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Research report

Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research

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ABSTRACT

Background: Concern exists that involving vulnerable individuals as participants in research into suicide and self-harm may cause distress and increase suicidal feelings. Actual understanding of participants' experiences is however limited, especially in relation to in-depth qualitative research.
Methods: Data were collected from four separate studies focused on self-harm or suicide. These included people with varying levels of past distress, including some who had made nearly lethal suicide attempts. Each involved semi-structured qualitative interviewing. Participants ($n=63$) were asked to complete a visual analogue scale measuring current emotional state before and after their interview and then comment on how they had experienced the interview, reflecting on any score change.
Results: Most participants experienced a change in well-being. Between 50% and 70% across studies reported improvement, many describing the cathartic value of talking. A much smaller group in each study (18–27%) reported lowering of mood as they were reminded of difficult times or forced to focus on current issues. However, most anticipated that their distress would be transient and it was outweighed by a desire to contribute to research. An increase in distress did not therefore necessarily indicate a negative experience.
Limitations: There was no follow-up so the long-term effects of participation are unknown. Scores and post interview reflections were collected from participants by the researcher who had conducted the interview, which may have inhibited reporting of negative effects.
Conclusions: These findings suggest individuals are more likely to derive benefit from participation than experience harm. Overprotective gate-keeping could prevent some individuals from gaining these benefits.

1. Introduction

Suicide research is important but ethically challenging. Particular concerns exist where 'at-risk' or otherwise vulnerable individuals are directly involved as research participants, the fear being that discussion of sensitive issues or past trauma may exacerbate distress or otherwise cause harm. In an international survey of ethics committee members, 65% of respondents expressed a concern that suicidal feelings or behaviour may be increased by research participation (Lakeman and Fitzgerald, 2009b). Researchers report similar concerns but usually put in place protocols to address such eventualities (Lakeman and Fitzgerald, 2009a). Various suggestions for sound practice have been put forward including that: researchers should be clinically trained or trained in risk assessment (Cooper, 1999;Cukrowicz et al., 2010;Lakeman and Fitzgerald, 2009b); participant well-being should be monitored throughout (Lakeman and Fitzgerald, 2009a, 2009b); patient information sheets should warn potential respondents that they may experience distress as a result of participation (Henderson and Jorm, 1990); and that de-briefing and follow-up care should be offered to participants (Cooper, 1999;Lakeman and Fitzgerald, 2009b).

However, it is also postulated that participation could be therapeutic or otherwise beneficial (Lakeman and Fitzgerald, 2009b; Rivlin et al., 2012) and researchers report few actual examples of participants who have become distressed (Lakeman and Fitzgerald, 2009a). Indeed it has been argued that ethics committees can be paternalistic, 'overprotective', or generally

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resistant to suicide research (Lakeman and Fitzgerald, 2009a, 2009b) and that a tendency to overstate risks has hampered research (Cukrowicz et al, 2010; Jorm et al., 2007), especially qualitative research seeking to explore the suicidal experience (Lakeman and Fitzgerald, 2009a). It is also noted that there is a lack of clarity about the ethical issues likely to arise from suicide research. In turn, guidelines for addressing these issues are such that advice may vary or even conflict across differing committees (Lakeman and Fitzgerald, 2009b). This confused picture can be attributed to a lack of sufficient evidence about the effects of participation (Newman et al., 1999).

A number of studies have explored experiences of research participation in relation to mental health and trauma-based research (Jorm et al., 2007). These mostly report on respondents' experiences of completing survey questionnaires or participating in structured interviews measuring psychiatric state, with experience of participation measured using closed response questions. Several consistent findings emerge. In each study, a small proportion of respondents report being 'upset' or 'distressed' by participation, with some indication that this is higher in studies focused on traumatic experiences. More commonly, respondents report beneficial effects such as finding the interview helpful or feeling better about themselves. Positive reactions to research also emerge as independent of negative experiences such that some of those who became distressed also rated their experience of participation positively or as useful and did not regret taking part. Two recent studies focused specifically on suicide research supported these findings (Cukrowicz et al., 2010; Gould et al., 2005): neither found an increase in suicidal thoughts or behaviour following the administration of survey questions including suicide-related content.

Understanding of participants' experiences is however limited. Few studies measure distress before and after participation or include a control group so the extent to which causal inferences can truly be drawn about the effects of participation is limited. Also, the existing evidence base includes minimal data concerning the experiences of participating in qualitative suicide research where experiences are discussed at length. An exception is a recent study conducted with prisoners, which investigated the impact of discussing suicide attempts alongside other issues including life events and psychiatric state (Rivlin et al., 2012). Some qualitative enquiry was combined with the use of structured questionnaires. For most respondents, self-reported mood improved by the end of the interview and many found talking beneficial though sometimes difficult. This study was unique in assessing the effects of participation on the person involved in the suicidal act. Other insights have been obtained from psychiatric autopsy studies of suicide (Cooper, 1999; Hawton et al., 2003; Henry and Greenfield, 2009) in which interviews are conducted with key informants who knew the deceased individual. While experiencing some distress, participants also reported benefits including the opportunity to derive meaning, purpose and support through discussing loss (Henry and Greenfield, 2009) (Hawton et al., 2003). Such findings are in keeping with current general understandings of the outcomes of participating in qualitative interviews (Cutcliffe and Ramcharan, 2002). It is recognised that interviews can stimulate self-reflection, self-disclosure and catharsis and that as such can be both uncomfortable and therapeutic. Interviews can represent the first or only opportunity to tell one's story and participants report a range of benefits even where they have also become distressed.

This paper provides evidence about the experiences of individuals participating in four separate qualitative studies, each using in-depth interviews to explore sensitive issues relating to self-harm or suicide. These studies included 'before and after' assessments and qualitative exploration of views about participation.

2. Methods

Data were collected from four separate studies (Biddle et al., 2010; Cooper et al., 2011) (Study 2 submitted, Study 4 submitted) conducted by research groups at the Universities of Bristol, Manchester and London. These are described in Table 1. Each study was qualitative and consisted of semi-structured one-to-one interviews with vulnerable individuals used to obtain detailed accounts of issues relating to self-harm and/or suicidal behaviour. Ethical approval was obtained for each study and all participants gave informed consent. Interviewers had either a clinical or social science background and were all experienced in conducting interviews on sensitive topics. Interview length ranged from approximately 15 min to over 2 h. Most were between 1 and 2 h. The longest tended to be in Study 1 and the shortest in Study 4.

At the opening of each interview, participants were asked to complete a simple visual analogue scale (VAS) measuring current emotional state. This was depicted as a thermometer with scores ranging from zero to ten and markings indicating 0, 1, 2, and so on. Zero reflected a poor emotional state and was illustrated with a sad face, while ten represented the best possible emotional state and was illustrated with a smiling face. A neutral face, neither sad nor smiling, was included at the midpoint. Faces provided a visual

Table 1
Details of the four contributing studies.

	Study/date conducted	Population	Aim of interviews	Sample size (characteristics)
1	Biddle et al 2006–9	Individuals who had made a near-fatal suicide attempt in the last 1–24 months.	Explore decision-making surrounding choice of suicide method	22 (10 female, 12 male; 19–60yrs)
2	Owen-Smith et al 2007–8	Individuals recently (within 3 months) discharged from psychiatric hospital	Explore stressors in the post discharge period and inform development of an intervention to reduce suicide risk	10 (7 female, 3 male; 20–53yrs)
3	Cooper et al 2008	Individuals who had recently self-harmed	Explore views of a contact-based intervention following self-harm	11 (6 female, 5 male; 18–53yrs)
4	Klineberg 2006	Adolescents at comprehensive secondary schools in an ethnically diverse, socio-economically deprived area who reported self-harm	Explore experiences of and attitudes to self-harm and help-seeking	20 (17 female, 3 male; 15–16yrs)

representation of mood to assist participants' understanding. Markings helped respondents conceptualise subjective feelings by allowing them to give themselves a score out of ten. The same scale was used in all four studies. Interviewers provided each participant with a brief explanation of the scale and then asked them to mark a line (Studies 1–3) or give a verbal rating (Study 4) without deliberation to indicate their current emotional state. Emotional state was described to respondents as 'how happy or sad they were feeling right now' and analogies were used such as 'on top of the world', 'really low' or 'down in the dumps' to explain this further. Interviews then commenced as normal and the completed VAS was put to one side where it was no longer visible. When each interview was complete, the participant was presented with a second copy of the VAS and asked again to rate their emotional state without seeing their previous score. Participants were then invited to comment on how they had experienced the interview and to reflect on any change of score. There was some variation across studies in the extent to which these issues were explored with participants, more detail being sought in Study 1.

Changes in score were calculated for each individual and then analysed by study and overall using descriptive statistics. 95% confidence intervals for mean score change were not calculated for individual studies because the sample sizes were small and the data were skewed. Interview transcripts were examined for any references to the VAS or other comments about experiences of participation. Such data were retrieved and subjected to thematic analysis, descriptive accounts being produced of those whose scores increased and decreased. Accounts about participation from each of the studies were then compared.

3. Results

All participants completed the VAS. In total, there were 63 individuals across the four studies. The VAS was completed quickly and with ease. Participants engaged with the concept of emotional distress without question. Indeed, in several interviews it served as a natural and unthreatening prompt for opening discussion around feelings of mental distress. Score changes are summarised in Table 2. Positive changes indicate improvement in emotional state.

A small proportion of participants in each study (21% overall; range 10% to 30%) reported no change in their emotional state following the interview but for most, taking part in a qualitative interview was a process that had some impact on their feelings. The mean score change was positive in all studies. Overall, mean score change was +0.7 (95%CI 0.2 to 1.2). This reflected the fact that at least half (range 50% to 70%) of the participants experienced a sense of increased well-being, mostly within 1 to 2 points on the 10 point scale, though for some the increase was greater. Some participants in each study reported a lowered mood after being interviewed. This was the case amongst approximately a fifth of participants (22% overall; range 18% to 27%). Mean score decreases were of a similar magnitude to mean score increases. It is noteworthy that where participants became distressed during the interview (for example, cried) this did not necessarily equate to a lowering of their well-being score at the end of the interview. Some such participants reported an increase.

The results from each of the four studies followed a similar pattern. A higher mean score change occurred in Study 2 but this can be attributed partly to one participant whose score increased from 0 to 10. With the outlier excluded, the median score change in this study was 0.2 and the mean was 0.5. More positive score changes occurred in Study 4 whereas the largest number of score decreases were reported in Study 1. Such differences could relate to the population group or interview topic. Study 1 focussed in-depth on a specific traumatic event—a near-fatal suicide attempt, which may explain why some participants found this more challenging. Participants in Study 4 were younger, mostly female, were a community-based rather than clinical sample, and probably had the lowest levels of morbidity; almost half reported just one episode of self-harm.

Five of the six participants whose scores decreased in Study 1 were female. Since an approximately equal number of males and females were included in this study, females may have been more likely to be negatively affected. The mean score change for females in this study was −0.2 compared to +0.7 in males. Study 4 also included an additional control group of 10 individuals who had not self-harmed (not included in Table 2). More of these (40%) reported no score change than those with a history of self-harm (10%, Table 2) and only one experienced a decline in mood. In both instances, sample sizes are too small to explore these observations further.

3.1. Qualitative data

Nearly all participants (n=57, 90%) were invited to comment on their score change (if any) and offer reflections on the experience of being interviewed. Of those not asked, 2 reported no score change (Study 4), 1 reported an increase of 0.5 (Study 1) and 3 reported a score decrease: a minimal decrease of −0.2 (Study 1), a decrease of −2.0 (Study 2), and a decrease of −3.0 at which point the interview was concluded and switched to debriefing/supporting (Study 4). Comments provided ranged in detail and some participants either could not account for the change or offered no reflections. This was mostly where the score change was less than +/−0.5 or there was no change (n=7). However, 47 participants did comment providing further insights to assist with interpretation of the VAS data reported above.

3.2. Score increases

In total, 36 participants' scores increased (improved) across the four studies and of these, 29 discussed their experiences of the interview and the reasons for this change.

There was some indication amongst a small number of participants that their increase of score may in part reflect relief from feelings of nervousness or apprehension prior to the interview. This theme also emerged amongst some participants

Table 2
Summary of score changes by study.

	Mean score pre-interview	Mean score change (range)	% (n) score increase	% (n) score decrease	% (n) score unchanged
Study 1: Biddle et al.	5.7 (1 to 9.6)	+0.3 (−3.7 to +3.0)	50% (11) (Mean=+1.4)	27% (6) (Mean=−1.4)	23% (5)
Study 2: Owen-Smith et al.	5.7 (0 to 9.5)	+1.5 (−2.0 to +10.0)	50% (5) (Mean=+3.4)	20% (2) (Mean=−1.2)	30% (3)
Study 3: Cooper et al.	5.6 (2.0 to 8.0)	+0.2 (−3.0 to +2.5)	55% (6) (Mean=+1.0)	18% (2) (Mean=−2.0)	27% (3)
Study 4: Klineberg	5.8 (3.0 to 10.0)	+1.2 (−3.0 to +5.5)	70% (14) (Mean=+1.8)	20% (4) (Mean=−0.8)	10% (2)
Total	5.7 (0 to 10.0)	+0.7 (95%CI +0.2 to +1.2)	57% (36) (Mean=+1.8)	22% (14) (Mean=−1.3)	21% (13)

registering 'no change'. Some noted surprise at how relaxed the interview had been and at how freely they had spoken.

> I: What's made the difference [score increase]?
> R: Because at first you're a bit, I was a bit nerve… nerve-racking like and everything. And now I'm more chilled out (Study 4, ID20, Female, score change: +3.0)

Some also expressed relief at receiving a non-judgemental approach and not feeling pressured to account for themselves or their behaviour.

> I enjoyed it actually… I thought it was going to be a lot more morbid than what it was. I thought you was going to start asking me as to why I'd done it. (Study 3, ID9, Female, score change: +2.5)

Over three quarters of participants discussing a positive score change (and some whose score remained unchanged) stated that this was explained by the opportunity the interview had presented them with to 'talk' at length about their difficulties with someone interested to listen. Some noted that this opportunity was unusual. They described the usefulness of being able to 'tell someone' how they felt or about what had happened—for instance, when they had harmed themselves or attempted suicide.

> I feel better when I've been talking about it. I feel more (pause). I feel a bit better than I have all week actually…I think it [talking] helps me actually. (Study 1, ID13, Male, score change: +3.0)

> I do feel better. You know, speaking to people, yeah, it does help. (Study 4, ID4, Female, score change: +0.5)

> I: It's [interview] made you feel a tiny bit better?
> R: Yeah…It's like someone listened to me, you know, basically I felt someone wants to know. (Study 3, ID6, Female, score change: +0.5)

Some participants described the benefits of talking in more detail. Several explained that talking at length during the interview could bring about a cathartic release of feelings, which might have a longer term benefit.

> It's good to get it all out because it's very rare to actually talk about it. Either some people say 'oh don't talk about it, you want to think about the future, move forward let it go' - that's all very good but sometimes, especially if you're having nightmares or flashbacks or things, sometimes if you get it out I might get a sort of a week or two off now because I've said it. So it's almost like (pause), it's like quite cathartic. Like it's all gone now. I might have sort of a bit of a break from it because I've said it out loud… When you talk about it you get it out, it's almost like a big relief. It's like a safety valve… it's like going to confession. (Study 1, ID4, Female, score change: +2.1)

> I: What's the difference [score change] do you think?
> R: Because I feel like whatever was in my mind, I've said it out, I've opened out. (Study 4, ID12, Female, score change: +5.5)

A smaller group also indicated that the process of describing and being encouraged to reflect upon issues had given them a new perspective and supported a process of working through difficulties.

> I feel better for like laying stuff out and talking about it (Study 4, ID9, Female, score change: +1.25)
> I just think now that I've talked about it, it just feels like all the problems that I have, they're less of a problem. (Study 4, ID16, Female, score change: +0.9)

> Actually it makes me feel better to talk about it. It's nice for me personally, yeah it's nice because sometimes I think the more I talk about it the more I accept what I did and who I am. (Study 3, ID11, Female, score change: +0.5)

The opportunity provided to talk at length led some participants to assimilate the research interview with a therapeutic encounter:

> Well I feel halfway there because I feel a bit (pause) I feel like you've been my counsellor (Study 1, ID12, Female, score change: +2.6)

3.3. Score decreases

Participants whose scores had dropped were also asked for their reflections on the interview. Ten out of 14 commented. Some were individuals with on-going distress and they accounted for their lowered score on the basis that the discussion had caused them to focus on current problems or had brought these to the fore.

> You haven't upset me, it's just, it's bringing everything to the forefront…but you haven't brought up anything I didn't already know (Study 1, ID2, Female, score change: −3.7)

Others said the interview had reminded them of difficult past feelings and experiences. Some explained this was particularly the case where they were required to recall in detail a specific crisis event, such as a suicide attempt, or a time where they had not coped well with difficulties. Negative feelings were heightened where participants felt shame or embarrassment about their actions.

> I think it was just a bit upsetting in the bit when you're asked to think back about what you've done and your actions and what seems the only way out at the time really (Study 1, ID14, Female, score change: −1.0)

> I: A bit below [score change]. Is there anything that's made the change?
> R: Er, just thinking about the stuff [self-harm] that I did. (Study 4, ID15, Female, score change: −0.25)

A further participant indicated that her decreased score reflected regret that the interview was over, rather than that she had found participation distressing (Study 3).

It was notable that participants expressed little concern about their lowering of mood:

> It's just bringing up things again and even though I don't mind doing it [interview], but to me, it's just a bit, I don't know really. What's the word? (Pause). It's just painful to be

honest… it just brought things back, but it's alright. (Study 3, ID7, Female, score change: −1.0)

Several believed the feelings would be transient, and some normalised it as a common, almost inevitable effect of 'talking'.

Probably later on I will feel better. Usually, when I used to go and see counsellors I would feel worse until later on and then I would feel better so it's not something that's going to stay with me probably. (Study 1, ID2, Female, score change: −3.7)
It's just sort um, you know, thinking about it really, but no, I shall be fine. I shall get some tea. (Interviewer: Will it stay on your mind?) No, no it won't, don't worry. (Study 1, ID5, Female, score change: −0.3)

I do feel sort of lower now, probably tips you up slightly. But I have got my friend coming round as well so, you know, outside things boost you up. (Study 1, ID20, Female, score change: −2.0)

Furthering this view, one participant with a positive score change also noted that talking about the past had been emotionally difficult but could be translated into a gain.

R: it's not bad, may be like to have to talk about obviously the past.
I: That was difficult for you?
R: A bit, yeah. Like to always you know repeat, it's difficult but in another way for me I find it good in the end. (Study 3, ID11. Female, score change: +0.5)

A common viewpoint was that any feelings of distress were outweighed by the desire to contribute to research. This was regarded as necessary and valuable and meant that a positive outcome could be derived from participation even where scores reduced

There's only one way people are going to learn isn't there? That's my philosophy…doesn't hurt does it? Might help somebody one day. (Study 1, ID2, Female, score change: −3.7)

The whole research was done well, but um, yeah, just sort of I suppose hit a spot and that's all you know… but I think if you're gonna do this kind of research you have to ask questions like that. You know, you can't sort of pretend it doesn't happen (Study 1, ID4, Female, score change: −1.0)

The desire to contribute to research as a motivation for and positive outcome of participation emerged across all groups of respondents:

It's been really nice to help you and to tell you how I felt and how I was treated, so to speak… because ultimately if this study goes to fruition I imagine it would eventually change practice (Study 3, ID2, Male, no change).

There were no criticisms of the content or conduct of interviews. One participant (Study 1) noted it had been helpful to take a break from the interview and to have the audio-recording stopped where she had become distressed. There were no further suggestions about how interviews could be improved or made easier.

4. Discussion

The majority of individuals taking part in the four separate qualitative interview studies described here indicated that they had experienced a change in mood at the end of the interview. A half to 70% of participants in each study reported a modest increase in well-being. This was linked to the beneficial effects of talking at length and being listened to. Few had been presented with this opportunity elsewhere. Disclosure could have cathartic value and for some, taking part in an interview was likened to a therapeutic encounter. Around 20% of participants reported no change. Approximately a fifth of participants reported a lowering of mood as they were reminded of difficult times or forced to focus on current issues. However, most anticipated that their distress would be transient and it was outweighed by a desire to contribute to research in order to bring about change. An increase in distress did not therefore necessarily indicate a negative experience. There was some indication that interviews requiring participants to recall in detail a specific traumatic event – a near-fatal suicide attempt – were more likely to provoke distress, though 50% of participants in this study (Study 1) still reported positive score changes.

4.1. Strengths and limitations

This paper reports on the experiences of vulnerable individuals participating in qualitative suicide/self-harm research and pools together the results from four separate studies conducted by differing researchers. It therefore adds to the existing literature, which focuses on participants' experiences of completing survey questionnaires or structured interviews measuring psychiatric state (Jorm et al., 2007). The findings are consistent with these other studies, indicating a similarity between in-depth participation and a survey approach. Existing studies have primarily measured the experience of participation using closed response questions (Jorm et al., 2007). In addition to completing a ten-point VAS, qualitative reflections on the interview process were obtained in the studies reported here adding further insights into individuals' experiences of participation and the reasons for any resultant changes in well-being. Improving upon a limitation of many previous studies (Jorm et al., 2007), well-being scores were obtained before and after the interview so change could be identified, discussed, and attributed directly to the research process. To our knowledge, only one other study has taken a similar approach to that described here (Rivlin et al., 2012). This was a mixed-methods study of prisoners, which included some qualitative exploration of recent suicide attempts. Mood was measured before and after the interview and open-ended questions were posed about experiences of participation. Our findings are highly consistent with the comments and scores reported in this study.

There are two main limitations. First, individuals were not followed up and so no further light can be shed on the longer-term experiences of participation. This research gap has been identified previously (Jorm et al., 2007). It seems likely that the in-depth discussion occurring during a qualitative interview may initiate a period of reflection in some individuals, which may be positive or raise issues that require further discussion. Second, in each study, VAS scores and qualitative reflections on the interview process were collected from participants by the researcher who had conducted the interview. It is possible this may have inhibited reporting of negative effects. More females were included (40 compared to 23 males), largely due to the sample included in Study 4. Females commented more readily and in greater depth than men on their experiences of participation.

4.2. Implications

There are three main implications. First, the findings support the use of in-depth qualitative approaches in suicide/self-harm research and suggest that many vulnerable people may in fact derive benefit from participating in well-conducted research of this nature. Concerns that participation may cause harm were not supported for the majority of respondents. These findings are based on a self-selecting group of individuals who responded positively to a research invitation and therefore demonstrated willingness to take part. An interpretation could be that considerations about emotional fitness to participate contribute implicitly or otherwise to individuals' own decision-making when approached for a study. If this is true, these data would imply their judgements are mostly sound. These findings should be of relevance to ethical committee members and clinicians who may be involved in study recruitment and 'gate-keep' access to potential participants. Gate-keeping was evident in studies 1–3 reported here. The limited examples of distress may indicate this was appropriate and functional. However, it is also possible that excessive gate-keeping could prevent some individuals from gaining the beneficial effects of participation.

Second, despite broadly reassuring findings, a small number of participants did report a lowering of mood. Researchers should maintain a careful approach when involving those at risk of suicidal feelings or behaviour in research and monitor distress during the research process. The VAS used in this study could serve as a quick and accessible means of achieving this. It was completed easily by all participants and where scores had lowered, interviewers were alerted to a need to provide post-interview de-briefing and in some cases telephone follow-up. In a small number of cases, score change information was forwarded to clinicians with the participant's consent where there were concerns about the participant. More generally, the VAS could also serve as a useful, non-threatening prompt for opening discussion around emotional health. Routine use of such a scale could therefore help broach sensitive topics, alleviate anxieties reported by some researchers about recognising risk should negative effects arise (Lakeman and Fitzgerald, 2009a) and provide a tool for communicating with clinicians about patients that have taken part in research. Consideration could also be given to employing this approach in qualitative studies addressing less sensitive topics since the in-depth nature of interviewing may cause unexpected emotional responses.

Third, there is a need for awareness of the methodological and ethical issues that might arise where research and 'therapy' blur. While positive score changes are gratifying, they do not necessarily equate to good research data or sound practice. For instance; participants may disclose information they would not wish to be used for research purposes (for example, if obtained by inappropriate or misconstrued rapport), data collection may lose focus, or there may be a shortfall in the researcher's capacity to respond. Such issues could be averted by adequate interviewer training and support. The observation that several respondents who became distressed during their interview (for example, cried) reported improved well-being at the end of the interview also highlights the need for experienced interviewers who can use techniques to diffuse emotion and make skilful judgements about when to terminate interviews and when to continue, since some respondents will derive benefit from being able to express emotion and bring closure to their account. These considerations may contribute to debate about whether or not interviewers should be clinically trained. On the one hand this may provide a strong skill-base but on the other, it could make it more difficult to negotiate the boundaries between therapy and research.

Some broader issues are also raised. Comments from some participants indicate that some positive score changes may be attributable to a relief from apprehensiveness about what the interview will be like once it has taken place. These participants registered surprise at the informality of the exchange. This raises questions about the way qualitative research is described to potential participants. Terminology such as 'research interview' may generate inaccurate perceptions and anxieties, which may decrease response rates. Consideration could be given to re-badging such methods of data collection.

The accounts of two participants reveal further ways that being involved in an interview process can be emotionally charged, over and above content. One with a decreased score gave the impression that this was because she had felt buoyant about being invited for interview and was 'sorry' that it was over, rather than that she had found participation distressing (Study 3, ID3). The second experienced a much improved sense of well-being during the interview due to the 'boost' of meeting the researcher but believed this would quickly deteriorate once the researcher had left: "when you're gone there'll be like an adrenaline hangover… bit like having a drink, but then afterwards you're [respondent slumps] "cor blimey, now I've got a hangover" (Study 2, ID2, Male, +10.0). Such experiences may be more common amongst vulnerable populations and raise questions about the long-term effects of participation.

4.3. Further research and conclusions

It is important that further research now establishes the longer-term effect of participating in qualitative research. This should include exploring the longevity of any immediate positive or negative changes in mood and whether the interview prompts further rumination, which may need to be supported. However, such research might be challenging since it may be difficult to separate interview effects from intervening events occurring in the wider contexts of participant's lives. Also, it was not discernable from the data collected whether there are particular features of a research interview or aspects of interviewing technique such as level of directedness that are more or less likely to bring about a change in well-being. This could be explored in further research. The consistency in findings across the studies reported in this paper though is notable given that each was conducted by differing researchers—some clinically trained and some not. Exploration of the effect of participant characteristics on likely response and other relevant factors, such as temporal proximity of the interview to the event being discussed, may also be fruitful and assist clinicians' decision-making when approached to recruit patients for research.

Overall, the findings from this study support the use of qualitative methods in suicide prevention research. Such research provides great insight into individuals' experiences of living in a suicidal state and allows more in-depth understanding of issues around suicidality (Hjelmeland, 2010), such as why particular individuals might choose certain methods of suicide (Biddle et al., 2010). Of equal importance, qualitative research can generate ideas around successful interventions for severe depression and suicidality and provide access to stories of hope and recovery (Lakeman and Fitzgerald, 2008; Ridge and Ziebland, 2006). The findings may also have broader relevance, encompassing suicide research employing other methods such as structured interviewing or mixed-methods approaches. Contrary to the concerns of gatekeepers, involvement in sensitive research seems more likely to benefit participants than harm them.

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Study 1

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Study 2

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Study 4

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Conflict of interest

All authors declare that they have no conflict of interest.

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