident exposures in the course of their jobs. It is noted that victims' ages, for example infants' and children's injuries/deaths have long been felt to have a greater impact on the first responder (Hartsough, 1985). However, it became apparent that these fears were not post-event, more so imagined fears in an imagined space created by the passing on of stories and experiences of other paramedics. Paramedics and firefighters have been reported to experience varying degrees of stress severity in relation to the 'experienced and 'not experienced' (Beaton *et al.*, 1998). In navigating work-related trauma, veteran paramedics appear to have anomalous resilience among the paramedic population, that could be due to the longevity of service (Jenkins, 2020).

Cameron- *'Much like our fear of spiders and snakes can start even before we are faced with them, or have any real reason to fear them, we gain this fear from others, when they tell you about their experiences'.*

Me- *'oh ok, so nothing you carried into the field with you, it's what emerged after spending time on the road?'*

Cameron- *'yeah, I suppose so'.*

He hadn't had any *'big jobs'* related to *'kiddies'* or ones where he felt the need to call his mother and have a cry.

Cameron- *'When I do call my mom, she tells me it's ok to feel this way, but she reminds me why I am doing this'.*

The support of family is allegedly paramount to reducing the impact of highly stressful work on paramedics and other front-line workers (Weiss *et al.*, 1995;

Regehr, Hemsworth and Hill, 2001; Regehr *et al.*, 2002; Regehr, 2005; King and DeLongis, 2014). There is a prompt to pause and consider this dynamic further. If we explore the concept of surveillance which observes and monitors people, we can see a construction of power that does not merely lend on the professional/occupational and educational institutions in which Cameron's sense making plays out. Indeed, we see a diffused spread throughout society and can be found in all relationships such as that he shares with his family. Whilst the dynamic Cameron constructs might produce a caring, benign force, I am drawn to '*she reminds me why I am doing this*' which may act as a continuous signifier to remind Cameron that he must not quit.

4.5.5 Cameron- Nightmare: The Man Reflected at Me

Cameron was faced with one of the jobs he dreaded within his first two weeks of his first placement. His imagined fear became his real nightmare when he was exposed to a hanging.

Cameron- (sitting adjusting his body position from quite slouched to upright, he looked at the floor) - *'It had been called through as a category one cardiac arrest. We pulled up to the job, and the man was being cut down from the tree; but was still hanging. It was clear he was dead; I could see his discoloured face and no life in his body. He wasn't hanging from a great height and it's why I think he may have gone unnoticed for some time.'*

Cameron- *'This was the first dead person I had seen'*, Cameron looks to the floor and sighs. *I felt overwhelmed, sick, and felt myself standing back for a while and observing them attempting to revive the man'.*

Cameron's imagined and real nightmare is the most common method of suicide in England and Wales for men. In 2019, this accounted for 61.7% of all suicides among males (2,654 out of 4,303 deaths), increasing from 44.5% of suicides (1,643 out of 3,696 deaths) in 2001 (ONS, 2019). Research does speak back to Cameron's sense-making in the anticipated nature of a death from hanging and

accessibility to the means. It has been constructed as a signpost of decision-making for those who have planned suicide (Biddle *et al.*, 2010) where those who opt for this method believe, amongst other things, that it will not leave a harrowing scene for those who discover them.

This job didn't prove to be the worst job Cameron had been to so far. He thought he would cope with an overdose death better. He didn't as there was symmetry in his own story.

Cameron- *'The man looked just like me Clare, he was the same age and, and I still don't know if it was intentional or not, and if anyone even cares based on his choices'*.

Me- *'So what has made this job stand out Cameron, that he was the same age as you and looked like you?'*

Cameron- *'Yeah, and my biological Dad I suppose'*.

This experience proved to haunt his dreams, was locking into his memories with force, and was serving to make him feel quite unwell.

Cameron- *'I would wake up in cold sweats, not be able to regulate my breathing and couldn't get the picture out of my head, I couldn't sleep'*.

Cameron's physical symptoms are not unique for those who are involved traumatic experiences. This was also exposed in a law enforcement context of suicide exposure in Cerel *et al.*, (2019) where some respondents noted that they could not 'shake' the scene.

Overall, each shift has a series of jobs that Cameron has forgotten about, and he constructs a method of survival in this mode of thinking. It's only the jobs that he feels the need to call his mother about that he knows have stuck out.

Cameron- *'I haven't attended any other hanging[s], but I have attended loads of suicide attempts and I don't know if all of them survived or not;*

some I do know and others I don't it's, like, back to front isn't it- sometimes you get to find out, because you are back in A and E conveying another patient and you ask for an update or someone tells you in passing because they remember you dropping the person off

Me- *'So where does suicide as a cause of death feature- compared to others Cameron?'*

Cameron's construction is in an evolving state. He draws on his own life story when suggesting that people have their reasons, and that people don't fit in to boxes. They need our understanding before our judgement. Cameron portrays a resolute relationship with death given the role he has decided to take in our society as a helper adorned top to toe in green.

Cameron- *'Death and dying are part of my job I suppose it is why we are called out, people aren't well, have had an accident, are already dead or they are dying. Some of those jobs will stand out and others I will forget quickly. I don't think its suicide, why a job will stand out, there is more to it than that, it's the person, not what they have done.'*

4.5.6 Hope- Nightmare and Frustration: Did You Not Tell Him to Perform a Dive?

Hope sits hugging one of her legs, hoodie sleeves over her hands-

Me- *'so in relation to the focus of this research- suicide'*

Hope sighs and interjects immediately and narrated a story that she coined 'the bridge job'.

Hope- *'We were on our way back to the station last week and we noticed a man walking along the dual carriage way, can of beer in his hand and looking lost. We realised he was in trouble, and we needed to intervene. We stood talking to him, a sheer drop one side of him and a busy dual carriage way the other, and he was saying he did not want to*

be here anymore, that he'd had enough of not being listened to and wanted to end his life.'

We both sat in silence, for what felt like hours.

Hope- *'the technician was great Clare, she was brilliant in how she responded to him, the other paramedic said we just needed to grab him'.*

Hopes relief and resolution in retelling this story, soon turned to frustration when she moved us on to discuss how the story transpired. Several actors in the job frustrated her, including the police, A and E and his family.

Hope- *'When we got back to base, we told the manager in charge of the shift about what had happened, his only response was 'did you not tell him to perform a dive? I didn't find it funny'.*

Black or gallows humour has been recognised as having therapeutic value for paramedics and is thought to enhance their resilience and wellbeing. Perhaps this colleague didn't intend for it to be a joke, this may have been an invitation to share the load of the incident or lift her mood. Whatever the intentionality of the statement, it might prove to be a culture shock to university entry paramedic students (Christopher, 2015). Viewed another way, by not challenging 'humor' where the brunt of the joke is someone in distress, may unwittingly add to the unwritten and unadmitted attributions that can go on to shape the help those in such distress receive (Weiner, 1995).

Hopes response hints to spaces being created where this kind of response is possibly common and is born out of frustration. These tenets also emerged within the story boarding session. This resonates with McCann's observations with paramedic's use of gallows humour, where it assisted the paramedics in the short term when they initially attended a "nasty" incident, (2022, p. 149), however, this may have also symbolised that colleague' 'old school' lack of empathy and forgiveness for calls of this nature where they attend to the 'worried well' (McCann, 2022, p. 151), remedying his unease with a sardonic

quip. Patients who are categorised as mentally ill or suicidal can be subject to moral judgment from paramedics, and as a consequence are more likely to prompt anger rather than sympathy (Lawrence, 2015). Given Hope's subsequent statement, there is evidence she may be grappling with this way of seeing on route to an intolerance for the non-medical, non-emergency type jobs.

Hope - 'If you could hear every conversation that goes on in that cab, I am not sure they would make a programme out of it like you see on the TV. We can get frustrated by the mental health jobs, we get called to so many where there is no medical intervention needed, and I think this adds to our belief (right or wrong) that people are just doing it for attention, a cry for help- and I know this should be challenged.'

And yet, despite the paramedic being a profession of increasing scope and skill, where their clinical autonomy and discretion can flourish (Eaton, 2019), there will be no escape from attending these types of calls or the responses to them. It has been posited that responses and storying telling such as that outlined above, acts as a tactical resistance to the various groups with whom paramedics come into contact with on a daily basis, including their patients and each other (Tangherlini, 2000).

It would be unfair to apportion this lack of sympathy or intolerance of those who are in such distress to paramedics such as the one Hope depicts alone. Suicidal thoughts can occur when someone's prolonged self-perception of burdensomeness, sense of low belongingness and social isolation drives their desire for escape (Joiner, 2007). A 'cry for help' has over time been interpreted to being a 'mere' cry for help, from many professional/occupational contexts and not serious enough to warrant support. Consequently, there is a call to frame our sense making as a 'cry of pain' (Williams, 2017), but I query whether a simple change of description would really achieve a shift in perception for those who construct such a sense-making associated with those who express suicidal thinking.

Me- *'so you don't perceive it is a paramedics role to offer this talking intervention?'*

Hope- *'possibly not, or that there is or should be better services available to offer this. I think the mental health bit isn't the issue, but in comparison to other jobs where we are there to intervene and offer emergency medical intervention, it possibly creates this difference'.*

Hope's frustrations are playing out within a ripple of influences she may not be aware of that involve the political, professional body and paramedics own leadership motives to further expand the span of their practice. An important Department of Health report from 2005 sets out a very clear strategy which involves taking healthcare to the patient (DH, 2005), with much of the policy surrounding urgent and emergency care creating a neat binary between emergency and routine (Turnbull, *et al.*, 2019), that does not translate into reality. This is also met with considerable uncertainty and confusion regarding urgent and emergency care provision within the populations who may use them (Pope, *et al.*, 2019).

Me- *'so have there been any mental health jobs that have also necessitated more medical intervention?'*

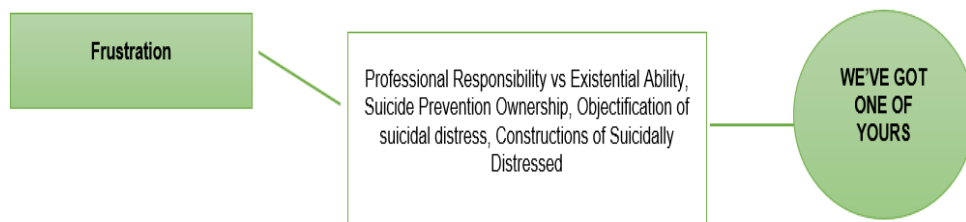
Hope- *'erm, yeah, I have had a few overdoses and a couple of them have been really poorly. One job, he had taken a massive overdose, I can't remember masses of detail about him other than his parents who were really annoyed with him, they said he keeps doing this'.*

Self-harm, as defined by NICE guidelines is any act of self-poisoning or self-injury carried out by a person, irrespective of motivation (NICE, 2020). It is the most common precursor to suicide (WHO, 2014), but we should also note that self-harm can have many functions to include coping and communicating pain and can occur in the absence of suicidal intent. If death occurs consequent to an episode of intentional self-poisoning or self-harm, then the 'diagnoses could become one of suicide, (De Leo *et al.*, 2006). Suicide attempt survivors, highlight that family members can play an essential role in the recovery process after an attempt occurs. This has important implications for both researchers

and clinicians who seek to decrease stigma for attempt survivors while simultaneously decreasing the likelihood of future attempts (Frey, Hans and Cerel, 2016), but I must consider how family members are currently supported to play that role, or if they are supported at all?

4.6 Discussion- We Have got One of Yours: Constructing the Suicidal Subject

Diagram 5: A collocation of sense-making across the frustration stages



The realities of suicide are socially constituted, they are given to us by the society in which we operate and negotiate power. Within the literature review, I present an uncontested latent theme considering the inconceivability at this point in our history and political milieu, that a search on pro-choice professional/occupational alignment would elicit many results. The literature may be restrained by the epistemic authority that sanctions it (Scotland, 2012). The personal stories (of paramedic students and the nested stories of others) within this study offer important signposts that signal meaning-making, power, and social identity. However, they may also serve to propagate and normalize particular ways of communicating and thinking that reinforce the institutional logics of suicidology. These have political force as they help to frame the ways suicide and those who experience suicide are understood (Fitzpatrick, 2016).

Individuals become subjected to technologies of power through objectification, because of *'dividing practices'* (Foucault 1982, p. 777). They operate in the way

a person becomes separated according to norm and deviance (Foucault, 1991b). I outline some of the tenets of the contemporary UK based Suicide Prevention governmental strategy within the introduction chapter which sets a prevention trajectory, and yet in the parameters of the literature review one social workers ability to cope was underpinned by their belief '*he did what he had to do*' (Sanders *et al.*, 2005). This might be considered a deviant way of viewing suicide within a professional/occupational context, given any such view is themed as absolving responsibility. This highlights that there is no 'natural order' of things and the world has no intrinsic ways of knowing, but only the ordering which we impose on it through the '*linguistic description of it*' (Mills 1997, p. 52). Discourses therefore make comprehension both possible and impossible (Dreyfus and Rabinow 1982), and this is apparent within this study. There are foundational narratives that are privileged, whilst others would appear more difficult to say. In between these spaces, when making sense of and constructing meaning from professionally or occupationally situated suicide exposure, we must consider those who have struggled with ongoing suicidality or who have been hospitalized after a suicide attempt and have reported a degree of divergence between their experiences and the language of the supposed experts used to describe them (Webb, 2006).

This is an interesting thread of exploration to unpick, when we consider the promise often set out to suicidal individuals that those within the paramedic services will always be there for them (Lara-Millán, 2021; Malone, 1998). In their cross analysis of three paramedicine case studies that explore the labour pressures of ambulance-based staff, Seim, Corman and McCann (2022) highlight that workers can sometimes feel like they are being held hostage by patients with threats of complaint which may result in a threat to their livelihood. The report that they are navigating pressures from a bottom-up perspective where they are increasingly called to jobs which they do not believe fit within their remit and are less professionally fulfilling.

In 1976, Foucault introduced the concept of bio-power in which he discusses the 'Right of Death and Power Over Life.' He refers to this modern form of

power that does not rely on the more commonly understood threat of punishment by a sovereign which possesses supreme and ultimate power over its subjects. Instead, it exerts a positive influence on life, administering, optimizing, and multiplying it, and in doing so subjects it to *'precise controls and comprehensive regulations'* (Foucault, 1980, p. 137). Suicide would appear to have become entangled in this right of death and power over life conflict, grappling with its production of sin, heroism, rebellion, and sacrifice, to one that is performative of mental illness, and in the case of paramedicine it would appear, as a social issue which does not require their skill. Foucault describes the merging of such institutions onto each other as the production of protective combining continuity. As 'switch points', they allow differing notions to enter and operate in each other's spaces (Mader, 2007; Puar, 2012).

Exploring the archives amongst which we live, using an archaeological lens to explore the history of the present, Hobbes highlighted the inconceivability of self-murder that lends to a notion that the *'person cannot be compos mentis'* (Hobbes, 1971, p. 116–17). We can trace some of the societal and political lineage seen in chapter one (Durkheim, 1897; WHO, 1999) in Hume, who wrote: *'to you it belongs to repine at providence, who foolishly imagine that you have no such power, and who must still prolong a hated being, tho' loaded with pain and sickness, with shame and poverty'* (Hume, 1980, p. 101), adding that the decision to end one's life could be *'courageous, and benefit society'* (Hume, 1980, pp. 98–104). There have been assertions that authorities should focus on countering the causes of suicide, ensuring *'better education and better morals'* (Frank, 1976, pp. 238–240).

These historical arguments could be read as representative of another age, but through his theory of genealogy Foucault warns us of omitting to consider the mechanisms and effects of power, which don't pass directly via the State apparatus. This is because even when it has changed hands, it leaves legacies of social hierarchies, family life, and the *'body as they were before'* (Foucault, 1980, pp. 72-73). We should therefore attend to exploring the archives among

which we live (May, 2005) searching for clues related to the historical conditions which motivate our conceptualisations (Foucault, 1983, p. 209). In doing so, we may see some of the historical legacies evident in the discourses and discursive practices that are drawn up on within our student paramedics narrations, and other professional/occupational sense-making in how they construct the suicidal individual. For example, Jodie narrated that she had heard of those that end their life being selfish, but she rejected that alignment. However, within the literature review '*those poor children*' appears as a narration of sense-making in Sanders *et al.*, (2005)', and in Gaffney *et al.*, (2009), we are asked, '*how will their relatives cope?*', those themes of sense-making shifting the focus of understanding the suffering experienced by the person who has died, to those who are now left to deal with the loss and fall out of their decision.

There are jobs which frustrate our student paramedics, which aligns to the earlier discussion around bottom-up pressures from patients and jobs that they do not find necessarily fulfilling. Examples of resistance depict suicide attempt 'jobs' as jobs that they don't always believe belong to them. In my own sense-making I scribbled in my journal notes, 'we have got one of yours'. Indeed, we see in chapter one that survivors of suicide attempts have been vocal in highlighting the problems with some of the help-seeking narratives set out within suicide prevention campaigns, given they often do not consider structural and relational barriers when doing so (Maopolski, 2018). This study finding does support this, exposing a layer of relational barrier for those seeking help via the emergency services. Hope almost spoke on behalf of paramedics adding to her list of frustrations where she outlined the mental health jobs that do not require medical attention as jobs that they scoop up due to poor service provision that should be offered elsewhere.

In the midst of his collection of experiences where suicide was clumped in with commonly known mental illnesses, Matt had a lot to say about the state of mental health services also. Similarly in Nelson *et al.*, (2020), a summation is offered outlining that ambulance staff are often the first at a scene and may become involved with tasks that are beyond their usual job-role, to include

negotiation with a person in crisis. The sense-making seen here holds aloft a notion of suicidal crisis response belonging to a particular professional/occupational context, and typically those who tend to the mentally ill. This is also constructed in the theme of 'Dominant professional voice and space' presented in chapter two. This objectifies mental illness as a red flag predictive of securing one's own quietus, forming a saturation of professional/occupational exposure sense-making within the literature. Indeed, in Kelleher and Campbell (2011), patient status, diagnosis and suicide characteristics were collected. In Landers *et al.*, (2018), consultant psychiatrists reported the most impactful suicides were those they had not predicted, this also suggests that they did foresee some. The responses in Gibbons *et al.*, (2019) indicate that most psychiatrists had high expectations about their own capacity to prevent suicide but found the weight of public expectation that they should always prevent suicide unreasonable. There is a suggestion in wider literature that a new paradigm may be needed in psychiatry, which holds that some suicides may be inevitable (Sadock, 2012).

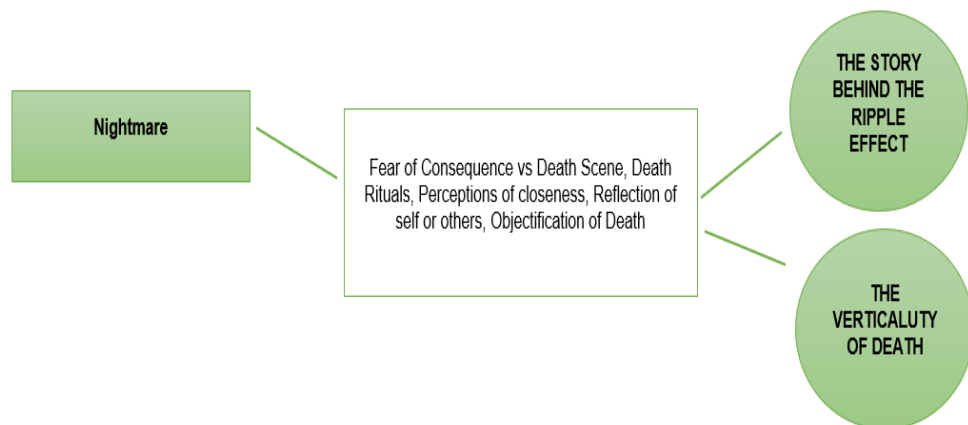
In Erlich *et al.*, (2017), respondents reported that they had stopped accepting patients they deemed at risk of suicide following a suicide loss. One consultant psychiatrist described their services aims around developing a risk assessment programme for general practitioners in the community in Gibbons *et al.*, (2019). Through a Foucauldian lens, we might see a power that is defined as 'actions on others' actions', that is, it *'presupposes rather than annuls their capacity as agents'* (Gordon, 1991, p. 5). After co-constructing the suicidal subject and accepting them as one of theirs, does psychiatry in this instance assume the right over life when upholding its superior stake in suicide prevention. An apparatus appears that is intrinsically connected to a complex web containing knowledge, competencies, institutional practices, and culture that are *'legitimised within legal and ethical frameworks'* (Foucault, 2001, p. 56-7).

However, does psychiatry then relinquish that power as a means of sense-making and retribution post suicide? Through mitigating the terror of culpability,

do we see it retrospectively let go of control in the face of a patient's death, assuming their agency given perceptions that they have failed to persuade them to act in certain ways, and choose to live?

4.7 The Story Behind the Ripple Effect and the Verticality of Death

Diagram 6: A collocation of sense-making across the nightmare stages



4.7.1 The Story Behind the Ripple Effect

Extending the collocation of constructing the suicidal subject to the construction of those who complete suicide. We have heard narrative threads that emerge within this study, of suicide being objectified as a cause of death that can be prevented, but in some cases attests that it cannot always be. Viewing these signposts through a lens of archaeology, we see this within this study across the span of the literature review, and the student paramedics narrations. As a potential cause of death, our student narrators performed a resolute stance towards the notion that they will attend jobs where people are either already dead or they are dying, suicide may be one of those causes. This resonates with Durkheim's understanding of suicide, acknowledging that a certain number of suicides was a '*normal element of any social constitution*' (Durkheim, 1951,

p. 363). This embrace of a certain number of losses to suicide might be viewed as the *'necessary correlate of the state'* (Foucault, 2007, p. 350), and highlights our contemporary social technology demand for the norm. In the case of suicide prevention, for its goals to be set, people must survive, and people must die for us to create the mean/average, counting and comparing characteristics.

The basis of an accepted suicide mortality rate emerges in the 2012 UK suicide prevention strategy and subsequent adages, which challenges the NHS to contribute to a 10% reduction in suicide completion in their local areas (DH, 2012; Farmer and Dyer, 2016). Notwithstanding how the NHS might go about proving the correlation of lives saved due to their input alone (Althaus and Hegerl, 2003), the 10% reduction aim might communicate 90% of the previous year's tally is ok the following year, because this target is reached. These groupings of individual members of our society who die are joined and *'homogenized by the bureaucratic, medical, police and social scientific application of a definition of suicide'* (Puar, 2012, p. 16). This also informs targets for those who are deemed to belong to a 'high risk' group, possibly closing our ears to consider the overlapping stories behind the statistics. Through governmentality, this technology of power opts to characterize the arithmetic relations of measures within the high-risk group, creating an illusion of an assured targeted approach and a confidence in risk assessment practice within suicide prevention. It is noteworthy to mention that the mean/average number of methods of suicide completion have long been a feature of our attention for tallies and informs the basis of prioritisation for reducing such access to means of dying by suicide (Gunnell *et al.*, 1997).

Our student paramedics performed a face value sense-making that the act of suicide itself is not what made it a job that stands out, as they didn't feel any sense of responsibility to prevent it. More so, it is the story behind the statistic that makes such a job stand out. For Lucy, she came into the course affording little time to think about suicide as a topic, in so many cases on the road it is also a lottery as to whether they even find out this outcome. However, it is

within the space of not knowing, the narratives that filled this void were connected imaginings which complete the conundrum and lent on the hope of survival. This constructs an affirmation of life, pitched against someone's attempted negation of it (Gemes, 2008; Reginster, 2009).

What compounds life affirming complexity for our student paramedic narrators, is where attempts to save life are in vain. If someone was dead when they arrived, and hope was not present in the first place, this was constructed to mediate any potential impact of any cause of death. Each death, whether it be suicide or otherwise can represent something different. Indeed, Cameron seemed to construct a sense of security that he would cope with an overdose death better. He did not within one overdose death, as there was symmetry in his own story which he could not have anticipated.

This adds a layer of sense-making and speaks back to the literature reviewed in chapter two, where suicide was posited as more impactful than other causes of death, for example in Draper *et al.*, (2014) and Causer *et al.*, (2021).

Furthermore, perceptions of closeness to the deceased can formulate adverse impact within the ripple effect of exposure posited in the introduction chapter (Cerel *et al.*, 2014). Here, Cameron informs us that in constructing a perception of closeness, the individual does not have to have had a relationship with the deceased. Rather, the impact can be felt in the constructed symbolism of the person who has died, and what it reflects to their own story involving characters who they do know, and in some cases love.

4.7.2 The Verticality of Death

It is argued that attempts at making sense of suicide is reflective of biopower (Kosonen, 2020), rendering it as taboo, bad and threatening, as well as being symptomatic of mental ill health. This in turn shapes the practice of normative techniques aimed at the subjugation of human bodies which are dependent on normative biopolitical discourses in the medical world and other institutions of

knowledge such as public health and education. Indeed, the whole premise of suicide post-vention research and practice is an extension and feature of suicide prevention overall, that seeks “*to foster life or to disallow it to the point of death*” (Foucault, 1990, pp. 138- 139). Death, therefore, becomes “*the point zero: it is nothing more or less than the moment at which human control over human existence finds an outer limit*” (Giddens, 1991, p. 162). There is some resonance in this latter statement within an earlier discussion where our paramedic student narrators talked of their contemplation of death jobs. Here, they constructed a relatively impartial reaction to a death when there was no semblance of hope to restore life. This was in parallel to the idea of losing the battle with death when hope was indeed present, and they had to then grapple with the proposition of failure.

This collocation of sense-making sits within a more specific professional/occupational exposure, where exposure to the death scenes emerge. Here, the dead, who no longer possess voices to speak, cannot answer the questions of the living. As a result, those of us left behind are stranded without answers, and the stories of the deceased are replaced by narratives shaped through partial understandings of the living and the discourses authorised for defining suicide (Davis, 2014). In turn, the deceased become objects/ subjects of knowledge. In Wang *et al.*, (2016, p. 357) a nurse describes ‘*terror of the death scene made me all of a quiver*’. For paramedics, there was a reported lack of acknowledgment in the workplace that suicides may be traumatic, and no guidance existed for staff on how to cope (Nelson *et al.*, 2020). This sits within a wider postvention framework which depicts exposure to the scene of suicide as a category worthy of classification of bereavement.

Within Matts sense-making, he narrated a story in relation to his own death scene rituals, which I suspect he would apply to anyone, regardless of their cause of death. Such rituals may play out on a psychological plane that aims at providing solace for the bereaved relatives of the deceased who are present at

the scene (Salmani Nodoushan, 2016). Consuming the Dead is a term that is used to refer to how we make meaning of death and is associated with a focus on such rituals. Consuming-for-community and consuming-for-security are key death-ritual consumption practices and contribute to cultural reproduction, (Bonsu and Spence, 2008; Harju, 2015). Here, we may begin to unpick how power is working through institutions which in turn shapes individuals into subjects, but I remain curious as to what makes such practices legitimate, desirable, and efficacious.

Knowledge is composed of statements and visibility, and within the networks of what was said during the story telling sessions of this study, and what can be seen in a set of social arrangements within the nested stories of the student paramedics, there is a benefit to making visible and opening up statements, through a lens of inquiry that is attentive to peculiarities. Matt constructed a resolute sense-making about his own death rituals, and the fact someone has passed in the assumed comfort of their own bed, peacefully, lying flat, eyes closed and calm. Here, such a death is constructed as a normalizing process, and a proclamation that this was one of various good deaths he had attended (Hawkins, 1991). He constructs comfort from the doing, not the feeling, mediated by a series of institutional and professional practices (Giddens, 1991). Here Matt's sense-making might be facilitated by the care given to the deceased's body, and indeed their soul, and I am drawn to the hybridizing of biological, sociological, and spiritual styles of thought which are performed through his actions. They are grounded in a perceptual ritual and performance that ends in objectification, of being '*set free of their earthly remains*' (Csordas, 1994, p. 7). The performative nature of Matt's actions may position them as extending a rite of passage (Van Gennep, 1960) acknowledging, marking, and communicating a transition from life to death.

A sense of identity through a system of representations is what we may perform as the result of engaging in such rites of passage and objectification. Why does Matt deem it necessary, and why is a resolute sense-making constructed through their post-mortem position? That body might have already endured

physical trauma prior to death, and after they are conveyed from the home their bodily remains are then viewed as a source of potential infection risk (Árnason and Hafsteinsson, 2018), so it is a laudable suggestion that such rituals are indeed for the benefit of the remaining living.

We might trace some of the lineage of constructed sense-making through paramedic's narrated fear of hangings, which I can only describe as inherently destabilizing for them and are far from good deaths they attend. All but one of the student paramedics within this study narrated a fear that had been passed down to them through the hanging '*atrocities stories*' that had been shared with them (Cousineau, 2016), and perhaps these stories were given the space to be heard because they contained an element of difference and gore, earning their place as part of the paramedic folklore. Cameron's imagined nightmare became a living reality when he was faced with one of the jobs he had soon learnt to dread. Early on within his first placement exposure, he had to bear witness to a hanging. Linking this to Matt's sense-making and death rituals, there is a co-construction of both imagined fear and coming face to face with death due to hanging. This is constructed as the 'unnatural' position of the body, which is not horizontal, but vertical. Such earthly remains and the verticality of death, make for '*potent memories*' (Verdery, 1999, p. 27) which are permeated to the next generation of paramedics through their proclivity for storytelling.

The symbolism of bodily remains is performative in their static form, but they do not have a single meaning as they are open to many different interpretations (Verdery, 1999). We see such a multiplicity of meaning in shared sense-making with survivors of suicide attempts. Those favouring hanging in one study say they believed it was a 'clean' method that would not damage the body, or leave harrowing images for others (Biddle *et al.*, 2010). Foucault asserts that the control over individuals is not present via consciousness or ideology alone, it is also present in the body and with the body (Gastaldo, 2002). This study extends the discussion to affording sanction in our deaths, within a particular historical and bio-political context. Such virtue over death is co-constructed, where in this

study we see a less correctional stance toward the act or aims of suicide itself. Indeed, Cameron added in his own sense making of a suicide death that *“people will have their reasons”*. His statement was not so forceful that I might interpret his view of someone opting to die by suicide as bulging with agency and intent. More so, that there may be reasons and motivations we do not understand. What we do see within this collocation of sense making within the visualisation of the verticality of death, is a fear and condemnation of a death by hanging and the bodily remains it leaves behind. We see a co-construction of the unerring deceased bio-political object, that is then linked to the wellbeing of the living.

4.8 Return

The return signpost of the narrations sees our student paramedics return to their home. They have experienced exhaustion, peril, fear, and challenges but nonetheless they have developed means of coping and making sense of those experiences having learnt much about themselves.

4.8.1 Matt- Return: We All Wear Green

Matt has a real appreciation for his educational experience and how the course is designed, but he is navigating exhaustion.

Matt- ‘I am knackered, ask any of us how much sleep we get, but I couldn’t see this course working well any other way. I like that what I have learnt in a lab on Monday can then be applied and tried out on my night shift on Friday.’

Matt lives in a student flat with other paramedics, which means he can off load some of the day’s experiences and the mad world in which he has spent 12 hours, to *‘people who get it’*. Here his means of coping and his making sense of jobs that have stuck with him aren’t judged.

Matt- *'there isn't any possible way I could talk to my mom or my girlfriend about some of the jobs I go to. Some jobs I go to are awful, even how I describe them doesn't seem right and it's that they possibly wouldn't cope with either.'*

Me- *'would you feel able to access counselling at university if you needed to Matt?'*

Matt- *'honestly, ermmm no! if I am struggling this soon on in my career, it doesn't look good, does it?'*

I reflect here when the right time for Matt to admit he is struggling will be, who his plea for support might not look good to, and how long his performance of being stoically ok will hold out.

Matt- *'on the base there is access to a SALS service though, and though it's aimed at paramedics employed and fully qualified, I can use this if I want to, 'they wouldn't exclude us from it because we are only students, we are part of a family and 'we all wear green'.*

Staff Advice and Liaison Service (SALS) offers 24-hour support through the ambulance trusts management team. This service is predominantly run by paramedic peers and some trusts have gone on to employ psychotherapists who will provide dedicated help for paramedic staff. I have not been able to locate any evaluative literature that has explored the barriers and facilitators to accessing this service, nor any academic literature exploring either efficacy or experience. Regardless, paramedics have a vast toolkit of resources to take care of others; it is the duty of researchers, clinicians, and the community to aid in taking care of their health as well (Stanley, Hom, and Joiner, 2016)

Matt- *'I mean if the uni can fight for us to gain a bursary so we can afford to live a bit better, this would be good, and put some of the mental health content of the course in the first year, because it will be one of the first jobs you go to '*

Me- *'do you think simulation would be a good way of learning and preparing for these bad jobs that stick out.'*

Matt- *'yes and no, you cannot replicate the adrenaline you get when you attend a job'.*

I reflected with Matt that this cannot be good for him, his response fits a *'trauma junkie'* narrative (Palmer, 1983) where he feels this physiological response is required to get him through the real jobs that paramedics are meant to do.

Matt- *'no, it isn't, but it gets you through it- it's afterwards you feel knackered'.*

This mixture of high intensity or edgework, and mundane work is constructed to create a difficult shift for paramedics' mind set, with little respite or time for debriefing and dealing with administrative requirements during periods of intense emotions (Granter *et al.*, 2018).

4.8.2 Lucy- Return: The Reasons I Can Feel So Low

We sat and reflected that given her experiences, and if she could have any say on how the course is designed or the support that is offered, what Lucy may suggest would help.

Lucy- *'erm I think, university-based support is needed, people can be quick to say ask for help if you need it, but I know I would have to hit rock bottom before I did'.*

Me- *'do you know what your rock bottom is?'*

Lucy- laughing *'no not really, but I know it would have to be really bad for me to seek help. We all have personal tutors, and I do think you should have to have at least semester check ins with them to ask how you are doing, this can be there to discuss anything on our minds. This could be course pressures, home pressures, experiences in practice, it can feel like a pressure cooker, and I also work part time to be able to afford to live'.*

I asked if her placement-based mentors could offer any of this support.

Lucy- *'No, only last week I made a passing statement about being tired and the response I got was – 'what possible problems could you have? Dee dums! 'He had the cheek later on to ask if I was ok, on that day he was actually one of the reasons I felt so low'.*

We both laughed at the conflict this experience posed.

Lucy- *'at university, I think there would be more scope from the tutors to ask us if we are ok and actually mean it, but also understand some of our experiences, but they shouldn't judge my bad job, to mean the same as someone else's view of a bad job, what makes it bad is how we have experienced it'.*

Lucy- *'I know this kind of discussion we are having is important Clare, I know that there are paramedics that are dying by suicide'.*

In 2015, Ambulance Service Medical Directors raised concerns regarding a perceived increase in suicide deaths among ambulance service staff. The ONS analysis of occupational suicide risk between 2011 and 2015 indicated that there were 20 suicide deaths amongst paramedics in England during that period. The risk of suicide amongst male paramedics was 75% higher than the national average (Hird *et al.*, 2019).

4.8.3 Jodie- Return: Got to Keep It Together

Jodie constructs an admiration of those paramedics who appear to be holding it all together, those colleagues who have seemingly developed ways of regulating their emotions in an *'emotionally laden'* context where they are directly involved in delivering care to the human body (Boyle and Healy, 2003, p. 356). I reflected with her that this really stuck out for me on the observer shift I attended, and how the paramedics had forgotten most of the jobs we had

attended that day before the shift had finished, building what I described at the time as a 'deliberate armour of amnesia'.

Jodie- *'I am that paramedic, you have to be, I hope that doesn't sound bad'.*

Me- *'goodness no, I get it, but it does bring in to focus that the jobs you have talked about, you have locked in, and you didn't forget them, so there must be some that feel more up close and personal'.*

Me- *'So for example a good job, does not necessarily [have] a happy ending, but that a lot was taken from it, or that it was one you have got out of the way and had either dreaded or knew you had to tick off the list, or that they remind you of something or someone in your life'.*

Jodie- *'yeah spot on'.*

Me – *'Given your experiences and sense-making of suicide so far, do you have any views about the topic itself?'*

Jodie pauses

Jodie- *'I have heard of people talking about those who try to end their life or do end their life, as being selfish, because of who they leave behind, and I don't feel this is fair.'*

I was glad Jodie reflected this given the focus of this study. I have found that judgment of suicide as being selfish, is accompanied by the imagined impact on those who must respond. Yet when we look to the literature this has seldom been asked of those who respond and including people like Jodie. Though her sense-making shouldn't be considered representative of all student paramedics, whilst avoiding the pull to generalise, it does create a space to unpick these sometimes-automatic, essentialist attributions.

Jodie led the discussion after this point and reflected on her own struggles.

Me- *'I haven't pulled this from you have I, or you felt an obligation to admit this through our conversation?'*

Jodie- *'no, I am ok, it was based on how I was figuring out how I felt about suicide as a topic, I felt this anyway, and wanted to share this with you.'*

Me- *'thank you.'*

Jodie- *'I do think there would be scope to tell people if I am worried about certain types of jobs, there seems to be a shared fear of kid's cardiac arrests, and hangings, so this may make it easier to say, but you are the first person I have spoken about my fears to in so much depth.'*

Me- *'is that ok?'*

Jodie- *'yeah, I suppose, if I didn't want to, I wouldn't have'*

Me- *'So how do you think you will cope if you get this kind of job-?'*

Jodie- *'I don't know, but I do know I could talk to any of my peers on the course, we are good friends '*

4.8.4 Cameron- Return: The Myth of the Typical HE Student

Cameron spoke to his mom, his partner, and his university lecturer and accessed university counselling following the overdose death that locked into his dreams, but noted:

Cameron- *'by the time I got my first proper appointment, I almost felt like I had sorted myself out by that point. It wasn't that long to wait really, but in the days, I was waiting I got support from my lecturer and my family.'*

Cameron can't quite decipher if there is anything that the university or the course can do to better prepare him or his peers for these kinds of encounters. As student paramedics, they are dealing with life and its complexity which cannot be rehearsed.

Cameron- *'There might be scope for lecturers supporting students to all be equipped with better listening skills, and confidence to ask if we are ok, I was lucky that the lecturer I approached after the overdose job, did'*

Cameron suggests the University staff could: *'prepare us better at the beginning of the course that it isn't going to be easy, and that resilience is something that is built not given or taught to you!'*

Working within the complex layers of stress and trauma, it is apparent that paramedics themselves can experience emotional, psychological, and physical trauma (Gayton and Lovell, 2012). They receive little education and training about how to effectively manage this, and paramedics are constructed to experience symptoms of Burnout, PTSD and Depression (Millar, 2004; Shakespeare-Finch, 2006). Cameron reports a complication in his sense-making of any job because he finds himself stuck in limbo, where he does not quite fit in to a student in higher education identity but also does not fit in to a paramedic's identity. The initial transition to higher education can result in alienation (Mann, 2001), and the transition back from placement can intensify any feelings of not quite belonging (Auburn, 2007). Should transition activity be underpinned by a commitment to recognise and value students' wealth of social and community interactions and their external commitments. Should it forge intentional links to support students to *'find their places, be inspired and excited'*? (Kift *et al.*, 2010, p. 3)

Cameron- *'we aren't like other students at university, we aren't better or worse, but we are different with different demands.'*

4.8.5 Hope- Return: The Need to De-clutter

We sat and reflected how Hope managed to file away the jobs that get to her, such as the bridge job.

Hope- *'It was only after this shift with the man on the bridge, that I got in my car, and I cried my eyes out, I called my parents and then they were crying their eyes out with me, I was upset about him, but also the response from my peers- I really didn't find it funny.'*

Like with Cameron, Hope seems to really lean on her parents to offer the emotional support she needs. Organisational support systems that focus on emergency workers, generally neglect to consider their family members. However, it has been suggested that if they do consider them, they may do so at the risk of distracting from the employee's needs (Regehr, 2005).

Me- *'so if you could have your say, and speak to those who are designing the course, what would you say?'*

Hope- *'we were actually talking the other day; we believe there should be compulsory check-in for well-being every month with a member of the academic team. I mean for example I haven't spoken about that job I have to you since my parents, no one at uni knows about it.'*

Hope- *'My friends when they go to other jobs, big jobs that have got to them, they will not go out of their way to seek help and with these check ins there may be a better in road for students to speak out'.*

The barriers for help seeking within emergency responders can emerge through fear of being judged as weak, lack of availability and the fear of being burden. Overcoming these barriers can also be facilitated by the 'I'm not alone' buy-in, positive experiences with support and recommendations from peers (Jones, Agud and Mc Sweeney, 2019). Hope recommended that any such support session at university should not be obviously linked to well-being, but instead be bannered as a de-clutter session. She suggested weekly meetings where they can meet and discuss the jobs from that week. She also proposes that this would inform learning as well as wellbeing. Where student paramedics are not ok, it may be more easily spotted.

Me- *'So we are calling it a de-clutter session'.*

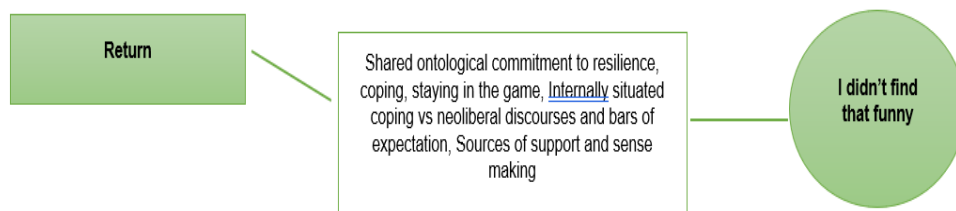
Hope- *'Yeah, we will go for that'.*

[Laughter]

Hope- *'Look, I know that counselling is there, but I don't think I would go to it as it isn't what I need, I don't want to sit down with a counsellor who I would have to spend more time explaining the context and language to. I have liked being involved in this research though, as it tells me that someone outside of our profession cares, we will all have that one job that we remember, I know this because I hear this so many times from loads of paramedics I work with. It's good for us to be able to talk about them to someone who doesn't tell us how to feel- but just listens.*

4.9 Discussion- I Didn't Find That Funny: Support Need and the Support Offer

Diagram 7: A collocation of sense-making across the return stages



Death by suicide, and the professional/occupational exposure to it has been problematised within this study as something to be dealt and coped with. It is also bannered as an occupational hazard in (Rothes *et al.*, 2020; Sanford *et al.*, 2021). Within wider discourses and structures that shape and nudge professional/occupational sense-making, remove focus from the loss of the person who has died, and instead set out the parameters of navigating guilt, fear of blame and legal consequence for the professional who is left behind.

These then construct emotional turmoil and stress reactions (Bohan and Doyle, 2008; Darden and Rutter, 2011; Draper *et al.*, 2014; Matandela and Matlakala, 2016; Gibbons *et al.*, 2019; Murphy *et al.*, 2019).

Such obvious sense-making was not narrated for our student paramedics, more so, nightmares and death scene images were a feature for Cameron. Similarly for fire fighter exposure in Hom *et al.*, (2018) and Law enforcement officers in Cerel *et al.*, (2019). In opting to focus and report back on individual sense-making and individual support need, it may see us engage in a convergence of suicide exposure 'impact' unified by the presence or absence of illness alone. Favouring symptoms over experiences and upholding illness is a sum of its symptoms associated with specific reactions (Faravelli, 2004), in chapter two I present a synthesis of post suicide responses aligned to a pathological gentrification of distress. Continuing the conversation within this chapter, the body of literature reviewed alongside some of the wider theory that situates some of our student paramedics narrations, appear to share the ontological commitment of adding to a toolkit enabling individual resilience and coping. For example, a notion of veteran paramedics is constructed as an anomaly of resilience among the paramedic population given their longevity (Jenkins, 2020), and schoolteachers 'staying in the game' in Erlich *et al.*, (2017). Though laudable at face value, resilience sets the bar to perform the ability to withstand and survive shocks and disturbances with a '*capacity for renewal*' (Gunderson, 2003, pp. 33-52), and I am not entirely sure that this is a healthy picture at all, because its someone else's bar of expectation. The adaptive capacity of the professional/occupational representation, and their sense-making of suicide exposure is therefore assumed to see them emerge as more rounded and adaptive souls, but again, I ask, by who's standard? This must also surely depend on the bedrock of their social, family, and professional institutions and the ability to absorb such shocks (Berkes, Colding and Folke, 2003).

Our student narrators constructed pre-existing and overarching challenges with their wellbeing, navigating a lack of sleep, muscular skeletal complaints,

irregular dietary intake, study demands, and little space to make sense of any of their experiences let alone suicide exposure, navigating external social and political constraints such as lack of financial support whilst they are studying. Of concern is that those pressures are only set to amplify when they do eventually graduate and enter a work force that is subject to microprocesses and macro-forces (Erickson and Grove, 2008).

The previous discussions focused on the pressures from below (Seim, Corman and McCann, 2022) which are framed as regimes that emphasize patient rights and their expectations of timely, person-centred care, who then in turn have the power to shape and shift clinical encounters (Latimer, Roscamp and Papanikitas, 2017). It is useful to pick up here the paradox of the pressures also encountered from above. Situated in wider suicide prevention aims which are embedded in fidelity to curb the economic and social impacts of suicide, paramedics and paramedic students alike have imposed pressures which include performance around response times. I noted within the observer shift I undertook in preparation for this study and within the stories narrated by the students, that scope expansion of their role was also a prominent feature and not believing some jobs belonged to their remit. It is worth reflecting if this scope creeping is as a result of solutions further rooted in neoliberal logics, banners of fiscal responsibility, and the ethos of “New Public Management” which are pervasive (Clarke and Newman, 1997).

Exploring the support utilised and the support that was found to be useful, support from a source that loves me and gets me was a compass guiding the narratives throughout the literature review. Our student narrators added to the construction of family support proving one of the most utilised, with them being described in wider theory as an important resource for paramedics (Regehr, 2005). Yet, this does assume some element of empathetic attunement, indeed there are some hints of restraint in calling up on family for support from Matt, suggesting that a sense-making triage might be constructed before the decision is taken to disclose to them.

Peer support is also commonly constructed as a means of coping and sense-making, for example, speaking to colleagues, particularly those who have previously had patients die by suicide helped to reduce feelings of isolation in Kelleher and Campbell, (2011). This suggests that coping is constructed in a collaborative process with peers, and where sense-making that is akin to one's own can be reached. However, for Hope, one of the sparks of frustration emerging from her sense-making, which burdened her coping, was being asked a question from a source that could be said to 'get it'. One of her paramedic colleagues asked, '*did you not tell him to perform a dive*' in response to her retelling the details of the bridge job. Framed as dark humour, our student paramedics need to adapt to this situated and accepted remedy given its alleged therapeutic value for paramedics, and is constructed to enhance their resilience (Christopher, 2015). Hope remarked '*I didn't find this funny*', and yet she opted to say nothing in the moment it was said. This was in stark contrast to her assertive disdain in my presence. Either response may emerge from the fear of being labelled deviant in a paramedic context, and in the HE context in the presence of myself, compelling her to behave per the norms she sees before her (Foucault, 1982).

Within this emerging professional juncture, Hope and her student paramedic peers have some optionality to support their resilience via their HEI context. For example, Cameron spoke to his mom, his partner, his university lecturer, and accessed university counselling. Hope presented a suggestion of 'compulsory' check ins with wellbeing in mind given her view that she nor many of her friends would go out of their way to seek support for the big jobs that have got to them. She framed such checks ins via pedagogic space within a teaching timetable as a de-cluttering.

This sits against a backdrop of HEI's in a UK context who are challenged to meet the 'crises of increased mental health disclosures (Thorley, 2017), which

has led to a call for action within the *Step Change* model (UUK, 2017). The campaign asks universities to reconfigure themselves as health-promoting and supportive environments aided by mental health literacy training to staff. I believe we need to ask if this HE culture which is informed, constructed, and performed by its mental health literacy, will do any better in mediating the risk of students being labelled deviant, thereby compelling them to behave in accordance with the norms (Foucault, 1982). I don't think we can in any way assert that it will, which then challenges the practice and theory binary. Such mental health literacy may be aligned to viewing the individual as the sole source of any issues they are navigating. Furthermore, there may be a compulsory pull to pathologize such distress due to the default alignment of such mental health literacy, situated within a taken for granted Eurocentric construct. Therefore, we risk default alignment of hearing such distress through the filters of diagnostic styles of listening (Anderson, 1997) fostering diagnostic '*sensibilities and sensitivities*' (Shotter, 2010, p. v). Interestingly, of the reasons our student paramedic narrators said they would not attend a university counsellor, was because they didn't want to be placed in a position of explaining their context and language to someone else. If we train academic staff to speak the same language as the informed mental health professionals within, HE, it is a laudable question to ask where students such as our narrators would go?

The aim of developing individual resilience fits with a social ontology that urges us to turn our backs on a concern with the outside world, to a concern with our own adaptability, reflexive triages of need and our coping acquisition. This also rests on the assumptions of the autonomous individual (Joseph, 2013). As emerging and fully fledged professionals who navigate suicide exposure, we may have started out cognisant of the bigger picture, but we arrive at a view that the best way to govern it is through a greater awareness of our own behaviour. We are assimilated to the '*natural processes*' of the economic sphere (Foucault, 2007, p. 353). Therefore, our choices are always made within the confines of the prevailing historical and cultural discourses (Foucault, 1982). Such mental health literacy training should therefore raise broader questions

around the primary role of academics and professionals in HE, and whether their role is it to support students to passively slot within society, or to support and educate them to engage critically and act agentively in society to challenge the status quo (Dhillon, 2018).

Positioning an individually situated professional/occupational resilience and productivity within a wider context in which it works, this collocation of sense-making highlights that it is necessary to understand the constructed interplay between individual, relational, and external factors. This is because they play a productive role in shaping, mediating, and constraining the responses and sense-making associated with professional/occupational suicide exposure. Through a lens of governmentality within which technologies of power and technologies of self emerge (Holmes and Gastaldo, 2002; Martin *et al.*, 2013), we must remain alert to the dominance of neoliberal ideologies in the field of professional/occupational suicide exposure 'impact' and HE student support needs. What is illuminated is that neoliberalism privileges and favours individual competition, accountability, self-care, and performativity. This governmentalisation works by telling us to be buoyant, resourceful, and productive citizens, which is the basis of rationality for any liberal government. It operates subtly under a banner of promoting individual freedom, that we then perform to and in turn can find ourselves judged against, by others and indeed by ourselves (Foucault, 2008). Therefore, I would pose a challenge to the default '*occupational hazard*' framing of suicide exposure (Rothes *et al.*, 2020; Sanford *et al.*, 2021). What we unveil here is that suicide exposure for our student paramedic narrators, plays out in occupationally circularly hazardous conditions. Here, their placement learning, which offers an apprenticeship and preparation for their working life, is undergoing significant changes and is becoming increasingly demanding as they navigate dimensions of intensity, including temporal, physical, emotional, and organisational pressures (Granter *et al.*, 2019). I explored and argued in the literature review of this study, that paramedics are 'professionalising', and picking up this thread again, I would ask at what cost?, just as I would for any other allied health professional group

which has been depicted in this study. We therefore might not ever develop and nurture resilience in response to suicide exposure. We might, however, do and perform it, before we bow out, opting for poorer but healthier retirements (Roy, Weyman and Nolan, 2020).

Chapter Five: Conclusions

Introduction

Within this study, these re-told stories of five undergraduate student paramedics offer a source of oral history that mediates between the individual paramedic students and society (Tonkin, 1995). They can now serve to contribute to and facilitate a co-construction of understanding. They can also speak back to the partial understandings of other professional groups, and the field of suicide postvention within their situated contexts as higher education students. The collocations presented within the previous chapter have exposed some of the essentializing practices that might be said to freeze professional/occupational exposure to suicide into subject positions, or categorizations.

Emerging from our student paramedics stories of voyage and return, a recurrent plot line continues across this whole thesis. It depicts multiple journeys and truths across the signposts of anticipation, initial fascination, frustration, nightmare, and return. Adopting a Foucauldian way of looking up on the narratives has also offered a '*map charting genealogical trails*' (Tamboukou, 2008, p. 103). Constructions of navigating complex and varied terrains of experiences are sketched out, and so much is reflected within my own doctorate journey which I aim to capture in one space. A map of experiences will now be presented, which will navigate the reader through this concluding chapter. This map will visit some of the landmarks of this study and explore its contribution to knowledge, which opens new possibilities for postvention research, and paramedic science pedagogy.

5.1 Map of Experiences

“*Stories are a way of redrawing maps and finding new destinations*” (Frank, 1997 p. 53).

Travelling and journey are re-current themes within our student paramedics’ and my own experiences, their sense-making plays out ‘on the road’ and their love of the profession is in part aligned to its non-anchored geography. A journey also plays out in suicide and suicide prevention, navigating terrains of causation, remedy, and intervention. Though we have not produced or directed our own trajectories, we have co-existed within the texts in which professional/occupational exposure to suicide is constituted. It’s here where contradictions have been embraced within this study (Cixous and Derrida, 2001), and it’s a possibility that within these spaces’ that metaphors are pervasive and inescapable (Lakoff and Johnson, 1980). As linguistic devices, metaphors can offer conceptual aids, making patterns visible which may then facilitate re-interpretation (Anderson, 2008; Carpenter, 2008). Playing with them creates spaces for possibilities (Barthes, 1977), and within these spaces a metaphor of travelling could create a bond of understanding. I am aware of the risk that I may be viewed as trivializing the experiences of the student narrators (Manhas and Oberle, 2015), but I believe I have avoided the risk of oversimplifying this study’s findings and of ‘*depicting the complex as trite*’ (Carpenter, 2008, p. 280). This is because I have offered space for the stories to be heard, and the metaphor has occurred unintentionally. There is also an emphasis on common experiences and emergent possibilities between me, the student narrators, and academia (Lakoff and Johnson, 1980).

I have been encouraged to think poetically on the way to knowing within this doctorate journey (Cross and Holyoake, 2017), and I believe maps can offer us a certain poetic power which may also communicate some of the unification I discuss above. I also hope to show a concern with conceptual utility for the reader (Rossi and Freeman, 1985; Cahnmann, 2003), and through subjective

projection, to create a useful and evocative artefact (Klare and Van Swaaij, 2000). As another layer of analysis, it may offer a “*commingling of analytical and artistic ways of knowing*” (Conquergood, 2002, p. 151).

5.1.2 We all Wear Green: A Map of Collocated Experiences



5.2 Contributions to Knowledge

Depicted on the map of experiences as a **drop in the ocean**, this study offers a contribution to knowledge extending the literature by advancing an understanding and appreciation of student paramedics exposure and sense-

making in relation to suicide. In answering the first of my research questions: what are the stories that are re-told by student paramedics who have experience of direct exposure to suicide? and what sense and meanings have student paramedics applied to these experiences? and then exploring the similarities and contradictions that arise from the collective narratives of the whole study. I have found that creating a space to hear stories and homing in on the '*grey meticulous details*' (Foucault, 1986, p. 76) has opened up analytical pathways to read and hear them. This study shows how sense-making in relation to suicide exposure have been mere discursive constructs of historical contingencies, that have then been receptive to being interrogated and reversed.

Therefore, this study's findings might not grant automatic similarity or verification to the apparently universal and widely accepted notions of professional/occupational exposure to suicide and its distinct 'impact' that research holds aloft. My study findings main contention is that professional/occupational exposure to suicide is subject to any number of contingent factors which could have easily been different, such as personal experiences, the reactions of others and the organisational structures and micro-cultures in which suicide exposure and sense-making plays out. As such, the associated sense-making will never be a stable, fixed and ordered entity that can be presented as truth, rather it is constantly in flux. Postvention research and practice needs to be receptive to this fluidity and uncertainty, I would go so far to say that it should embrace it.

5.2.1 Mayday Call

As one of its contributions to knowledge, this study has looked up on a body of research and is depicted as the **lighthouse**. Engaging in a critical interpretive synthesis, I have resisted a pull to pool and assemble data in order to prove what works. Instead, I have explored the ways in which the professional/occupational suicide exposure literature constructs its problems, and some of the assumptions on which it rests. In doing so, it has heard the

mayday call of paramedic science which sits far out on the horizon of our research conscience. There is an appeal to focus on such exposure in more quantity and depth (Maple, Poštuvan and McDonnell, 2019). Only one paper from Nelson *et al.*, (2020) has explored this context with any degree of specificity. My study adds a further layer of discussion and a way of understanding the perspectives shared via Nelson, *et al.*, (2019). The student paramedics add to the narratives of suppressing emotions, navigating the complexity of death notifications, and dealing with the emotions of family members at the scene. However, the student narrators in this study also construct a phenomenon of not always knowing the outcome, which is unique to this professional/occupational group. They expose a life affirming pull in how they navigate those spaces in-between not knowing, and the chance encounters that shape their sense-making. They depict how they have to navigate the reactions of their paramedic mentors within an organisational micro-culture to which they do not quite belong.

5.2.2 An Alternative to Pre-determined Hypothesis and Ideas Around Professional/Occupational Exposure to Suicide.

Pulling professional/occupational suicide exposure sense-making over the **sandbanks of sadness and madness**, is owed to some of the dominant and deficit framing of experiences seen in the critical interpretive synthesis of available literature in chapter two. Resisting the temptation to frame their experiences via a compulsory pull to pathology, there is a unique space created that can hear the stories of five student paramedics within their emerging situated professional and higher education student contexts. Now we find ourselves navigating a **new terrain** in the context of professional/occupational exposure to suicide. This novel study plots the new territory of student paramedic sense-making, in response to suicide exposure which has been cognizant of the dominant policy and practice paradigms that surround it.

5.2.3 A Perceived and Co-constructed Harsh Emotional Culture

By creating a space to hear student paramedics stories, this study has also added some layers of understanding situated in a professional paramedic context, as it is in this space that our student narrators navigate such exposure, performing technologies of self. The **dark side of the humour moon** highlights discourses that are possibly veiled or more difficult to say within a research context if we were to speak to paramedics directly, such as within Nelson *et al.*, (2019). Nevertheless, they are discursively there, constructed in wider literature as a means of coping which student paramedics may find difficult to adapt to (Christopher, 2015). They offer a signpost for our students to navigate their journeys on-board their **rockets of resilience**. The student narrators set out a desire for support from a source that 'gets it'. However, if they are to gain benefit from this peer-to-peer support, sense-making might need to be unified and akin to each other, they must in some cases quickly assimilate to remedial gallows humour. This study has also further exposed paramedic's proclivity for storytelling, which as a pedagogic and coping principle may be adopted to **bridge the theory and practice divide**. It may also mitigate the risk of potentially deleterious health effects of a perceived harsh emotional culture, where a 'deliberate armour of amnesia' or 'keeping my mouth shut' tact is adopted by our student narrators as a means of performing an ability to cope.

5.2.4 Paramedic Folklore

This study has exposed how story telling can also construct legacies of fear to the next generation through paramedic folklore. Within the **forbidden forest of hanging trees**, we are exposed to a co-constructed fear of death by hanging within this study, which I have not been able to locate elsewhere. My analysis of this fear sits within other nested stories our student narrators offer and is linked less to the condemnation of suicide, more so, as an objectification of death itself and how the deceased is positioned.

5.2.5 Journeys within journeys

We also see students co-constructed sense-making play out on the **mountain range of HE**. Commonality across their experiences was the desire to reach the summit and achieve paramedic status. Within the anticipation stages of their journeys, they arrive at base camp. Here we are exposed to nuances of their personal backgrounds, and how they may offer some of the building blocks that aid constructing meaning around suicide exposure. They navigate journeys within journeys, and within any given 12-hour shift they make sense of, and learn from **life, suffering, and death**. They offer us signposts of their own sense-making with recommendations for pedagogic practice and HE based support, which will offer some of the basis of possibilities that emerge from this study.

5.2.6 Narrative Compass

Methodologically, a **narrative compass** has offered the mainstay within this study. It has steadied a navigation of our **MAD WORLD**. This study offers a novel source of oral history that mediates between the individual paramedic students and society (Tonkin, 1995), co-constructed through story form. Our student paramedics experiences are in some small way accounted for, given meaning, and significance (Usher, 2018). They can now be housed on the map in the **museum of time and experiences** in relation to professional/occupational postvention research.

I have situated this study as a way of knowing (Hatch and Wisniewski 1995), but there was a need to adopt an analytical style which moves beyond the *'novelty, and celebrity of narrative itself'* (Atkinson and Delmont, 2006, p. 166). Therefore, I have not merely collected and presented narratives in the hope that they do all the talking. This study goes some way in documenting the methodological decisions I have taken, and the conceptual framework that I have developed could be viewed as a contribution itself. For example, I adopted

a receptiveness to exploring ideas for narrative analysis, and augmented narrative signposts of Broadening, Burrowing, and Storying, Evaluation, Resolution, and Coda.

I have showed a creative means of extending the broadening lens, adding to what I thought I knew, and about the story tellers (Mishler, 1986) in the form of storyboarding. This broadening was enhanced by the observer shift and the pilot of the study, which situated the student paramedics within a wider emerging professional/occupational context. This offered a contextualisation of their statements within their plotlines of voyage and return (Tsoukas and Hatch 2001). In this manner, I have also demonstrated the benefit of spending some time in the field as a basis of rapport building and piloting the study, depicted as **testing new ground**. Here I could absorb some of the situated discourses and discursive practices that are narrated within a context that I am an outsider to and may have otherwise overlooked. For example, *the jobs*, which embodies a theme within the previous chapter.

5.2.7 Trust in the Tale

Adopting a narrative methodological approach has demonstrated it as a way of navigating a journey to knowing within professional/occupational postvention research, and that we can therefore trust in the tale (Kreiwirth, 2000). If the approach does not feel right for everyone, it may still be beneficial to expose ourselves to epistemological diversity (Pallas, 2001). In doing so, we do not need to construct a rejection of those paradigms we have become disillusioned with. Making them redundant in our thinking (Kreiwirth, 2000) does not replace them with better ones. This is because within this space of epistemological dualism, we may only construct illusions which turns each into some great historical individuality (Foucault, 1972). Within the map of experiences, you will see that this study is a **drop in the ocean**, alongside a patch of land, on an island you can barely see in contrast to the atlas view. It is made up of an

infinite number of other drops in the ocean, and patches of land which communally co-exist in the same world and historical milieu. Each epistemological approach has its place here.

5.2.8 No Stats Without Stories

The narrative turn I have taken within this study has created new ways of thinking about professional/occupational suicide exposure research. As social actors, the student paramedic narrators in this study have shared their sense-making, which has allowed for a co-construction of meaning and intentions. Through narration, I have communicated and captured nuances of these events, relational sense-making, and purpose, rather than predicting and explaining the behaviour of the student paramedics and those around them (Dodge, Ospina and Foldy 2005). The analytical lens that I have adopted, does not leave the stories stranded, as I have analysed and made sense of them within larger discourses and discursive practices. Therefore, I maintain that narrative has its place in the world of professional/occupational postvention research. As such, there should be no correlations without exploring the how and the why, and no predictions without critical engagement with wider discourses and contingent histories that co-construct them. In summary, there should be no stats without stories.

5.2.9 The Sea of Let it Be

This study has demonstrated to some extent how meaning making occurred throughout the study rather than being a separate activity carried out after the stories were spoken (Gehart and McCollum, 2007). Indeed, I highlight a view of the stories as interactional conversations (Williams and Cheepen, 1998). This methodological decision demonstrates '*narrative multiculturalism*' which involved making myself vulnerable to not knowing, to be surprised, and to feel bewildered. I also had to '*learn with and from those moments*' (Phillion, 2006, p. 23). It was within these spaces where I would often look to the sky, depicted on

the map as **GOD ONLY KNOWS**.

This also did not come without risk of bewilderment; this is because I needed to manage the tensions between advancing my arguments without blocking out the possibility for the reader to co-narrate their own. Depicted on the map as **sinking ships**, I also had to remain aware that the stories must serve the ideas, and there was a need to manage the risk of the stories being '*sunk by the ideas*' (Nelson, 2011, p. 476).

5.2.10 The Pull to Foucault

Depicted on the map as **take me to church**, I demonstrate a subjective pull to Foucault, taking his works up as spiritual exercises of self-cultivation (May, 2005; McWhorter, 2005). This offered a way of further analysing the stories, creating a duet between the who and the what of the narratives, with the how (Bucholtz and Hall, 2005; Pavlenko, 2007). His **lenses** offered a way to view and construct a collocation of discussions, bridging the student paramedics stories, my own sense-making, and that of the wider literature within the discussions. It also offered a space for me to explore a response to the third of my study questions. This analytical approach has exposed some unique contributions to knowledge, which include the lens of governmentality shaping the need of our student paramedics to perform a withstanding and need to learn from suicide exposure. This study has exposed the connective interplay between power, where suicide exposure responses are connected through chance relational dynamics and are mediated and performed.

Adopting an archaeological lens has exposed some of the archives in which our student paramedic narrators navigate suicide exposure professionally/occupationally, and how varying switch points of acceptance and condemnation of those who die by suicide are allowed to co-exist. We see suicide as a cause of death aligned to a pathology of distress and an existential right for which someone should not be judged harshly. Genealogy has allowed

this study to expose some of the little details that may have been otherwise overlooked, by avoiding a measure of impact we are exposed to some of the nuance that connects sense making, such as death and its verticality. However, one of the limitations in adopting any of Foucault's lenses is that they may have been subject to misreading's (Gordon, 1990), and I also rely on abridging translation (Soyland and Kendall, 1997).

One of the Foucauldian lenses adopted is governmentality in which technologies of self in response to technologies of power can be performed. This is depicted on the map as the **dam of self**. It demonstrates a complex understanding of power as '*pervasive, productive, positive*' (Peters, 2001, p. 13). Here the power of the water coming down stream (technologies of power), isn't simply allowed to engulf us. We respond to it, hold it back, and this can prove to be productive. This is because it creates energy, shelter, a prompt for learning, identity formation, and belonging.

This theory has invited some critique given it might not sufficiently detail the micro level, bottom-up perspective (Armstrong, 2015). Through honouring 'little stories' like these (Palmer, 1993), this study has explored and exposed narrative modalities of how power operates as productive and demonstrates a bottom-up perspective of how technologies of self might be constructed. Furthermore, how they might influence sense-making in response to suicide exposure. One example we see is with Lucy's story, and within the theme of 'I didn't find that funny'. She reported not saying anything at the time but was more than able to express her distain in my presence. Either response could have been constructed for either benefit, compelling her to behave in accordance with the norms she sees before her (Foucault, 1982), offering a prompt for learning and identity formation. This also exposes a way power intervenes in creating conditions of possibility for specific narratives to emerge as dominant, and for others to be marginalized. This poses a further line of tension which could be explored further within future research, exploring the possible co-constructed unadmitted attributions that may manifest because of

technologies of self (Wiener, 1995), which then become the 'habits' of mind (Mezirow, 1997). These may form the basis of the thresholds those in suicidal crisis (to include those professionally or occupationally exposed) may then have to navigate, and yet would never appear explicitly within any risk assessment device.

5.3 A Summary of Original Contributions to Knowledge

- 1) This study has exposed student paramedics as an emergent professional/occupational group constrained within institutional forces, which is comprised of human beings who navigate human plights in the context of making sense of exposure to suicide. Until this study, these five student paramedic's stories have been buried.
- 2) In a wider overarching context of postvention research, this is a novel study given student paramedics have not been a sole focus of inquiry up until now.
- 3) This study has exposed paramedics as a professional/occupational group who have seldom reached the conscience of postvention research, more so, postvention research has tended to focus upon mental health professionals.
- 4) Given our student paramedic narrators sense making plays out in this professional/occupational context as placement students, this study has also exposed nuances of their sense -making as a professional/occupational group. The role of paramedic folklore and proclivity for story telling offers an insight into the co-constructed fear of a death by hanging.
- 5) This study has exposed a perceived and co-constructed harsh emotional culture within the student's placement learning and where their exposure to suicide unravels, navigating remedial dark humour. The student narrators still attest that they would prefer to gain support from a source that gets it, namely within their professional/occupational/ pedagogic space and from their family.

- 6) This study has highlighted the need of student paramedics who navigate 'the jobs', some of those jobs may affect them, they may be suicide or may not. This study has exposed the need of our student paramedics to perform a withstanding and a need to learn from suicide exposure, akin to any other cause of death, and they express needs within a pedagogic space to de-clutter and re-set.
- 7) My study offers an alternative to those studies that have pre-determined their hypothesis and ideas around professional/occupational exposure to suicide. It has exposed the connective interplay between power, where suicide exposure responses are connected through chance relational dynamics, co-existing switch points of acceptance and condemnation of those who die by suicide; and such responses are then mediated and performed and are by no means fixed and certain.
- 8) This study poses a challenge to the default 'occupational hazard' framing of suicide exposure (Rothes et al., 2020; Sanford et al., 2021). What we unveil here is that suicide exposure for our student paramedic narrators, plays out in occupationally circularly hazardous conditions.
- 9) This study has exposed narrative modalities of how power operates as productive and demonstrates a bottom-up perspective of how technologies of self might be constructed. Furthermore, how they might influence sense-making in response to suicide exposure.
- 10) This study has demonstrated that narrative has its place in postvention research and has added to its epistemological diversity. Creating a space for a non-deficit way of thinking about professional/occupational suicide exposure, this study has captured nuances of these events, relational sense-making, and purpose, rather than predicting and explaining the behaviour of the student paramedics and those around them.
- 11) This study has demonstrated a way of adopting an analytical lens that does not leave stories stranded, offering a way for them to speak back to larger discourses and the relevant discursive practices where suicide exposure plays out, embracing similarities, contradictions, and spaces alike.

5.4 Limitations

At this stage of the chapter, I will not try to justify this studies existence and to theorise its rationale (Nelson, 2011; Barton, 2020). Therefore, in its clear turn away from inquiry that aims to prove universal relationships between abstract concepts (Fenton and Langley 2011), I will not pitch it against those positions, or their aims. These might set out requirements of a larger sample size, generalizability, or, to achieve greater objectivity. More so, I take the retrospective standpoint of the *'hind-sightful observer'* (Dray 1997, p. 776), against narrative method and my post structural positionality. This is a landmark on the map that sees me looking into the **cave of if only' s**.

5.4.1 It's Story Time

This study has upheld contingency rather than truth (Webb and Brien, 2008) given there are no facts, *'only interpretations'* (Nietzsche, 1967, p. 481). In chapter two, I highlight that those studies engraved with statistical prevalence and measures, still gave me some threads of stories, context, and sense-making. To expand on this observation, researchers who use any form of data might carve individual stories and reshape the pieces into new stories. The coherence and context of each narrative might get *'lost and forgotten'* (Franzosi, 1998, p. 548), because of the way we impose our own context and understandings. Depicted on the map as **it's story time**, all research to some extent involves a process of re-storying. We simply select the ways we do so, and it is here epistemological difference lies.

I have also highlighted that this study operates within a non-positivistic paradigm, and as such, may be received uncomfortably in its difference to the well-established Doxa (Bourdieu, 1990). It's within the subjective reading of any research text, that differing capacity and interest for storytelling might still create some tension for the reader of this study (Czarniawska, 2006). This is because some people may still prefer non-narrative devices such as scales and tables to convey the messages they are seeking (Strawson, 2004).

Interest in narrative has highlighted growing disillusionment with the removed, objectivist approaches of some of the existing social scientific research (Hyvärinen, 2006). And yet, although the benefits and uprightness of narrative as an epistemological tool has been praised as a way of morally enriching our understandings of suicide (Nussbaum, 1990; Cunningham, 2001), there is a hidden danger of viewing the stories within this study as benign and interested only in enhancing our understanding of suicide and exposure to it. Narratives can of course exclude and hold aloft privilege at the same time, valuing certain kinds of reasoning and knowledge over others, and this study is no exception. The stories in this study could be accused of offering ways of seeing and representing suicide that have practical and ethical implications and, therefore, should not escape critical scrutiny either, (Fitzpatrick, 2016).

5.4.2 The Hidden Treasure and Assumptions of Voice

There is also no way of separating personal stories from the beliefs, values, and expectations of the cultural narrative bedrock that give rise to them (Freeman, 2001). This study, therefore, might make some misguided assumptions about the student paramedics as human actors and their social action, emerging from a belief I have gained privileged access to their stories (Atkinson, 1997).

Depicted on the map of experiences as **X marks the spot: hidden treasure of voice**, this study is underpinned by the aim to hear the experiences of unheard voices, and thus increase our cultural awareness of their exposure to suicide within a wider postvention context. I have been guided by my desire to not force assimilation by design, or to collapse their sense-making into any compulsory pull to pathology. However, I might privilege the notion that in adopting a differing approach, I can then render their voices as truly heard (Orner, 1992; Soloranzo and Yosso, 2002), and that I have '*permitted them*' to self-define their experiences and sense-making (Ladson-Billings and Donner, 2005, p. 283).

Though I have tried to attend to such considerations in the design of the method for hearing and co-constructing the stories, they may be no more than survey snap shots, and they emerge from no fixed 'essence' of the student

paramedics. Furthermore, the identities I have imposed on them at the outset are socially produced, negotiated, and discursively constituted (Butler, 1993; 2004). Therefore, we must seriously question if these student paramedics can self-define their experiences (Pillow, 2003), indeed, if any of us can. This study is also limited in rendering the students' experiences revealed and heard, because I have engaged in a process of co-constructing them (Butler, 1993; 1997; 2004). The discourses they draw on also pre-date them, therefore, this might pose a further limitation of this study that the student paramedics are not the '*authors of the discourse they speak*' (Weedon, 2006, p. 427). Indeed, the explanations we can draw from any narrative must bear in mind that they are not born from something, but '*proceed*' in some way or another from discourse that already has a narrative form' (Ricoeur, 1984, p. 149). Burke's rhetorical question: '*Do we simply use words, or do they not also use us?*' (Burke, 1966, p. 6) seems a pertinent statement to offer a summation to this paragraph and is a point for us to all ponder on.

5.4.3 The Waves of Temporality

The plot and sequencing of the student paramedics narrations are two bodies of water where the stories have a '*temporal unity*' (Ricoeur 1984, p. ix-x). The plot line of voyage and return might steady the cause and effect, and the thinking and doing of the stories. However, Foucault tells us '*So many things can be changed, more arbitrary than self-evident, more a matter of complex, but temporary historical circumstances, than with inevitable anthropological constraints*' (Foucault, 1988 c, p. 156). Therefore, presenting the stories in the way I have, might portray a simplistic, linear time structure of a beginning, middle and an end (Dawson and Skies, 2019). I have also succumbed to forming the essential characteristics of narrative from within the signposts of anticipation, initial fascination, frustration, nightmare, and return (Ospina and Dodge 2005).

I believe narratives are ongoing and can be constructed in an infinite number of ways by readers or listeners, not just the storytellers (Bal 1985; Currie 1998).

For example, how different would the narrations have been had we co-narrated them outside of the confines of the university setting. Or how differently might they be received if the reader is also professionally/occupationally exposed to suicide, or not. Though I make some attempt to draw on the past of wider theory to make some sense of the present of the narrated stories, I may not have demonstrated enough regard to the temporal sense-making of the experiences narrated, nor to the philosophical concerns of time itself.

In offering a sequenced contextualised statement within a plot (Tsoukas and Hatch 2001), I may not have considered in enough detail, the objective and subjective assumptions of time. It could be said that the time on my watch constructs the perception of duration of the students' experiences (Levine 1997). Therefore, I may have naively situated the student paramedics experiences within a placement block of time within the last 18 months of the story sessions, given the stage of the course they had reached. Between the bodies of water that are the plot and the sequencing, I may have omitted to look closer at the fluidity of that water. This includes the way pasts and futures come together in temporal sense-making of an emergent present, depicted on the map as the **waves of temporality**.

If I were to have that time again, I would pay much closer attention to this construction. For example, within the follow up sessions I would have extended the sense-making beyond simply offering the student narrators the scope to add further layers of understanding to the transcriptions. I only focused on the transcribed stories as they had been told, whereas I could have extended the sense-making to consider if anything in the time since we met has shifted, and then drawn on that within the analysis. During the story-telling sessions, I might have paid closer attention to asking the students how re-calling that memory felt in relation to temporality. Here, subjectively a 'job' might have felt like it only happened yesterday, though it happened six months ago against an objective measure of time.

Therefore, this study has also seen me theorise their narrations in an objective way, distancing myself outside of the time they were narrated. Here, I sit between the narratives of the student paramedics and the academic worlds (Van Maanen, 1988). I have engaged in removing them from the moment of being told, and I have then interpreted, theorised, and rewritten them. I have therefore distanced myself, picking the research methods and procedures to make sense of the experienced lives of others (Linstead, 1994).

5.4.4 Smoothing the Narratives

Revisiting the **dam of self**, here we see power as '*pervasive, productive, positive*' (Peters, 2001, p. 13) rather than just being oppressive. It is this productive energy that powers the **city of secret sense-making**. The students' narratives took place in more than one discursive time and place, and they would have improvised, responded, and drawn on past narratives to shape novel ones. Therefore, the discourses our student narrators drew upon are not representative of reality, they give form to 'a reality' (Linstead, 1994; Hatch 1997; Alvesson and Karreman, 2000; Galbin, 2014). This sees the student's sense of self and others as '*relationally responsive*' conversant encounters (Shotter 1993, p. 29). It is within these encounters that they can smooth those stories, tacitly editing their self-narratives. This then constructs the student's self as someone who might need to be protected, defended, or enhanced (Spence, 1986; 1990; Castelló and Botella, 2006). This is less a limitation and more a consideration of any research participant and the responses they offer.

Within the **cave of if only's**, I ponder if enough ethical responsibility of my own interpretations of the student paramedics narrations has been afforded. This study has required reflexive sense-making throughout, interpreting my own elucidations and looking at my own perspectives from other standpoints (Alvermann, 2001). I make attempts to unearth some of that sense-making,

offloading authorial surplus (Smith, 2009). However, I have been minded not to be carried into the **reflexive sunlight** at the risk of it shadowing the student narrators (Finley and Knowles, 1995; Finley, 2007). Trying to support this balance will have also seen me engage in a process of narrative smoothing, selecting what I view as appropriate strands of the plotlines to support the study aims. These choices are value laden (Sparkes 1995; Pillow 2003), constructing me as much as they do the student paramedic narrators. I have been the architect and writer of this study, therefore, the limitations I outline are unavoidable (Lather, 1991). I might however have the opportunity to expose the story of the study to make some of those decisions and co-constructions more transparent within future publications.

5.5 Possibilities

My narrative approach to knowing reveals further research and practice potential. Appearing from the cave of if only's, we now look out to those landmarks of possibilities that hold the potential to '*inform new visions*' (Finley 2005, p. 689), offering up its understandings that could lead to a '*better world*', (Clandinin and Connelly, 2000, p. 61).

5.5.1 Research Possibility: Counting Heads

Within this study I have exposed a contemporary social technology demand for the norm in relation to suicide statistics. This is achieved through counting and comparing characteristics of statistically driven information which is felt to allow us to understand areas of suicide prevention priority. One of the challenges we encounter within suicide prevention, is that for us to make sense of that information to better inform suicide prevention strategy and practice, we need to wait so that we can trust the tally within any given year. This is because of intricacies such as delayed verdicts, and that a suicide may have occurred in 2020, but the verdict was passed in 2021, the statistic will capture the date of

the verdict, not of the death. If **counting heads** drives investment, owing to being better informed by the need, we require a real time data surveillance system that not only captures completed suicide, but also suspected and attempted suicides. This study has exposed Paramedics as a potentially vital source that could feed into that real time tally and are better situated to identify and offer initial signposting and support to those who are exposed and bereaved within the postvention ripple effect (Cerel *et al.*, 2014).

5.5.2 Research Possibility: The Mayday Call Continues

As allied health professionals who are exposed to suicide, Paramedics are colleagues who we find via this study are routinely exposed to suicide death scenes. They navigate the fear and realisations of death by hanging specifically as a death scene image that has found its place in paramedic folklore, and it is this group we call up on when suicidal crisis hits, navigating a shifting professional identity absorbing the pressures of under resourced services. They must be seen and heard as a group of professions/occupations who have seemingly developed ways of regulating their support needs in an '*emotionally laden*' context (Boyle and Healy, 2003, p. 356) adorned in a 'deliberate armour of amnesia'. More research is needed to better inform support for them. However, this research must scrutinise practices, discursive performances of the paramedics' role, the economic systems in which they navigate their duties, relations with others, and the ways in which they are embedded in a complex array of moral sentiments, values, and norms in relation to suicide exposure (Palomera and Vetta, 2016). This will in-turn avoid a further set of studies which adorn a neoliberal agenda.

5.5.3 Research Possibilities: Revisit the Study Pilot.

It is with the above considered that a possibility lives within the pilot of this study which offers an invitation for me to revisit that data. I consented my paramedic

academic colleagues to be able to analyse and publish the data that was co-constructed. As situated paramedics working within a HE context, these co-constructions of sense-making might also serve to open further contributions to knowledge and research possibilities. I might also pick up the thread within the introductory exploration of paramedic education within the literature review chapter of this study, that highlighted a potential concern that within a process of academisation (Givati, Markham, and Street, 2018), and that paramedic educators may have lost touch with the realities of paramedic practice developments.

5.5.4 Research Possibility: Continue the Conversation

The Coda of the student paramedics stories offered an open-ended summation, and therefore considers their stories as in process, and always in transition (Naples, 2003; Connelly and Clandinin, 2006; Day, 2012). Therefore, there is a possibility to consider ways of continuing the conversation with Matt, Cameron, Jodie, Lucy, and Hope. Picking up on the plotlines of anticipation, initial fascination, frustration, nightmare, and return, we must consider how they make sense of suicide exposure now.

5.5.6 Research Possibility: Show Students that We Care

Within a wider HE postvention consideration, the UUK and Papyrus document sets out guidance for suicide safer universities (UUK and Papyrus, 2018). This constructs postvention consideration against a frame of suicide exposure existing within the university community, and Causer *et al.*, (2021) study has explored the experiences of HE professionals occupying this space. However, these five student paramedic stories tell us that exposure to suicide can occur with much more frequency and complexity, through the eloquence of a student's course design. Where placement exposure is a prerequisite of any allied health course, students can be exposed to the beauty and barbarity of our mad world within the space of a 12-hour shift! An extension to the 2018 UUK and Papyrus guidance was published in October 2022, which offers a placement learning

checklist for HE providers, but I would argue that postvention research needs to identify and explore with much more specificity, the suicide exposure experiences and needs of HE students. Therefore, postvention research and HE strategic thinking alike, must not omit to show students, who are constructing their emerging professional identity, that we care. As Hope tells us *'I have liked being involved in this research though, as it tells me that someone outside of our profession cares'*.

There may be a concern that doing so, would inadvertently invite risk by asking for students' participation in such research. Indeed, within the ethical consideration's discussion in the methodology chapter of this study, I attempt to offer reassurances to the reader that I had pre considered, and tended to throughout, the potential impact of being involved in this study may have on the participants. However, I may have naively made some broad assumptions in that the potential impacts may be by default, negative or undesirable. Secondly, I assumed that the students who were involved knew and had already somehow made sense of their exposure to suicide in their placement learning context and having already given it some considerable thought would be ready to reveal that to me, again assumes some level of impact.

A thread within the stories and revelations was that the research process involving conversations and discussions, interviews and story board creation was in itself a formative and potentially beneficial endeavour for the student paramedics. Offering them this space, supported an opportunity for them to understand and realise their perspectives, to connect their sense making, and was an opportunity that hadn't been offered before that point. Therefore, if I had my time again, I would have taken the time to reflect the merits of this study and the potential benefit of the process of research. It seems obvious to me now given the positionality of this study where language has been viewed as both performative and constructive (Burr, 2003). Through our dialogue the student paramedics and I have constructed and co-constructed a reality, albeit a temporal and contingent one.

Our paramedic students' stories, and accounts of the benefits of telling them through this research, do in some way demonstrate how meaning can be crucial to any need for a potential healing process, supporting us to endure and prevail (Denzin and Lincoln, 2005). This is closely linked to the need for us to tell our stories (Bracken and Thomas, 2005) and opportunity to make sense of, and give meaning to, experience (Kvale 1996). Such an approach might be used to move beyond potentially restrictive postvention frameworks, partial understandings and allow us and any research participants to work our way through the challenges of everyday life, and to gain an insight into events and experiences that are shaping us and our sense making in relation to suicide exposure (Ochs and Capps, 2001). Further consideration is that the political, policy and professional power landscapes and the dominance of scientific suicidology will be further challenged, by the use of research participants ingenuity and eloquence of their buoyancy without the need for interrogating and asserting their experience pathologically (Webb, 2006).

Whilst I attempted to maximise the therapeutic benefits for participants involved in this study, I was guided forcefully by my duty of care to those who expressed an interest to take part, to do them no harm. Nevertheless, I do now veer into the territory of questioning and partially regretting my decision and guidance towards some of the students who came forward to take part in this study, where we mutually decided it wasn't the best time for them to participate based on pressures of time and other emotional burdens they were navigating at that point. Reflecting now on the potentially transformative power of stories emerging from their living experience at both individual and policy level, I realise that I have possibly downplayed the benefits of participation in this study at its outset, and yet they were revealed and communicated very quickly within the story boarding session and initial consent gathering stages.

5.5.7 Research Possibility: Technologies of Self

Pedagogic research focusing on placement-based learning might aim to explore student retention, wellbeing needs and satisfaction, using the lens of technologies of power. Here, we may see the obstacles and struggles

encountered by students involved in genealogical insurrections (Foucault 1980). Foucault argued that as *'every counter power move within the horizon of the power it intends to overcome, is likely that with resistance, a fresh counter power is provoked'* (Foucault, 1976, pp. 95–96). I have continually reflected on the metaphor of the **dam of self**, and how this powers a construction of our student's sense-making, identity formation, productivity and belonging through technologies of self. However, what happens when that dam begins to break and the water (technologies of power) within their emerging occupational/professional, and HE contexts begins to engulf them? What happens when assimilation or fighting to uphold their ideals becomes overwhelming? The lights in the city of secret sense-making may dim.

5.6 Pedagogic Practice Possibilities

5.6.1 Pedagogic Practice Possibility: Multiple and Intersecting Transitions

Our student paramedics navigate the **mountain range of HE**, and at its base camp our students begin to anticipate the task ahead. As a transition point, we could engage in individual exercises via an individual learning profile task with a whole student emphasis. This should also be repeated, recognising their stories as multiple and intersecting. This exercise might act as a means of checking in, straddling the theory and practice gap, that is cognisant of their emerging sense-making, navigating those jobs that they are learning to dread. Pedagogic space may be created to walk and talk them through those imagined nightmares, and the experiences that see them navigate life, suffering and death.

5.6.2 Pedagogic Practice Possibility: What Mental Health Literacy?

HE staff may need support to navigate these conversations as a student's climbing buddy within the **mountain range of HE**. Sometimes that climbing buddy may need to offer a helping hand, other times a rescue effort may be needed. However, within the **ivory tower** of strategic thinking that shapes and invests in the training offer supporting 'mental health literacy' for staff (UUK, 2017), good intentions may get lost.

This is not to say that what exists already is wrong or there in error, but have gaps been created by increasing what is on offer, before asking students what is needed? Our five student paramedics teach us a lot through the eloquence of asking such questions. Therefore, should such thinking critically engage with the neo liberal ideology that may sit within contemporary resilience or mental health awareness training? Asking, the question, what 'literacy' are we talking about? In avoiding a compulsory pull to pathology, further spaces might be created. Here we may view the emotional distress of a student as a personal response to sense-making, and possible structural complexities in the university and placement context. Students may have to perform technologies of self and surrender previous ideals and commitments, to simply hold on. Strategic thinking must therefore be guided as a cultural and political project, much more than an economic one (McKinlay *et al.*, 2010), otherwise training models may prove to be no more than remedial sticking plasters, that are destined to fall off.

5.5.2 Pedagogic Practice Possibility: Timetabled Space, to De-clutter and Re-set

Within the ridges of rest on the mountain range of HE, the environment might carve out spaces where students can de-clutter, re-set, and connect with course aligned support before they set off on the next climb. It is within these spaces, where contextual language might not have to be explained, where those students who might not appear to be becoming lethargic and struggling may be able to seek support for the big jobs that have got to them. Pedagogic planning

could carve out those ridges of rest and offer 'de cluttering' sessions each week when students return from their practice shifts.

5.5.3 Pedagogic Practice Possibility: Narrative as a Learning Tool

To assist this de-clutter, narrative devices such as storyboarding, mapping or poetry could be explored as a means of communication and sense-making which offer a prompt for learning. This study has further highlighted paramedics proclivity for storytelling. therefore, this sense-making tool does not have to have an aim of distraction and does not need to be framed as a wellbeing intervention. However, with intentionality on the academic's part, it might hold therapeutic value. Shared experiences might then aid the academics to incorporate neglected or unheard perspectives into curricula, and they may learn lessons themselves by unravelling and dispelling notions of the practice-theory binary (Shore 2004). Here, the student paramedics possess new moral norms that might be realised through self-expressive techniques, that may then aid the realisation of new social norms at the level of the paramedic population (Hunter, 1989).

5.5.4 Pedagogic Practice Possibility: Suicide Awareness on Par With CPR

As previously noted, wider discursive practices and discourses, suggest suicide crisis calls are mismatched with the paramedics' craft (Seim, Corman and McCann, 2022) and form a line of bottom-up pressures of jobs they do not necessarily find fulfilling. Yet our student narrators expressed a need for more mental health content much earlier on within their course, pragmatically accepting that such calls are part of their professional fate. Paramedics have also been highlighted as an occupational group who respond to suicide, often without enough training or support (ACEE, 2021; Nelson, *et al.*, 2019) and this study adds to the construction of this need. Pedagogic space might be created to share inter-disciplinary, co-constructed meaning, and foresee their role in suicide prevention within a more democratised and politically aware vision.

Here, they might reflect on their own role and where it fits in the bigger picture aided through viewing other professional vantage points also. In the context of suicide being a potential cause of death, and distress or crisis being a potential 'symptom', any professions intervention could play a role in saving someone's life. Within a life affirming pull that would appear to steer paramedicine, I would argue that a life saved by suicide is therefore no less valuable than any other cause of death. This may disrupt the constructed frustration that we see emerge, where student paramedics assimilate to the discursive practices that sees them not believe that they have a role in suicide prevention. This exploration of possibility does not seek to imply a negative or deficient view of the positions that have been constructed within this study, positions that arguably in many ways differ from my own. Indeed, part of my own reflexive journey within this study has compelled me to ask how much of our educational practice hinges on a principle of generalising one set of standards and discourses, comparing them to others, and conclude with accusations of insufficiency (Hosking, 2008).

Therefore, within this pedagogic possibility, we should of course be cautious of the nexus of dominant education, scientific and health discourses. We should also not neglect to recognise potential naivety through consideration of how unrealistic it might be to think that any single training strategy could ever adequately equip student paramedics to respond to the complexities of suicide and those navigating such thinking. Indeed, it has been argued that mainstream suicide prevention education programs can centre on medicalized constructions of the suicidal subject which may serve to freeze meaning, and silence alternative views (White and Morris, 2010). From a pedagogic standpoint, they can prove static and adopt technical models of teaching and learning that might not be particularly socio-politically attuned (Fullagar, 2003; Wexler, 2006).

Perhaps all we can really aim for within this pedagogic possibility, is for the emerging generations of student paramedics to be aware of their own language games (Wittgenstein, 1953) within the journey of professionalisation that they encounter on their path to qualification. Their intended destination, with its non-

anchored geographical allure has its own foundations that set down localised interests, their own rules and create the basis for their own facts (Chan, 2000).

5.6 Navigating the Doctorate Path

The concluding paragraph of this thesis sees us arrive at the doctorate path. I recall the first day of the programme and though I felt overwhelmed, I also felt like I had arrived home. I have savoured what might be described as the self-indulgence of this level of study as I have been permitted to expose, get up close and give of myself to inform my thinking and writing. However, this has not been without difficulty because within the **swamp of old wounds** I submerge a lot of the pain I carry. This doctorate has needed to use that pain as a resource, to power the **stream of ideas**. Arriving at the stormy coast, I have never wanted to quit but there have been many tests to my stamina in that **sky that refuses to cry**, and I have sat for many hours in the **bay of procrastination**. I have navigated the rumbling clouds of frustration where I have felt stuck in the ideas, and the ideas have felt stuck in me. But her promises held true, as **Viny' s bolts from heaven** would often appear. They cleared the air and lit up the horizon. I would then have to manage the down pour of reading and sense-making that came thereafter.

It is within the demands of time, to include my professional working life, that I would often arrive at the **love on the rocks**. Time spent in my head space meant time away from those I love most: my husband and children, and the guilt was often overwhelming. I commenced this doctorate at the point my youngest boy was about to start secondary school, I am now completing at the same time he starts college. There have been moments where I have been **flying high**: winning awards, developing the confidence to publish, winning research and project bids, contributing to national policy development and being appointed as chair of my home city's suicide prevention stakeholder's forum. I have shaped and delivered national and local conferences and led on strategy development.

These dazzling junctures at high altitude have seen me meet people along the way who I wouldn't have otherwise, to include my supervisors. It's often on the picnic blanket of **let's do lunch** that they have offered me respite from this mad world we navigate.

It is within the stormy coastline where I have had to write many a **fare well love letter in a bottle**. Dr Vinnette Cross, Dr Pauline Fuller, Sheila Dixon, my Uncle Michael, my cousin, Matt, and my dogs. Then began the longest of goodbyes in 2019, where my gentle grandfather Edwin began to slip into another land. As the push and pull of caring responsibilities set in, an earthquake was rumbling under my feet. In January 2022 he slipped away. I recall in the moments I lost him uttering the words, ***I don't have a gramps anymore***. My paternal grandfather Dennis died when I was four years old, so, Edwin was all I had known. And yet, Dennis's legacy lives on, his story tells me that. As a **Romany Child**, he could not read or write well and was passionate about the power of education, and its ability to set you free. His decisions and sense-making trickled down stream to me. I am proud to be his granddaughter and honoured that in the near future I'm **off to the castle** to collect an MBE for services to education and improving suicide awareness. It symbolises a multitude of things, mostly, that his view of the world mattered.

5.7 Concluding Remarks

This critical narrative study offers a non-essentialist, social constructionist understanding of the sense-making of suicide exposure, for five student paramedics within HE and emerging professional/occupational contexts. Co-constructed in a post-structuralist world, their stories are visible in a collocation of sense-making with the exiting literature and wider discursive practices. Their experiences can be viewed as an interrelation between types of normativity and subjectivity in a particular culture at a particular time. They offer us many signposts to pause for a while and reflect. Here, we may question some of the

taken for granted assumptions and constructed truths and consider how they may complicate the sense-making surrounding professional/occupational exposure to suicide.

In order to have achieved this, I must briefly pause to acknowledge the tension and the challenge in embarking on such a methodological approach. I set out heeding the warnings of the difficulties inquirers can encounter when trying to make sense of data collected within a narrative approach (Wollcott, 1994; Hollway and Jefferson, 2000). One of the first realisations I encountered was that I had to let go of any notion that I could actually manage the data, and instead, had to position and situate myself in it (Savin-Baden, 2004). I would argue that this positioning was a common feature of the two distinct methodological junctures of this study, namely, narrative inquiry which then emerged as a critical narrative study moving into a more explicit poststructuralist space. To do so commanded questions of me to include what is being realised through this research, by whom, and for whom? How is the data communicating with the nestled constructs in which it is created?

I acknowledge the possible tension in the approaches I have taken within this study early on within the introduction chapter within the sub chapter “Critical Narrative Study Journey”, and indeed how they may straddle two contradictory positions of imposing augmented frameworks born of more conservative scholars in the field, alongside a more explicit poststructuralist endeavour. I would argue that I quickly moved beyond attempting to provide descriptions and thematic developments within the earlier stages of analysis, attempting instead to place emphasis on the relational engagement between myself and the student paramedics by co-exploring and constructing experiences (Clandinin and Connelly, 2000; Haydon, Browne, and Riet, 2018). Doing so assisted me to answer the first two research questions I posed within this study and using them as a compass, assisted me greatly.

However, whilst I endeavoured to keep the individual stories of the student paramedics intact, I had a number of realisations throughout the analysis of their signposts. I was aware that this was a result of my perspectives shifting whilst making sense of the student paramedics stories and contexts, and I was being drawn further into the embrace of critique. These moments might be framed as a personal epiphany or an '*interactional moment*' (Denzin, 1989, p. 70) occurring within the spaces of shifting between analysis and interpretation. Whilst invigorating, this was not without challenge as I felt it was pulling me further away from my overarching intention of this study which was to hear the stories of these student paramedics and to give them a platform to be heard. Upon reflection, I also experienced a sense of fragmentation characterised by confusion, self-doubt and indeed frustration, which was based on my need for concrete answers (Savin-Baden, 2000).

I then had to grapple with the notion that I cannot do the stories or their tellers justice if I do not acknowledge and indeed try to explore the comingling of the personal stories with the values, expectations, and standard cultural narrative that gave rise to them (Freeman, 2001), and indeed how they spoke back to the other narratives exposed within this study. To do so, commanded that I begin to question the limitations and idealistic notion of research that is "co-constructed" "co-explored" "co-produced" and is a signpost in my analysis journey. I pick this up in the section "Hidden assumptions of voice" where I discuss the limitations of this study.

The journey I have encountered, in many ways is represented through the methodological choices I have made, and indeed how I live my life and navigate my professional work every day. That is, finding some form of order, but order that exists in the process of never-ending change. Achieving some semblance of balance was challenging, with one of the primary junctures being the turning point at which I shifted from privileging a narrative inquiry-based approach which gave the stories space to breathe, to that of an explicit post structuralist analysis which lifted them further away from the student paramedics who

narrated them with me. This is a decision and interplay that might be described as “dancing methodologies” (Sunday, Ramugondo, and Kathard, 2020). In some way, this acts as an expression of my ontology, and signals my deconversion from being bound by convention, whilst at the same time remaining bound as a subject and object of my own understandings (Foucault, 1977; 1980).

Within my own emerging and co-constructed sense-making, at the moment of writing this chapter, reflections on my positioning within this study is that the life affirming pull is still strong. Therefore, as I have navigated a small patch of our mad world, I now sit in the field of **forget me nots**. It’s here where I reflect that behind every story of professional/occupational suicide exposure, is another story of a life or lives lost. They have been there throughout this study, and snippets of insight into the pain those people may have been navigating break through. I refuse to view them as a mere number, or a strand of a narrative plotline. They are someone’s someone. I am quietly comforted that anyone I have met who has a research interest in professional/occupational suicide exposure, honours the loss within the ripple effect of sense-making.

I also do not neglect to consider the readers of this study, and that they too may be navigating their own pain. The pull to critique bio-medical discourses, does not negate in my thinking that there are members of our community who navigate intolerable emotional distress. Nor do I dismiss their choice to seek and accept the western construction of it, that is the bio-medical model. I navigate my own turmoil in the dominance of such discourse and discursive practices. This is because we see that they may create thresholds that simply will not flex in response to help-seeking, leaving some people stranded. It may also construct a convenient illusion in this neo liberal landscape, that would have us believe what is wrong, lies intrinsically within us and therefore needs to be the focus of remedy.

A delicate and contingent history made us who we are today and has constructed the history of postvention and suicide itself. It's here where I look out to the **Ocean of Hope**, and reflect on Foucault's wisdom, *'there is an optimism that consists in saying that things couldn't be better. My optimism would rather consist in saying that so many things can be changed'* (Foucault, 1988d, p. 156). Therefore, I will hold on to hope, that learning the lessons from these five student paramedics, we can envisage what we can change in this fragile and contingent present. Where we recognise the importance of each one of us navigating this mad world, as an actor in the open-ended story our lives. Each of us are valuable, each of us has a right to be here, and each of us has a place.

We are all part of the same family. We all wear green.

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Glossary of terms

Archaeology

Archaeology is a key Foucauldian lens that is utilised within chapter four and unearths a respect for differences within discourses and relational discursive practices '*grasping them in their specificity*' (Foucault 1970/1994, p. xii).

Archaeology acknowledges an unstable and contingent history of the past. We may then look to the '*history of the present*' (Foucault 1979, p. 31; Dreyfus and Rabinow 1983) which are the social conditions and the taken for granted assumptions which have given rise to our ways of knowing now (Rabinow and

Co-narrator

I have been the architect and writer of this study; it has arisen from the narrative beginnings of my own emerging professional exposure to suicide. My reflexivity and subjectivity have been used as a resource throughout. My own sense-making has been '*enmeshed within an archive I cannot name*' (Foucault 1972, p. 130). Therefore, within this critical narrative study I am referred to as a co-narrator, and I am cognisant that I cannot achieve an objective or removed standpoint as a researcher (Rose, 2003).

Critical Narrative Study

This study started out as a narrative inquiry of five student paramedics re-told and co-constructed stories. The narratives offered plot line signposts, through which I have examined the discursive intricacies. That is, the who and the what of the narratives have been examined, along with the how (Pavlenko, 2007; Coffey and Street, 2008). This has brought the 'little things' to the surface that embody complexity and fragmentation of professional/occupational suicide exposure (Rowan and Shore, 2009). Analysing the narratives in this way draws a distinction between a narrative inquiry and a critical narrative study (Nelson, 2011). Therefore, this critical narrative study will be referred to as a study throughout.

Doxa

Doxa is a term I draw up on within the methodology chapter, here I discuss the discomfort a reader may experience in the reading of this thesis given it operates within a non-positivist doxa. To elaborate, the notion of doxa as common knowledge and shared opinions could be argued to trouble all contemporary disciplines that put stories, multiple truths and social interaction at the centre of their concerns.

Foucault

Within the discussions featured in chapter four of this thesis, a more explicit post structural lens is adopted, and lends on a Foucauldian way of seeing and hearing the narratives. The lenses that have been adopted are as follows: Archaeology, Genealogy, Governmentality and Power.

Genealogy

The use of Genealogy' within this study offers a way of seeing and hearing the discourses and attends to little things and details (Foucault, 1977a) that may otherwise be overlooked. Using genealogy within this study will attempt to reconstruct and problematise the conditions under which the student paramedics stories grew, evolved, and changed before they became '*trapped in narrative coherence*' (Jørgensen and Boje, 2009, p. 35).

Governmentality

'Governmentality' produces '*docile and practical citizens*' (Foucault 1988b, pp. 16–49). Foucault honed a Heideggerian notion of techne and technology, which treats everything including people '*as a resource aiming for efficacy, aiming for the maximum yield at the minimum expense*' (Heidegger 1977, p. 15). This is of significance within this study given the emerging occupational/professional identity of our student paramedics. It is worth highlighting the difference and interchangeable use of the word's technologies and technes. Technologies are referred to when discussing larger, overarching institutions or collections of specific techniques, whereas techne's refer to techniques that tend to be specific and localized. For example, our student paramedics make sense of suicide exposure operating within a wider NHS ambulance service structure, and Higher Education theoretical learning environment. Within these structures,

there are people who inhabit the paramedic profession, formulating their own micro cultures (McCann, 2022). Foucault set out four affiliated ‘technologies’ which are: i) technologies of sign systems, ii) technologies of production, iii) technologies of power, and iv) technologies of the self (Foucault, 1988 a, pp. 145–162). Each has its practical purpose and operates within a type of domination that requires some type of ‘*training and changing or shaping of individuals*’ (Besley, 2005, p. 78).

Postvention

The plight and emergent needs of those left behind following a suicide was first brought forward within a postvention framing by Shneidman, in the 1960s (Shneidman, 1969). In the decades since, postvention is a concept that has gained some momentum. Its aim is to facilitate ‘recovery’ amongst those ‘impacted’ by a suicide and to prevent adverse outcomes for them.

Professional/occupational

An occupation is arguably what we do for money, and one’s profession is what someone may have trained for. The terms are used in combination with each other within this study, reflecting intersectional preferences as well as the interchangeability of the terms within the literature.

Power

Foucault argued that he may have concentrated ‘*too much on the technology of domination and power*’ (Foucault 1988a, p 19). However, he rejected the notion of power ‘*being evil*’ (Foucault, 1991a, p. 18). He instead constructed power as ‘*games of strategy*’ (Foucault 1997, p. 298) that ‘*must be framed in terms of rules of law, rational techniques of government and ethos, practices of the self, and of freedom*’ (Foucault 1997, p. 299). Therefore, power is viewed to operate at the macro and the micro levels within this study.

Self-harm

Self-harm is any act of self-poisoning or self-injury carried out by a person, irrespective of motivation (NICE, 2020).

Student narrator(s)

This critical narrative study refers to the five student paramedic narrators as narrators, participants, and student narrators. They have been given pseudonyms to contribute to principles of anonymity.

Suicide

One definition of suicide is *'an act with a fatal outcome which the deceased, knowing or expecting a fatal outcome had initiated and carried out with the purpose of provoking the changes desired'* (De Leo *et al.*, 2006, p. 8). There is of course a possible issue with deciphering the nomenclature of suicide, and from an ontological perspective my positionality sees me receptive to any number of definitions that may be subjected to cultural and political nuance. However, for the purpose of this study, this is the definition I will be referring to when I discuss suicide.

Appendix 1: Professor Julie Cerel came to Wolves.

In the Autumn of 2017, Professor Julie Cerel was scheduled to visit the UK to present at the Annual Suicide Bereavement Conference. Through her own networks she had heard about some of the work we were doing at our university and within the wider city. She asked if she could visit us on her way to Manchester.

I immediately said yes but felt I could not pass up an opportunity to expand the discussion with a wider audience, so that they could meet Professor Cerel, whilst we could also share our experiences and priorities with her. Therefore,

within the space of two weeks, I organised a learning and teaching event where I brought together local stakeholders within the city to include the NHS, third sector, academics and survivors of suicide and suicide bereavement.

Agenda

12.45-13.15: Registration, refreshments and photograph

13.15 -13.30 Welcome by Dean of FEHW Dr Alex Hopkins

13.30 -13:50 Speaker Dr Alys Cole King

Suicide Mitigation: combining compassion and governance

13:50 -14:20 Key Note speaker Prof Julie Cerel

Title 'The ripple effect of suicide – examining the continuum of survivorship'

14:20 -14:40 Refreshments and networking

Within her own presentation, entitled #notsix, Professor

Cerel spoke of her extensive epidemiological efforts in the USA which critiqued the widely adopted notion of between 6 and 60 people being affected by one suicide death. What plucked my interest particularly, was her epistemological fluidity within her own research career. Within her vast publications, many of which adopt quantitative methodological approaches that test hypothesis, she has co-authored a book entitled: ***Seeking Hope: Stories of the Suicide Bereaved***. Her example within my own sense-making and journey, which has explored ways of knowing, has been inspiring.

Appendix 2: The Pearson Review

In 2018 I was invited as an allied health educator to present evidence to the panel of the Health Education England review, exploring the mental health needs of NHS staff and learners. I felt a degree of discomfort with evidence being solely drawn from academics, which might suggest that students are an amorphous group unable to define for themselves what their unique experiences are. Therefore, I negotiated with the panel to bring students along with me which I felt would add a degree of personalness and value to the review, and indeed the students' experiences. They were incredibly nervous and unsure.

They were not unsure of their experiences, sense-making, and recommendations, more so, how to convey them with impact and professionalism. We invested time to explore these principles, offering space to make sense of them and engage in trial runs,

where I could offer feedback and encouragement. Their testimonies and grasp of the challenges delivered to the panel, left the room in awe, and the story was picked up by one of our main UK nursing journals '**Nursing Times**'. Sir Keith Pearson commented '**the panel represents some senior leads in health within the UK, and if these students are the standard of professionals who we are leaving our NHS to, I am assured it is in safe hands.**'. (Nursing Times, 2018; Pearson, 2019;). The same two students, within the same year, were approached to co-develop an online safety planning resource, co-funded by NHS England.

Nursing students and staff at the University of Wolverhampton have presented a pioneering suicide prevention project to a panel of experts who are reviewing the mental health of the NHS workforce.

The major study is being led by Sir Keith Pearson from Health Education England and a final report will be presented to health secretary Matt Hancock in December 2018 with a list of recommendations. The review involves both NHS staff and learners.

"They did themselves, nursing and the university very proud in their exemplary professionalism and articulation"

Clare Dickens

As part of the research, the panel has been hearing from organisations delivering good practice in this area. The University of Wolverhampton was picked for its Three Minutes to Save a Life programme.

Senior lecturer in mental health nursing, Clare Dickens, who spearheaded the project, was invited to present information about the scheme to the

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Appendix 3: Conceptualisations apperaring within the samplin

The Scene	Death Scene	Imagining the way, they died	Gruesome scenes	Being with the dead	Trying to save them	First on the scene	The family	Children present	Haunting my dreams		
Counting exposure	How many over all?	Which was worse?	Most recent?	Your first?	Cumulative exposure	Personal	Professional	Kin	Non-kin		
Responding Suicide	Procedural	Dealing with relatives	Dealing with Legalities	Dealing with questions	Dealing with colleagues						
Experiencing suicide	Self-blame	Shock	Fear of litigation	Horror	Trauma	Acceptance	Bitterness	Learning to Live with it	Learning from it	Not effected	Time is a healer
Practice Impact	Learning from it	Glad it happened	More likely to assess risk better	I had a hunch so I should trust my gut	More likely to use the mental health act	Didn't see it coming	Feeling Responsible	Document everything	We need training	We need each other	Assess risk better
Emotion Impact	Anxiety	Fear	Shock	Horror	Coming undone	Guilt	Contain the emotion – avoid it or hide it	Confusion	Impotent	Powerless	Anger
Medicalised framing of responses	PTSD	Depression	Anxiety	Suicidality	Seeking treatment	Moderate	Severe	Low	Self-harm	Low mood	Burnout
Existential sense making	Link to own suicidality	Reflect on my own life	See the world differently	Realigned priorities	Need to practice what I preach	Family is everything	Searching and scrambling for meaning				
Contextual Sense Making	Personal	Professional	Societal	Cultural	Feelings towards the person who died	Feelings towards their family	Feelings towards other members of the team	What about us?	A ring around what can be said	Need support, but not that kind of support	Connection between the past and the present
Suicide as a cause of death	Worse than other ways to die	It's a fact of life	Some people will do it no matter what	It's not within my control	For some it's the only way	Can't save them all	Why did they do that?	They had everything to live for	Who they leave behind due to their choice	Youth lost	They really meant it
How to go about finding out about all of this?	Survey	Best of both worlds – survey and interview follow up	Telephone interviews	Semi structured interviews	Depicting responses with scales and measures	Its bad, so we will measure it as such	What is your story?	Let's get together and talk about this – focus groups	In depth – how in depth I do not know	Content, counting, thematic, grounded theory analysis	
Getting to know you – who are the authors?	Hidden	A professional and researcher shroud	We have no experience of this	Well-known in this field as a researcher	Interest in inquiry framed within what is already known	One voice, this happened to me	Researchers belonging to the same professional group as	Researchers outside the professional group being researched	A mixed team		

Appendix 4: Data Extraction Table

Due to the hopes of the iterative process and through developing the sampling frame conceptualisations, as I was progressing through this archaeological exercise, I was becoming ever more distracted by what the papers were saying to me. These interactions were more than mere themes, more so, I was compelled to ask the literature questions such as ‘Why have you framed it like that?’ ‘Do the participants have any choice but to respond like that?’ ‘What of the option, ‘some days I agree, and others I strongly agree, but today I don’t?’’. I was feeling compelled to capture these conversations in the moments they were occurring to prevent losing them. Therefore, I added a further tab on the template entitled ‘what is screaming out’, which defined further, were poignant statements or findings within the literature that stopped the flow of my reading, and which elicited an emotive response. Later, capturing these assisted me in the process of synthesis, therefore I named them the ‘pull to synthesis’. This pull to synthesis isn’t something we should resist at the data extraction stages, but we should try to manage.

Paper	Location of Research	Professional /Occupational Context Explored	Aim of Study	Data Collection	Data Analysis	Results/Findings	Pull to Synthesis
Bohan and Doyle (2008)	Ireland	Mental Health Nurses based in an inpatient setting N=9	To describe psychiatric nurses’ experience of suicide and suicide attempts in an acute unit and explore their	Semi-structured interviews—audio taped and transcribed	Burnard’s [39] method of data analysis – detailed systematic description of themes.	Four themes: Nurses’ experiences of patient suicide/suicide attempts	A psychiatric nurse! suicide and suicide attempts are interesting

			perceptions of the support they received after the incident.			Nursing care following an incident of suicide/suicide attempt Feelings experienced by nurses following a suicide/suicide attempt Support for nurses following a suicide/suicide attempt	
Causer <i>et al.</i> , (2021)	UK	12 higher education-based staff to include Executive Staff Student Facing Staff Facilities Staff Academic Staff	To explore the experiences of staff at two United Kingdom Higher Education Institutions following a student death by suicide	Mixed methods – electronic survey and semi-structured interviews	grounded theory	Analysis resulted in the construction of a core category 'bearing witness' that encompasses participants' experiences in six categories and four sub-categories, which incorporate sixty-three	Predicting risk within the participants based on their reported responses

						focused codes. The relationship between the focused codes, sub-categories, categories and core category iA grounded theory was constructed (Fig 1) that describes processes and relationships experienced by staff members between and across categories	
Christianson and Everall (2009) Reports the same study as Christian and Everall (2008)	Canada	School Counsellors N = 7	To explore the experiences of school counsellors who had lost clients to suicide Qu's = 'What are school counsellors' experiences of client suicide?' 'What impact do participants	Telephone interviews (geographically diverse population) – two interviews per participant.	Grounded Theory	Four themes: Taming the control beast Wearing the mask Interpreting the dance Staying in the game	Open ended question? What IMPACT do participants believe the client suicide had?

			believe client suicide had on their lives?'				
Clark (2009)	Not stated	Therapists N=2, 8 did give their narratives but due to word limit couldn't be included ?	Narrative Inquiry	Face to face story telling	narrative-type narrative enquiry (Polkinghorne 1995; White & Hede 2008), component story analysis (Nuttgens 1997) and paradigmatic-type narrative enquiry (Polkinghorne 1995; White & Hede 2008).	three plotlines identified in relation to therapist disenfranchisement after client suicide is examined. Plotline One: Invisible Losses Plotline Two: Invisible Relationships Plotline Three: Invisible Mourners	How was the choice made who to exclude? how does Clark feel about that?
Darden and Rutter (2011)	USA	Clinical Psychologists N = 6	An in-depth exploration of the clinician's experience in losing a client to suicide	In-person semi-structured interview	Consensual qualitative research (CQR) methods adopted themes, domains and categories	Six domains: Psychologist's view of suicide Clinical aspects of the case the suicide Impact Recovery Client's Family	How in depth? Please include me? can I have a say? This affects me too? emergency medicine colleagues asked to be

							involved when they heard of the research.
Daidsen (2010)	Denmark	General Practitioners N = 14	To investigate how GPs were affected by patients' suicides and whether their reaction was linked to their inclination to explore suicide risk in the patient who died by suicide, and whether the GP's current inclination to explore suicide risk has been influenced by their experience of a patient death by suicide	Semi structured interviews	conducted as part of larger study (Daidsen, 2009) Interpretative Phenomenological Analysis (IPA)	Super-ordinate theme: patients' suicides. Underlying themes: Emotional impact Self-scrutiny Talking about suicide	The framing of this research was to really explore impact on professional practice? can we separate the personal from the professional? Is there an assumption that exploring risk will prevent suicide?
Dransart <i>et al.</i> , (2015)	French-speaking part of Switzerland	666 mental health professionals	To explore Stress reactions after a patient suicide and their relations to the profile of mental health professionals	Survey – self administered	self-administered questionnaire including the IES-R (Impact of Event Scale-Revised). Profiles	36.6% moderately impacted and 7.7% highly impacted Professionals facing more than one patient's suicide	Framed as challenging experience for health care professionals (HCPs). Common

					were identified by cluster analysis.	(Mean = 2.7, SD = 1.4) 39.2% sought social and/or psychological support	reactions include disbelief, shame, anger, betrayal, guilt, feelings of vulnerability, loss of self-confidence, powerlessness, impotence, denial and detachment The death may trigger feelings of inadequacy, including self-doubt about competence and fears that professional reputation might suffer
Draper <i>et al.</i> , (2014)	Australia	The sample was derived from a sudden death-controlled psychological autopsy study of	To explore the impact of patient suicide and sudden death on	The HCPs were interviewed about their last contact		Shock, sadness, anxiety,	Suicide worse than other causes of death

		<p>suicide. HCPs were identified by deceased's next of kin, by other HCPs, from coroners' files and from medical records.</p> <p>Results 303 mental health professionals</p> <p>Two hundred eleven HCPs were interviewed following suicide; 92 after sudden death.</p>	<p>health care professionals</p>	<p>with the deceased and the impact of the death on their lives.</p>		<p>feeling upset, grief, anger, and guilt</p> <p>Increased vigilance and awareness of suicide risk, more assessment and management of at-risk patients, increased referral to a psychiatrist.</p> <p>Sadness at work, loss of professional confidence</p> <p>Suicide-exposed professionals needed support or counseling more often than those</p>	<p>– something to explore – is there a right way to die? Or is this about death full stop?</p> <p>Imagine getting that call – participants identified through records about or through family members of the dead - a call from beyond the grave?</p>
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						<p>exposed to other sudden deaths</p> <p>Suicide deaths have a greater impact than sudden deaths upon the life of HCPs. Clinical inexperience influences impact on professional practice and availability of support impacts on personal life.</p>	
Erlich <i>et al.</i> , (2017)	USA	90 psychiatrists	Evaluation a Survey of Psychiatrists Behaviors after the Suicide of a Patient	The questionnaire was developed using a modified Delphi process by an expert committee	Responses to paper surveys were entered into Excel and analyzed using STATA version 12.1. Summary	Half reported changing clinical practice, seeking supervision (50.9%, n = 27), using formal	Don't come near me – didn't want to accept high risk patients – what is high risk? what narrative

				<p>composed of members of the Psychopathology Committee of GAP based on the most recent literature about psychiatrists' response to patient suicide. Domains assessed by the survey included demographics, types of clinical contact with surviving caregivers, barriers to utilisation of postvention responses, support(s) sought in the aftermath of patient suicide, and how clinical</p>	<p>descriptive statistics for each domain listed above were first calculated. The subsequent analyses included psychiatrists who experienced at least one suicide of a patient (n = 59). For each domain, differences in responses based on years of experience, sex of psychiatrist, and number of patient suicides were evaluated using the analysis of variance statistical test.</p>	<p>measures to assess suicidality (25%). 9.1% began using postvention protocols. 9.8% (n = 5) stopped accepting at-risk patients. 66% had a client died by suicide. They coped by reviewing their notes (81%, n = 47), informal supervision with a colleague (71.2%, n = 42), and discussion with a family member or friend (70.4%, n = 38)</p>	<p>does one have to perform to be considered high risk? How many years of professional experience? interesting! what about students? Coped by reviewing their notes – my own reflexive experience</p>
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				<p>practice was altered in response to patient suicide. The survey consisted of both closed-ended (either binary questions or on a 5-point Likert scale) and open-ended questions to allow for respondents to share additional information. This survey was reviewed by an institutional research ethics committee, which found that because this study did not collect any identifiable data</p>			
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				from the participants or need informed consent, it was determined that this study was excluded from IRB review and oversight.			
Gaffney., <i>et al.</i> (2009)	Ireland	front-line professionals' N= 447 Front-line staff involved in child and adult mental health services comprised the majority of the sample; however, nursing and emergency medical technician (EMT) services were included after requests from staff in these disciplines.	To explore the Impact of Patient Suicide on Front-Line Staff in Ireland',	A survey of 447 front-line professionals'	Thematic analysis of open-ended questionnaire items.	concerns for the bereaved family, feelings of responsibility for the death and having a close therapeutic relationship with the client are key factors that influence the adjustment and coping of a health professional in the aftermath of the death of a client by suicide	Emergency dept workers learnt of the research and asked to be involved I construct front line as police and paramedics this study did not Responsibility and blame

							<p>Could it have been prevented?</p> <p>Impact of death on others</p> <p>How will family=relatives cope?</p> <p>Why did this happen?</p> <p>Participants posing more questions than the researchers</p>
Gibbons <i>et al.</i> , (2019)	United Kingdom – two south east trusts and two London based trusts	174 psychiatrists	To explore Effects of patient suicide on psychiatrists	Survey of experiences and support required.	Data were examined numerically and via thematic analysis. Responses of men and women were compared with parametric t-tests.	Sadness (71%, n = 85), worry, anxiety, and fear (40%, n = 40), guilt and selfblame (31%, n = 36) 98% reported effects on clinical practice. 72% experienced >1	<p>Counting sorrow</p> <p>The support we wanted and the support we got</p> <p>This has made me ill!</p>

						<p>patient's death by suicide, 15% >6, and 3% had experienced >10. Peer-support most helpful (48%, n = 43). Advice and support from senior clinicians (75%, n = 102) and formal support (70%, n = 97) were the supports most desired 8% (n = 9) felt their symptoms met the clinical threshold for the diagnosis of a psychiatric disorder</p>	
Hom <i>et al.</i> , (2018)	USA	276 Firefighters	Exposure to suicide and suicide	Women firefighters	Not Clear	exposure to suicide	This is making me ill -

			<p>bereavement among women firefighters: Associated suicidality and psychiatric symptoms</p>	<p>(N=266, Mage=37.64y) completed selfreport measures assessing their experiences with suicide exposure, history of suicidality, and current psychiatric symptoms and suicide risk</p>		<p>significantly associated with lifetime suicide attempts but not ideation or plans. Greater emotional impact associated with symptoms of depression, nightmares, insomnia and PTSD, and severe suicide risk 74.4% of exposure to suicide (personal life). 80.8% of the exposures occurred during their firefighting career Participants with lifetime exposure to</p>	
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						<p>suicide reported greater symptoms of depression, insomnia, and PTSD symptoms. Participants with career exposure to suicide reported greater symptoms of depression, nightmares, insomnia, and PTSD symptoms</p>	
Kelleher and Campbell (2011)	Ireland	psychiatrists N= 50	To explore consultant psychiatrists' response to patients' suicide.:	Following a literature review, a questionnaire from a previous study was chosen. This was sent to 74 consultants working in the	Statistical analysis	<p>27.5% reported personal lives affected by sadness, low mood, and self-doubt 32.5% professional life affected by sense of</p>	<p>This can't happen again – won't let patients go, family and peer support helped</p>

				Munster province. It asked consultants to recall their 'most distressing' suicide and their response to it. The results were analysed using quantitative methodology. A further literature review was conducted on the issues raised		helplessness and reluctance to discharge patients. Increased awareness of suicide risk assessment and documentation 85% reported family support as helpful. 53% reported peer-support as helpful.	
Kim (2019)	Korea	School Teachers N = 5	To explore the bereavement experiences of teachers and the challenges they face in coping with student suicide	Semi-structured interviews	Phenomenological approach	Four themes: Examination of the suicide Suspension of grief Tolerance of the suicide Renewed perception of role in preventing student suicide	Its ok I can do better Framed as bereavement? and challenges ? assuming their experiences are both- did the

							title emerge rom the findings ?
Kimbrel (2016)	USA	Firefighters N= 61	To test the hypothesis and explore Is Cumulative Exposure to Suicide Attempts and Deaths a Risk Factor for Suicidal Behaviour Among Firefighters	Six focus groups were conducted in three large U.S. fire departments (two focus groups per department) that had strong peer support programs, but did not yet have a suicide postvention SOP in place.	Questionnaire with statistical analysis and Participants were also asked to briefly describe the exposure had affected them most.	All exposed to suicide; 34.8% via occupation; 23% most affected by occupational exposure. Mean of 13.1 exposures to suicide attempts and deaths throughout lifetime. 13% of the firefighters sought treatment with 5% more than n once 41% reported lifetime	Depicted the status of the person they responded to and which effected them most – co worker more impactful than relative or friend ? approximately, 29% of firefighters who reported that they had been most strongly affected by an occupational exposure to a suicide attempt or death while on the job

						suicidal ideation, 11% in past year. 16% not affected by exposure to suicide; 8% reported a lifetime suicide plan; 12% positive screens for significant suicide risk.	screened <u>positive</u> for suicide risk on the SBQ-R.- are we treating suicide screening like pregnancy testing now ?
Landers, O'Brien and Phelan (2010).	Ireland	Psychiatrists (Consultants) N= 182 responded, 4 excluded	To study the effects of patient suicide on both personal and professional life of consultant psychiatrists in Ireland.	A questionnaire was sent to all practising consultants.	The questionnaire (available from the author on request) was divided into three sections: the first gathered basic demographic data; this was followed by a section relating to the consultant's most recent experience of patient suicide,	Most respondents (80%) had experienced patient suicide in their careers; in up to 97% it had an impact on either their professional or personal life. The most common effects were preoccupation with the suicide and	I want to see the questionnaire What is informal support ?

					<p>the individual patient's characteristics, the effect the suicide had on the consultant, both personally and professionally, and what coping strategies they used in its aftermath. The final section of the questionnaire asked the psychiatrists to provide that same information regarding the suicide they had found to be most distressing during their consultant career. Consultants had the opportunity to</p>	<p>guilt. Unpredicted suicides and perceived effect on patients' families worsened the distress. Informal support was of most help, with a large proportion of study participants suggesting independent case review would be helpful.</p>	
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					provide additional information in free-text boxes.		
Matandela and Matlakala (2016)	South Africa	Nurses in General Hospital N = 6	To present the experience of nurses who cared for patients who died by suicide while admitted in a general hospital	Interviews audio recorded and transcribed.	Manual general qualitative content analysis	Five themes: Experience of disbelief and helplessness Feelings of blame and condemnation Feelings of guilt and inadequacy Emotional reaction Fear of reprisal	Who is condemning them really?
Murphy <i>et al.</i> , (2019)	Ireland	179 mental health professionals	The impact of service user's suicide on mental health professionals	A mixed-method questionnaire with quantitative	thematic analysis was utilised.	Sadness (79.5%, n = 65), shock (74.7%, n = 62) and surprise (68.7%, n = 57). Reactions lasted for < 6 months for most Increased awareness of suicide risk (by nurses).	Reduced confidence? does this commence from a baseline that they felt more assured they could prevent suicide in the first place?

						<p>Reduced professional confidence (66.7%), fear of negative publicity (54.2%), fear of litigation (49.4%).</p> <p>46.6% reported patient's suicide Support through work (17.7%, n = 23), informal support (71.1%).</p> <p>Professionals more often preferred debriefing as a source of support.</p> <p>Burnout 47.6%.</p>	
Nelson <i>et al.</i> , 2020.	England	Ambulance Staff – N=9	This study aims to explore the perspectives of ambulance staff	In-depth, qualitative, semi-structured face-to-face interviews	Data analysed using thematic analysis.	Three key themes are presented using illustrative data extracts that	How in depth ? Paramedics as a group in their

			about responding to deaths by suicide	conducted with nine ambulance staff		capture participants' perspectives on responding to suicide: a profession under strain; responding to suicide in a professional capacity and lack of workplace support following exposure to suicide.	own right – not mixed in with others
Roths <i>et al.</i> , (2020)	Ireland	14 described cases of death by suicide as the most impactful experience in this specific practice area. Among these participants were seven women and seven men. Regarding their occupation, there were four physicians, eight nurses, and two prehospital technicians.	To explore the experiences of: Prehospital Health Professionals When Emergency Patients Die by Suicide	Qualitative with semi structured I would like you to think about the suicide attempts you attended in this service so far. Among them, can you select one that has particularly affected you or that has been	interviews – analysed for content	Negative Feelings and Emotional Reactions First Suicide Experience Intrusive Thoughts and Images Death Scene Influence	Framed as a professional hazard in the emergency context Paediatric Emergency as the Most Impactful

				<p>more significant for you? Furthermore, I would like to ask you to describe the situation and your own experience, in as much detail as possible.'</p> <p>Participants were personally contacted and invited to voluntarily participate in the study. All of them signed an informed consent approving the audio recording of the interview and the use of data for research purposes</p>		<p>Presence of Children and Other Family Members</p>	
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				guaranteeing confidentiality of their personal information. Most interviews were conducted in the participants' workplace and lasted approximately 35 min (range: 15–60 min).			
Saini <i>et al.</i> , (2016)	England	General Practitioners N = 198	To explore GPs views on how they are affected by a patient suicide and the formal support available to them following a patient suicide	Semi-structured interviews, audio recorded and transcribed	Descriptive statistics and a framework thematic approach	Three inter-related themes: Part and parcel Failing patients Informal support system	I am glad GPs had time to be involved – in wider research lack of time is noted as a barrier for exploring suicide risk
Sanders <i>et al.</i> , (2005)	USA	Mental Health Social Workers N = 145 Sample taken from a larger quantitative study	To expand the understanding of the reactions of social workers to client suicide. Three	Two open-ended questions at the end of a questionnaire. • Please describe	Coding and constant comparative methods by two researchers	Major themes immediately following client suicide: Deep sadness and	Short term long term, is there a space in between- a unifying link

			<p>research questions:</p> <p>1. What professional and personal reactions do social workers experience immediately following a client suicide completion? 2. What professional and personal reactions do social workers experience long term, following a client suicide completion? 3. What is the relationship between time since the client suicide completion and the social workers' reactions?</p>	<p>how you felt in the seven days immediately following the client suicide. • Please describe how you feel now when you think about the client suicide</p>	<p>working independently and comparing their results. Reviewed by third researcher</p>	<p>depression Trauma and shock Feelings of professional failure Anger and Irritability Self blame Worries and Fear Major themes at time of survey: Continued emotional reactions Changes in practice Reconciliation Power and control issues Nothingness</p>	<p>between the past the present and future? Is it contingent? Power and control issues ?</p>
Sanford <i>et al.</i> , (2021)	Australia	To exposure to suicide among Australian mental health workers N=130 – and the subsample of 53 participants who also provided a response to the open-ended question	explores the results of an online survey examining suicide exposure and impact. Of the 3010 Australian adult	Survey with qualitative features	mixed methods explores the results of an online survey examining suicide exposure	While distress levels were relatively low among participants with workplace exposure, the	Framed as an occupational hazard But then did discuss papers

		<p>were included in the qualitative analysis. does not really specify who – behavioural practitioners and MH professionals?</p>	<p>participants who identified exposure to suicide attempts and/or deaths in a larger study, 130 indicated that the most impactful suicide attempt and/or death exposure was that of a client or service user.</p>		<p>and impact. Of the 3010 Australian adult participants who identified exposure to suicide attempts and/or deaths in a larger study,</p> <p>A convergent mixed-methods approach was used</p> <p>collected qualitative and quantitative data in parallel, analysed the data separately, and then integrated the results.</p> <p>impacts of suicide exposure quantitatively via</p>	<p>qualitative content from 53 participants provides illumination into this experience. Themes that emerged in the qualitative responses include impact on the professional, organization response, and lack of adequate resources and supports to prevent suicide. Previous research has examined the impact of suicide exposure among professionals specifically, but this is the first known study of participants in a community</p>	<p>that offered some difference in perspective and less of a deficit approach- but all professionally aligned e.g.: improved skills</p>
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					<p>the scales delivered that could then be further explained by qualitative evaluation of the context of that exposure for the mental health workforce (Spillman 2014).</p> <p>Quantitative analysis involved the use of univariate and bivariate analyses to describe sample demographics and the nature and impact of exposure on the full sample of 130 participants. Quantitative statistical analyses</p>	<p>sample who identified the most impactful suicide attempt or death exposure they had experienced was that of a client in a mental health setting. Workplace exposure among mental health workers is common and can have both deleterious and positive effects. Bereavement focused outcomes, where the loss of an attachment relationship is the focus, does not capture the full range of experiences in workplace exposure. Systemic</p>	
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					were performed with SPSS 24. inductive thematic analysis	issues in mental health care contribute to further distress among exposed workers, and this requires additional investigation and response.	
Tillman (2006)	USA	Psychoanalysts/psychoanalytic psychotherapists N = 12	To explore - Interview question: 'I am conducting a study about the effect of patient suicide on clinicians; I am interested in how this event has affected you. Would you tell me, in as much detail as possible about your experience?	Semi-structured interviews	Transcribed and audio recorded. Coded by two researchers— using a psychoanalytic lens	a synthesis was made of the categories to arrive at a 'best fit' thematic analysis.' A research vignette is presented in the paper to 'illustrate the depth and range of experiences reported by the clinicians' Eight themes: Traumatic responses Affective responses Treatment specific relationship	Open ended, closed themes – are these collapsing the complexity of experience in the same way that surveys do /

						Relationships with colleagues Risk management Grandiosity, shame, humiliation, guilt, judgement, blame A sense of crisis Effect on work with other patients Sit within three domains Traumatic loss and grief Interpersonal relationship's Professional identity concerns	
Ting <i>et al.</i> , (2006)	USA	Mental Health Social Workers N = 25	What are the reactions experienced by a group of mental health social workers after a client suicide	Semi-structured telephone interviews. Audio recorded and transcribed	Constant comparative method with open coding	Twelve Themes: Denial and Disbelief Grief and Loss Anger at client Agency and society Self-blame and guilt Professional failure and Incompetence Responsibility Isolation Avoidant	Avoidant behaviours ? The atmosphere surrounding the loss Its ok

						behaviours Intrusion Change in professional behaviour changes in practice Changes in the professional environment Justification Acceptance	
Van der Hallen (2022).	International Sample	An international sample of 213 mental health practitioners completed an online survey on the impact of client suicide	aims to investigate the short- and long-term impact of client suicide and to what extent characteristics like gender, years of experience, therapeutic background, and exposure to suicidality are associated with the impact of client suicide on MHPs using structural equation modelling	Suicide exposure and the impact of client suicide: a structural equation modelling approach	Statistical analysis	Overall, results indicate MHPs are significantly affected by client suicide. A two-factor model in which impact of client suicide was predicted by two latent variables, MHP Characteristics and Exposure to Suicidality, explained 43% of short-term, 69% of long-term emotional, and 60%	Can we predict impact? should we predict impact? hasn't this study framed impact with well defined variables, so the data will in turn tell you what you want to hear?

						<p>of long-term professional impact. Whereas MHP characteristics did not significantly predict any of the three impact variables ($p > .05$), Exposure to Suicidality significantly predicted all three outcome variables ($p < .001$).</p> <p>Interestingly, lived experience or exposure to suicidality of friends/family members predicted more impact, while exposure to suicidality at work predicted less</p>	
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						<p>impact of client suicide.</p> <p>Implications for both research and clinical practice are discussed</p>	
Wang <i>et al.</i> , (2016)	China	Nurses in a General Hospital N = 15	To explore the impact of inpatient suicides on nurses working in front-line, the patterns of regulation and their needs for support.	Semi-structured in-depth interviews	Colizzi's seven-step phenomenological method by two interviewers	<p>Four 'centre themes' and associated 'sub-themes' were identified. Nurses' cognition about inpatient suicide</p> <p>Inpatients are at a high risk of suicide</p> <p>Inpatient suicide is difficult to prevent</p> <p>Shortage of suicide preventing skills</p> <p>Psychological reaction Shock and panic Sense of fear</p> <p>Self-accusation or guilt Frustrated or self-doubt Impact on practice Stress</p>	Another mention of front line – the definitions vary so much and none of them align to mine

						Excessive vigilance Burnout Patterns of regulation Pouring out bitterness Avoidance	
Wurst et al., (2013)	Germany	226 psychologists and psychiatrists was a category of 'other' – not sure what other they were	To explore How therapists react to patient's suicide:.	63 item questionnaire with some likard scale function	Statistical analysis	39.6% of cases of suicide reported by professionals caused severe distress. Shock and sadness. Professionals involved in suicide case review reported higher levels anger and shame 18.6% reported not being able to continue their work as usual 72.1% of the sample	Professionals – a category of 'other' – not sure what other they were Participants asked to respond to the prompts below in one section - . sad . guilty . angry . relieved . shocked . ashamed . unbelieving . offended

						<p>have had experienced exposure to suicide. 73.5% felt supported by employer and 87.9% by colleagues</p>	<p>. insufficient Did they have any option to say, none of these, but this is what I felt or feel ></p>
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Appendix 5: Critical Interpretive Synthesis Development

The first stage of synthesis involved developing a **synthesising argument**, Dixon-Woods *et al.*, (2006), adapted this from the lines-of-argument synthesis, originally proposed by Noblit and Hare, (1998), building on Schutz's notions of 'orders. This synthesising argument integrates evidence from across the sources of data in the review, into a coherent theoretical framework comprising a network of constructs and the relationships between them. A synthesising argument was generated through detailed analysis of the evidence, and it required the generation of what Dixon-Woods *et al.*, (2006), call **synthetic constructs**. These constructs occur because of a transformation of the underlying evidence into a new conceptual form. Synthetic constructs are grounded in the literature but result from an interpretation of the whole body of the literature being reviewed. They allow the possibility of several dissimilar aspects of a phenomenon to be unified in an explanatory way.

What is key, is the aim of being **critical**, here I attended to the ways in which the literature has constructed professional exposure to suicide, the taken for granted assumptions on which it rests, and what has influenced its choice of proposed solutions. This is what Noblit and Hare, (1998) would refer to as refutational syntheses, but Dixon-Woods *et al.*, (2006), go further, in arguing that critique may involve identification of the research traditions or meta-narratives that have guided fields of research, as well as critical analysis of forms of discourses.

Appendix 7: Prompt sheet for one-to-one story telling.

Aiming for an unstructured or conversational interview, without any pre-determined set of questions (Fontana & Frey, 2008; Glesne, 2011; Schwandt, 2007), I will be guided and guide participants to consider

Themes/Stages	My Notes
<p>Stage One: Story Boarding, Back ground and demographic data</p> <ul style="list-style-type: none"> • Age • At what stage in their studies are they? • Why are they studying to be a paramedic? • Significant experiences with in their placement experiences so far? • What are their hopes for the future? 	
<p>Stage Two; Story beginning Tell me about the/a time/times when you responded to a call involving someone who had made an attempt or had taken their own life..... I appreciate that students may have experienced more than one, and to encapsulate this I will owe regard to that, but invite them to perhaps discuss one that is significant for them, which may open up dialogue as to why this one is the focus of the story telling. 'Who were you with? Who else was present? This will invite other characters in to the story. 'What happened then ...?'; 'How long did that go on?'. 'When did you realise that the person had died? When did you realise that person was alive? Where were they? Who else were you aware of?-- Turning point 'what kind of sense did you make of all that? Who did you speak with in relation to that? What did they say? - Meaning-making</p>	
<p>Stage Three; Cultural Context and Embodied Nature of the story teller, giving details of values, habits and beliefs. 'How did you know that...?' 'Why do you think that happened?' 'What did you think about that?' 'Was that something you usually did or have seen before?' 'Was that OK with you? I will draw on their senses, feelings, thoughts, attitudes and ideas; thus locating the narrative in the experience of a real life. 'What could you see/hear? How did it look to you? 'What was your sense of what was going on?' 'How did you cope with that?' 'How did that affect you/make you feel/think?' 'How did you feel about what they did?' 'Did you have any ideas about this at the time?' Had you heard any stories from peers about previous experiences? Who were the other characters? What did your family or friends think of it? Did you ask anyone for help?</p>	
<p>Stage Four; choices and actions of the teller and the historical continuity as an active participant in events, making choices based on values, beliefs and aims. 'What made you decide to do that or say that?' 'What were you intending?' 'What did you want to happen?' 'When did you decide that?' 'What was happening in the rest of your life at that time?' 'How old were you?' 'What stage with in your training were you?</p>	

Appendix 8: Examples of the broadening stage of the narrative analysis

Segment from my journal within the observer shift

'The paramedics I am working with today, do not seem to rush themselves. Its 5:30 am, and Sam is spreading butter on her toast in the station's kitchen. Her radio goes off and the first job of the day is in. I anticipate a dash to the ambulance and for us to make our way to whoever it is that needs us. This rush doesn't happen- she just carries on buttering her toast, she takes a bite and then wraps it in blue towel paper. We then head off to our first job, calmly and gently, which is a lady who has fallen during the night and has not been able to get up by herself. When we arrive, the apparent nature of this woman's vulnerability and her daughter who she is caring for, hits me, I think it hits the paramedics too. We were at that job for an hour, we cleaned her kitchen, rang the district nurses, prepared their breakfast, and tidied the lounge which is now makeshift bedroom for the lady's dying daughter. An hour after we left, they had forgot the lady's name, and Sam's toast was still wrapped in its blue towel'

Segment from Cameron's story

Cameron wonders whether his emerging professional identity is really recognised and valued-

Cameron- *'student nurses are set to have their bursaries returned to them, aren't they? What about us?* (A slight elevation of assertion in his voice, and one I had not observed until yet)

Me- *But would you do it all again anyway, despite these political and social barriers?*

Cameron- *'once is enough I think, but if I could speak to my younger self last year, I would tell myself to believe and get my head down'.*

Segment from Lucy's Story

Lucy- ***'coming straight out of school and sixth form, and in my choice to go down the degree route and not the internal training route- I am constantly told I am young- it makes me feel that others think I am not up to the job and ready to take on the responsibility.'***

Segments from Matt's Story

Matt- ***'I can't imagine working in a hospital- well I suppose it's the same for nurses, in that no one day is the same, but I like the freedom of being on the road.'***

Matt was not naive in believing the transition to a job on the road would be easy, but he reflects nothing could have quite prepared him for the mad world he encounters, its barbarity and its beauty can be felt in the space of one 12-hour shift.

Segment from Hopes Story

When she started her course, Hope had a future planned with her childhood sweetheart. They had planned and plotted their life. At an early stage, she wondered if the sacrifice this course was demanding she make was really worth it. They have since split, and she now finds herself single and looking to a new horizon.

Hope- ***'I had lost the person I thought I would start my life with, and it hasn't happened how I thought it would, and I felt like packing it all in as I had lost all interest.'***

Hope- ***'he began to get on at me about the hours the course demanded that I was distant, and it wasn't what he wanted anymore.'***

Segment from Jodie's Story

I recall Jodie really struggled in the story boarding session, there seemed to be more to it than any reluctance to share her experiences, because she did- we reflected she struggled to collapse signposts in her life in to one single aspect of

a word or a picture. I gained an appreciation of this struggle as I get to know Jodie better- her life has included an army career- she hadn't revealed this to her peers before but did within the story boarding session. She is a single Mother to a young son who she hopes through the eloquence of her example and sacrifice, that he sees how to overcome adversity, and hold ambition and work toward goals.

Appendix 9: Examples of the Burrowing in stage of the narrative analysis

Segment from Cameron's Story

Cameron- ***'We pulled up to the job, and the man was being cut down from the tree; but was still hanging. It was clear he was dead; I could see his discoloured face and no life in his body, he wasn't hanging from a great height and it's why I think he may have gone un-noticed for some time.'***

Cameron- ***'This was the first dead person I had seen'***, Cameron looks to the floor and sighs.

Segment from Lucy's Story

Lucy- ***'here I am 18 and most of my mates are out partying tonight- but I am about to see something that I dread seeing- a hanging body.'***

Lucy- ***'I went to an overdose recently and this job stands out-we got to the job and his parents were just arriving- he was upstairs on the bed '***

Me- ***'What did you notice.'***

Lucy- ***'he was lying on the bed, half conscious and though he wasn't combative he didn't want us to intervene- he had taken an overdose and had a note at the side of him.'***

Segment from Matt's Story

Matt- ***'I mean, one suicide attempt we went to, the man had used a knife to slice his arms to bits but had also tied off his arm- when we released the ligature from around his arm we were sprayed with blood- there was blood everywhere and this man had really gone for it having also taken a large overdose.'***

Matt assumes this man is now ok, when they managed to convey him to A and E, they had stemmed the bleed and managed to give him activated charcoal,

and though he was very unwell and barely conscious, he believes he survived- but does not know for sure.

Segment from Hope's Story

Hope- ***'we were talking to him at the spot he stood, a sheer drop one side him and a busy dual carriage way the other- and he was saying he did not want to be here anymore, that he'd had enough of not being listened to and wanted to end his life. I remember thinking there is nothing I can do or say that would offer anything to this man at this point- I remember he said he had taken his kids out that day to say goodbye in his own way.'***

Segment from Jodie's story

Jodie- ***'I am dreading a hanging, I know I went on about this when we last met- but (and she physically shudders) I just don't want it to happen- I cannot imagine how it looks, I just know it won't look good- it isn't right, disgusting.'***

Jodie- ***'I know people who have done it, a family member and I felt angry with him that he left us with that image of him- even though I didn't see it.'***

Appendix 10: Examples of the tension between face value and scepticism

Segment from Lucy's Story

Lucy- ***'coming straight out of school and sixth form, and in my choice to go down the degree route and not the internal training route- I am constantly told I am young- it makes me feel that others think I am not up to the job and ready to take on the responsibility.'***

Me- ***'you haven't been called a snowflake have you.'***

Lucy- ***'Oh yes- of course! And it pisses me off and is an insult- it's a term that really permits ageism, isn't it?'***

It did occur to me as I was hearing Lucy's frustrations, whether any responses or sense making she offered me would be stifled and sanitised through fear of me also judging her in this way.

Segment from Matt's Story

Matt talks a lot about mental health, I pondered momentarily whether this was because he knew my professional background, or if this had emerged from his experiences. I asked Matt if he had seen many suicides and suicide attempts, he replied with an assertive,

Matt- ***'oh yes'- I have also seen Schizophrenia, Bipolar, Depression and mania.'***

Segment from Jodie's Story

'She wanted to kill herself, and I thought at times the way she was behaving towards me, wanted to kill me- it was such a shame for her, and you could see from her home environment she was alone, had been struggling for some time and needed help.'

My internal dialogue – can we really make such grand statements about someone's intentions – is it quite possible that you are determined to die on one hand, but on the other so scared by that, that you seek help not to? Did Jodie really feel instant sympathy for her in that moment? or is this now, she has

space from her anger, and it isn't a direct threat anymore? How did she feel then, in that moment and how does she feel now?

Segment from Hope's Story

Hope- [laughing, but not in a humorous way, but in a disbelief way] ***'when we got back to base, we told the manager in charge of the shift about what had happened – his only response was 'did you not tell him to perform a dive?'***

Me- ***'I can see that this has pissed you off Hope, and I get that, it isn't on- but do you think there is scope of trying to make sense of where that statement came from?'***

Hope- ***'I suppose so.'***

Hopes response hints to spaces being created where this kind of response is possibly common and is born of frustration. These tenets emerged within the story boarding session.

My journal notes – I wonder how Hope reacted in that moment before she sat in her car and felt the need to call her mom? Did she laugh along with him, but felt quite different inside? Or is this all for my benefit?

Appendix 11: Examples of the threads of intention and emotionality

Segment from Matt's Story

Matt has developed his own **rituals and coping**, he recalls the first dead body he saw, and she too had been dead for some time, the heating was on in the home and the smell **hit his stomach instantly**, **he had to leave and vomit**.

Matt reflected that there is something quite **resolute about these rituals** and the fact someone has passed in the assumed comfort of their own bed, lying flat, eyes closed and calm-

Matt- 'it is how death is meant to be and if this is how you die, you were possibly at peace'.

Segment from Lucy's Story

Lucy- 'I noticed around the house pictures of this woman's kids, graduation pictures, you could break your heart when you think about it too much, so we tend not to.'

Segment from Cameron's Story

Cameron- 'When I do call my mom, she tells me it's ok to feel this way, but that I should remember why I am feeling this way and why I am doing what I am doing.'

My internal dialogue- 'even talking about this support seems to re centre him- I can see his body relax.'

Cameron- 'I felt overwhelmed, sick and felt myself standing back for a while and observing the medics attempting to revive the man'.

Segments from Hopes Story

Hope - 'If you could hear every conversation that goes on in that cab, I am not sure they would make a programme out of it like you see on the TV, I used to love those programs – but it's not unkind, it's their way of coping I suppose and often it is about the pressure of their job.'

Hope- ***'We can get frustrated by the mental health jobs- we get called to so many where there is no medical intervention needed – and I think this adds to our belief (right or wrong) that people are just doing it for attention, a cry for help.'***

Segment from Jodie's Story

Jodie did not verbalise her sense of this experience, but I gathered this was **playing out privately in her thinking**, I respected this and sat with the silence of the next three or four minutes- I had forgotten how uncomfortable I can feel within silent spaces.

Jodie- ***'Yeah – one fella we attended he had been dead a while, sat in his armchair, looked like he'd had stroke and I remember my mentor telling me to pull myself together before the family arrived.'***

Appendix 12: Examples of Resolution stage of the stories

Segments from Cameron's Story

Cameron- ***'Death and dying are part of my job I suppose, it is why we are called out, people aren't well, have had an accident, have hurt themselves, are already dead or they are dying- some of those jobs will stand out and others I will forget quickly- I don't think because its suicide, is why a job will stand out, there is more to it than that- it's the person, not what they have done'***

Segments from Matt's Story

Me- ***'would you feel able to access counselling at university if you needed to Matt?'***

Matt- ***'honestly – ermmm – no! if I am struggling this soon on in my career, it doesn't look good, does it?'***

Segments from Lucy's Story

Me- ***'did you come on to this course with any ideas or conceptions about suicide as a topic before you started this course?'***

Lucy- ***'I don't think so no- I heard of it, and know it happens but I don't know anyone who has- and I don't suppose you don't think about it unless it has directly affected you- it's the same with death- we all die and it is part of living- but I may be able to say this more easily now because I have never experienced a close bereavement'***

Lucy- ***'yeah- ignorance isn't bliss, I know it is terrible, but it will not help anyone we help, me standing there crying with them- it isn't my grief [says with an increased volume]- but this may change if ever I have experiences where we share a similar grief.'***

Segments from Hopes Story

Hope- *'It was only after this shift with the man on the bridge, that I got in my car and thought 'WTF was that' I cried my eyes out, my parents were away, and I always seem to get big jobs when they are away – I called them and then they were crying their eyes out with me.'*

– I mean for example I haven't spoken about that job I have to you since my parents, no one at uni knows about it – I haven't spoken with another paramedic – however I did manage to speak to the technician who was at the job ' the bridge job' and she said after that she had two months off, I have no doubt she had other issues going on, but this may have been the straw that broke the camel's back'

Segment from Jodie's Story

Jodie- *'There are horror stories of children doing it.'*

Me- *'what? from experiences of other paramedics?'*

Jodie- *'yeah- a 13-year-old girl – her mom had nipped out and came back to her child dead, hanging.'*

Jodie- *'I don't know, I didn't think it was my place to ask only being student, but I think this is part of my frustration because now I wish I had have done, fought for her better and I dread to think where she is now, or if she is even ok.'*

Appendix 13: Section of Data Audit

Broadening	
Saturday 14th September 2019 – half an hour courtesy visit to West Midlands Ambulance Service hub	1 page of handwritten journal logging
Friday 20th September 2019 – 2-hour meeting with two paramedic academic colleagues	3 pages of handwritten notes and journal logging
Saturday 21st September 2019 – 12- hour observer shift with West Midlands Ambulance Service	10 pages of handwritten notes and journal logging Voice memos recorded on phone x 15
Sunday 22nd September 2019 - 3 hours of journal logging and sense-making	7 pages of handwritten notes and journal logging
Tuesday 15th October 2019 – 1-hour introductory meeting with Level 5 Paramedic Students to discuss study and gain expressions of interest	4 pages of handwritten notes and journal logging
Thursday 24th October 2019 – 1 hour supervision meeting with Director of Studies and Supervisor	3 pages of handwritten notes and summation email to self
Friday 25th October 2019 - 4-hours contacting 25 students who have expressed an interest in being involved in the study.	3 pages of handwritten notes and logs of discussion and decision-making. (Later shredded after 2 nd December 2019)
Wednesday 30th October 2019 - 3-hour pilot of the story boarding stage of the method with two paramedic academic colleagues	5 pages of handwritten notes and sense-making in journal logging. Diagram of suggested changes drawn 1 hour of voice recording discussing the story boards
Monday 18th November 2019 – 1-hour one-to-one story telling pilot of the method with one paramedic academic colleague (1)	6 pages of handwritten notes and journal logging, 1 hour of voice recording
Monday 18th November 2019 – 1-hour one-to-one story telling pilot of the method with one paramedic academic colleague (2)	5 pages of handwritten notes and journal logging, 1 hour of voice recording
Tuesday 26th November 2019 - 1 hour meeting with two paramedic academic colleagues to de-brief and gain their feedback	3 pages of handwritten notes and journal logging

<p>Monday 2nd December 2019- 6-hours = 1 hour to prep the room and collect materials for storyboarding</p> <p>1-hour consenting those students who attended/arrived to engage (n=5 of 18 who had agreed verbally)</p> <p>1 hour re-visiting and discussing the study aims, storyboarding, sharing my own example.</p> <p>2.5 hours storyboarding and discussing them individually.</p> <p>30 minutes de-brief and discussion about the next stage of the study, arranged dates for one-to-one storytelling, asked for preference of location.</p>	<p>3.5 hours of story boarding creation and discussion voice recording</p> <p>15 pages of handwritten notes and journal logging</p> <p>Retained story boards pictures.</p>
<p>Wednesday 4th December 2019 – 6 hours transcribing voice recording of the story boarding session</p>	<p>10,000 words transcription</p> <p>3 pages of journal logging related to the transcription</p>
<p>Burrowing in</p>	
<p>Tuesday 3rd December 2019 – 2-hour one-to-one story telling session with participant 1</p>	<p>2 hours of voice recording</p> <p>2 pages of story prompt sheet notes</p> <p>5 pages of handwritten notes</p> <p>3 pages of handwritten journal logging</p>
<p>Wednesday 4th December 2019 – 5 hours transcribing the voice recording of one-to-one story telling session 1</p>	<p>6,536 words transcription</p> <p>4 pages of handwritten notes</p> <p>2 pages of handwritten journal logging</p>

Appendix 14: Ethical Approval Letter



Dr Alexandra Hopkins RN PhD MSc MBA RNT RCNT DANE
Dean of the Faculty of Education Health and Wellbeing

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8th August 2019

Clare Dickens/ Dr Debra Cureton

University of Wolverhampton
FEHW

Dear Clare

Re: 'A Narrative Inquiry of student paramedics experiences of responding to those who have died by suicide or made an attempt to take their own life' submitted to the Chair Faculty of Education, Health and Wellbeing Ethics Sub-panel (Health Professions, Psychology, Social Care & Social Work)

Upon review by the Chair of the Ethics Sub-panel your Resubmitted Research Proposal was passed and given full approval (**Code 1 - Pass**). You are free to continue with your study. We would like to wish you every success with the project.

Yours sincerely

Angela Clifford
Dr Angela Clifford (BSc, MSc, PhD, FHEA)
Chair – Ethics Panel

THE UNIVERSITY OF OPPORTUNITY

Appendix 15: Consent Form

CONSENT FORM (V1.0)

Study Title: A Narrative Inquiry of student paramedics experiences of responding to those who have died by suicide or made an attempt to take their own life.

Researcher name: Clare Dickens
Participant name and contact email;

Please initial the box(es) if you agree with the statement(s):

Please tick and initial boxes

I have read and understood the information sheet (dated 18/03/19 V1.0) and have had the opportunity to ask questions about the study.

I agree to take part in this research project and agree for my data to be used for the purpose of this study

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected

I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication

I agree for my interview to be tape-recorded and for the data to be used for the purpose of this study.

I agree to take part in the above study.

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password-protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

.....
Name

Date

Signature

.....
Name of person taking
Consent (if different
from researcher, state position)

Date

Signature

.....
Researcher

Date

Signature