Portfolio Volume 1: Major Research Project

Giving Hope to Rebuild Lives: Practical and Emotional Support for Those Bereaved by Road Traffic Collisions

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Abstract

In the United Kingdom (UK), the Department for Transport (DfT) reported that 1,558 people died in Road Traffic Collisions (RTC) in 2021 (DfT, 2022). A considerable proportion of the UK population is impacted by RTCs yearly. RTC deaths involve police investigations, coronial processes, insurance claims, court (criminal and civil) proceedings, hospitals, and even media attention (Mitchell, 1997; WHO, 2004), which potentially impact the grief experience of bereaved families (Breen & O'Connor, 2009; Tehrani, 2004). There is limited literature on support for bereaved family members (Huang, 2016). To better understand what supports people bereaved by RTCs with their grief, feedback from RTC support service Road Victims Trust (RVT) was analysed, and RVT service users and staff were interviewed. Data was gathered and analysed using Grounded Theory, and a model of the process of grief, bereavement support and the impact of the Criminal Justice System was developed from the data.

The model conceptualises grief as a dynamic process positively and negatively impacted by psycho-social factors, including counselling, informal support, practical support and the criminal justice system.

The findings suggest that the Criminal Justice System significantly impacts the bereaved who wish to know what happened to their loved one. Family Liaison Officers (FLOs) can be a source of support and information for families but are constrained by the demands of their job and the needs of investigations. These constraints can frustrate families. RVT counsellors are given training in bereavement and legal processes; this specialist knowledge helps them to support bereaved families to normalise their grief and frustration. People who have been bereaved by RTCs believe they needed professional support from RVT very soon after bereavement and could not have waited six months, as is recommended in some literature. Some participants wanted to receive peer support from people who have been through RTC bereavement, but RVT does not offer such a service; they were ultimately satisfied with the counselling they received.

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1.0 Introduction

1.1 Overview

The research presented in this thesis aims to explore the experiences of people bereaved by Road

Traffic Collisions (RTCs) and how they use the support of a bereavement service to overcome their

grief and regain hope. This chapter begins by outlining the researcher's epistemological position and

relationship with the research topic, and relevant definitions, followed by an overview of the broad

research literature covering the prevalence and impact of RTCs, the psychosocial consequences of

RTCs, and support services for those impacted by RTCs in the United Kingdom (UK). Then, a

systematic review of the literature focusing on the experience of, and the psychological support

available to, family members whom RTCs have bereaved. The chapter concludes with the rationale

for the current study and a statement of the research aims and questions. This thesis aims to

address the experiences of those bereaved by RTCs and what supports them in rebuilding their lives.

1.2 Epistemological stance

Before studying psychology, my education was in theoretical physics; as a result, I have tended

toward a personal epistemological stance that, while reality may exist, what is observable are the

emergent properties of this reality, and subjective humans interpret it. This fits a critical realist

epistemological stance, which posits that reality manifests itself empirically through various

emergent properties (Looker, Vickers & Kington, 2021). Critical realism presupposes an objective

reality that exists independently of our thoughts and that all descriptions of that reality are

mediated through the filters of language, meaning-making, and social context (Oliver, 2011).

Speaking with an expert by experience whose husband died in an RTC, she spoke about the impact

and circumstances of her husband's death, which she understands as being materially real events

with real implications for her life. Social constructionism could be criticised as denying this reality

and the actual impact on people's lives (Webb, 2014). In order to honour the reality of my

participant's experiences and to accommodate my role in shaping the research and interpreting

participants' accounts, I will therefore adopt a critical realist position. In analysing and building a grounded theory, it is accepted that phenomena can be explained in part by, but not reduced to, their underlying generative mechanisms (Oliver, 2011).

As the experiences of people bereaved by RTCs will be studied from a critical realist perspective, the study will accept that the participants may describe 'their reality' and that this may agree or disagree with other realities. However, the participant's knowledge, the interview, and the interpretation will be historically, socially, and culturally situated (Archer, 2016). In addition, the processes underpinning the lived experiences will be explored to understand the less observable factors that impact bereavement. Therefore, within this study, it is crucial to value the insight into participants' individual experiences whilst also considering the broader context in which the research has been conducted, including the researcher's influence in all stages of the study.

For the critical realist Grounded Theory researcher, 'all is data' (Glaser, 1998); therefore, it is possible for grounded theory studies to mix quantitative and qualitative data. While this research aims to be predominantly qualitative, I remain open to quantitative data when it becomes available.

A critical realist attends to social and organisational structure as well as individual action. Taking a critical realist position requires that actions within broader social and organisational structures, together with meanings, must be located within the social, political, cultural, and racial frameworks, and so these are essential aspects of the analysis (Oliver, 2011). Conducting this research with an organisation, the Road Victims Trust (RVT), places the researcher in a position where the organisation's 'reality' is reflected in the context of the organisation and its practices. The organisational structure can be understood as being constituted by its structures (embedded meaning, practices and relationships) and staff (who sustain structures by enacting the meaning, practices and relationships) (Kempster & Parry, 2011). This perspective suggests that organisational structures causally affect staff actions and, in turn, structures are causally affected by staff. As a researcher, I must remain aware that communication with RVT staff should be considered in the

context of the meanings, practices and relationships of the organisation and the messages the

organisation would wish to communicate.

1.3 Introduction to and Definition of Key Concepts

1.3.1 Hope to Rebuild Lives

The title of this project is taken from the tag line of RVT. In the bereavement literature, there is much

debate about the use of the term *recovery* following a bereavement (Balk, 2008). Some argue that

the term recovery trivializes the loss bereaved people suffered. For some bereaved people, the term

recovery may signify the ending of their connections to their loved ones, a connection that carries

much meaning and comfort (Tedeschi & Calhoun, 2008). In discussions with an Expert by Experience

(EbE) consultant, it was felt that recovery was not a useful term and that the RVT tagline, Hope to

Rebuild Lives, signified growth and continuance rather than being fixed. To honour the opinion of the

EbE, I will refer to Hope to Rebuild throughout this thesis.

1.3.2 Road Traffic Collisions

The literature on traffic injury and death describes these collisions using various terms that vary

across time and geography. These include, but are not limited to:

1.   Road Traffic Accidents (Papadatou et al., 2018; Lenferink et al., 2021)

2.   Road Traffic Crashes (Tehrani, 2004; Breen & O'Connor, 2012; Palmera-Suárez et al., 2016)

3.   Motor Vehicle Collisions (Bolton et al., 2013)

4.   Road Trauma (Burrai et al., 2021)

The charity RoadPeace advocates using the word crash instead of the word accident. Their argument

is: the "Accident' implies the crash was unpreventable and no one was at fault. It is inappropriate,

upsetting for families, and serves only to propagate the idea that road deaths are an acceptable pay-

off for having roads" (RoadPeace, 2022). Following similar logic, there have been calls to no longer

use the term accident when referring to events that cause injury and death; as a result, the British

Medical Journal (BMJ) banned the use of the term accident (Davis & Pless, 2001; Loimer, Driur & Guarnieri, 1997). Following consultation with an Expert by Experience and the arguments laid out in scientific and road safety charity literature, I have adopted the term Road Traffic Collision.

Many types of road users could be involved in RTCs; pedestrians, equestrians, cyclists, vehicle drivers, and passengers (in cars, trucks, buses, and motorcycles). Along with the cohorts listed above, the family, friends, and communities of those directly involved in RTCs are also impacted. Breen and O'Connor (2012) defined the various groups impacted by RTCs, these include:

1.   People bereaved by RTC fatalities

2.   People injured in RTCs

3.   Families, friends, and unpaid carers of people injured in RTCs

4.   Witness and first responders to, RTCs

5.   Offenders/people who allegedly caused the collisions

Most literature on the impact and consequences of road-traffic crashes concentrates on studying the surviving injured victims of serious collisions (Attwood et al., 2022; Huang, 2016). The impact of fatal RTCs on the deceased person's family has received limited focus from researchers. Family members may experience intense grief and have contact with police and legal systems that can impact them directly and indirectly (Huang, 2016). Therefore, in this thesis, I will focus on the experiences of the first group, i.e., people bereaved by RTCs. More specifically, this research will investigate people whose immediate family members (spouse, parent, child, sibling) have died in an RTC.

1.4 Overview of the Empirical and theoretical literature

1.4.1 Prevalence and Impact of Road Traffic Collisions

Prior to the COVID-19 pandemic, the World Health Organisation reported that RTCs accounted for an average of 1.35 million deaths globally per annum (WHO, 2018) and were the leading cause of death for children and young adults (WHO, 2018, pp 3). In the United Kingdom (UK), the Department for

Transport (DfT) reported that 1,558 people died in RTCs in 2021 (DfT, 2022). As such, a considerable

proportion of the UK and global population are impacted by RTCs yearly. A European-wide study

(FEVR) found that families of people who died in RTCs experience depression, anxiety, suicidality,

and feelings of anger and resentment (European Federation of Road Traffic Victims, 1997). RTC

deaths involve police investigations, coronial processes, insurance claims, court (criminal and civil)

proceedings, hospitals, and even media attention (Mitchell, 1997; WHO, 2004), which could

potentially exacerbate the grief experience (Breen & O'Connor, 2009; Tehrani, 2004). There is

limited literature on the impact of fatal RTCs on bereaved family members (Huang, 2016), although a

large body of literature on bereavement suggests grief and intense distress can lead to Persistent

Complex Bereavement Disorder (PCBD) or Post-Traumatic Stress Disorder (PTSD). Given the stressors

highlighted above, this could mean that family members bereaved by RTCs could experience PCBD

or PTSD.

1.4.2 Psychosocial consequences of RTCs

   1.4.2.1 Grief and Bereavement. The death of a loved one has been identified as one of the

most challenging life stressors humans can experience (O'Connor, 2019). Descriptions of grief, its

symptomology, course, and adjustment have been researched by psychiatrists and psychologists,

with early research stemming from psychosomatic medicine dating back to 1944 (O'Connor, 2019).

Du Bose (1997) defines bereavement as the moment or time of death of a loved one and defines

grief as the psychological and physiological reactions that follow the loss of a loved one. Following

the death of a loved one, people typically go through painful but natural grieving, where the

intensity of grief-related distress typically reduces over time (Du Bose, 1997; Lundorff, 2017). While

bereavement can be a highly stressful life experience, most people cope with grief and gradually

adjust to a new life (Prigerson et al., 2009; Zisook & Shear, 2009). For some, rather than decreasing

the intensity of grief-related distress, severe grief reactions become persistent and increasingly

debilitating over time (Prigerson et al., 2009; Zisook & Shear, 2009).

        1.4.2.2 Stage Models of Grief. Many psychological theories have been proposed to explain how the grieving process unfolds. Some psychological models of grief rely heavily on attachment theory to understand the process of adapting to bereavement (O'Connor, 2019); these models are stepped or stage-wise (Bowlby, 1960; Kübler-Ross, 1997). Bowlby's (1960) theory of loss was grounded in his work on attachment theory, in which he posits that separation results in feelings of painful loss. Bowlby believed this 'split' evokes the separation anxiety developed in early infancy and manifests as grief. Bowlby's method of modelling grief was four-fold: shock and numbness, yearning and searching, despair and disorganisation, and reorganisation and recovery (Bowlby, 1963). Kübler-Ross also proposed that grieving is a process of stages, each to be worked through and re-worked until it is manageable and efficiently carried out (Kübler-Ross, 2005). This notion of 'process' is a common reoccurrence in grief literature and sets time frames for grieving that occurs after the death of a loved one. Stage models of grief have become embedded in the Western zeitgeist as the culturally understood model of grieving (Breen & O'Connor, 2009; Campbell, 2020, Prigerson, Kakarala, Gang & Maciejewski, 2021).

According to Bowlby (1963), the final stage of normal grief was the ability to stop yearning for the deceased, accept the loss, and be emotionally attached to others. Those who could not reach this stage were considered to be in pathological grieving. Bowlby (1963) identified four types of pathological mourning, including (a) a persistent yearning to recover the lost person, (b) persistent anger at both others and the self, (c) compulsive caring for another bereaved person, and (d) denial of the reality of the loss (Prigerson et al., 2021).

1.4.2.3 Dual Process Models of Grief. The Dual Process Model (DPM) (Stroebe & Schut, 1999) of grief is a theory of coping with bereavement that has its foundations in the Cognitive Stress Theory of Lazarus & Folkman (1984). DPM identifies two categories of stress associated with bereavement, loss-oriented versus restoration-oriented (Stroebe & Schut, 2010). Loss orientation concerns appraising and processing aspects of the loss, such as searching for the lost person (Stroebe & Schut, 2010). Restoration orientation concerns adapting to a world without the deceased person (Stroebe & Schut, 2010). Both are sources of stress and are associated with distress and anxiety. DPM suggests that dynamic cycling or oscillation between attending to or avoiding these two types of stress is dynamic and changes over time (Stroebe & Schut, 1999; 2010). Oscillation involves the bereaved confronting aspects of loss or restoration and avoiding them at other times; there will even be times when the person is not grieving (Stroebe & Schut, 2010). The oscillation between positive and negative emotions or (re)appraisal is central to the coping process. Stroebe & Schut (1999) posit that DPM offers a framework for understanding pathological forms of grief. Grief rooted in denial or inhibition is restoration-oriented (Stroebe & Schut, 1999). Avoidance of the reality of death would be signified by efforts to carry on as "normal" in the world. These pathological forms of grieving can be understood as errors in oscillation (Stroebe & Schut, 1999).

1.4.2.4 Pathologized forms of Grief. Both stage models of grief (Bowlby, 1963; Kübler-Ross, 1997) and the DPM (Stroebe & Schut, 1999) conceptualise pathological forms of grief. To classify the experience of intense grief leading to notable dysfunction for prolonged periods following a significant loss, Prolonged Grief Disorder (PGD) was added to the ICD-11, and Persistent Complex Bereavement Disorder (PCBD) was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Lenferink, 2021; Lundorff, 2017; Prigerson et al., 2009). For a summary of diagnostic criteria see Table 1. Maciejewsk et al. (2016) argue that PGD and PCBD are the same diagnostic entity. Lenferink et al. (2021) argue that while PGD and PCBD criteria differ (e.g., in the number of symptoms and prevalence rates), they share core symptoms, and therefore the difference between PGD and PCBD are predominantly semantic. Maciejewsk et al. (2016) argue that

the semantic differences between PGD and PCBD revolve around the question: "is all grief normal?"

For PGD, the answer to this question is: "no, not all grief is normal; in particular, prolonged,

unresolved, intense grief is not normal" (Maciejewsk et al. 2016). Conversely, PCBD omits the term

"grief", which avoids pathologizing any form of grief (Maciejewsk et al. 2016). Therefore, the term

PCBD will be preferred.

Symptoms of PCBD include a pervasive yearning for the deceased, or persistent preoccupation with

the deceased, accompanied by intense emotional pain (World Health Organization, 2016). A

duration criterion of six months is proposed to ensure that natural grief reactions in the acute state

following bereavement are not confounded with the syndrome of PCBD (Prigerson et al., 2009).

Researchers have found symptoms of PCBD to be associated with impairment of the bereaved

person's familial, social, and occupational functioning and to be on a level with other mental

disorders, e.g., depression and post-traumatic stress disorder (Jordan & Litz, 2014; Maercker et al.,

2013; Prigerson et al., 2009).

Table 1 Diagnostic Criteria

DSM-5 Persistent Complex Bereavement Disorder	ICD-11 Diagnostic Requirements for Prolonged Grief Disorder
Criterion A: History of bereavement following the death of a partner, parent, child, or other person close to the bereaved	**Criterion A:** History of bereavement following the death of a partner, parent, child, or other person close to the bereaved
Criterion B: Since the death, at least one of four symptoms experienced on more days than not and that have persisted at least 12 months • Persistent yearning/longing for deceased. • Intense sorrow and emotional pain in response to death • preoccupation with the deceased • Preoccupation with the circumstances of the death	**Criterion B:** A persistent and pervasive grief response characterized by longing for the deceased or part of one's self, an inability to experience persistent preoccupation with the deceased accompanied by intense emotional pain This may be manifested by experiences such as sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, and difficulty in engaging with social or other activities.
Criterion C: Since the death, at least six of 12 symptoms experienced more days than not and that have persisted for at least 12 months. • Marked difficulty accepting death • Experiencing disbelief or emotional numbness • Difficulty with positive reminiscing about the deceased • Bitterness or anger related to death • Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame) • Excessive avoidance of reminders of the loss • A desire to die in order to be with the deceased • Difficulty trusting other individuals since the death • Feeling alone or detached from other individuals since the death • Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased • Confusion about one's role in life or a diminished sense of one's identity • Difficulty or reluctance to pursue interests since the loss or to plan for the future	**Criterion C:** The pervasive grief response has persisted for an atypically long period of time following the loss, markedly exceeding expected social, cultural or religious norms for the individual's culture and context. Grief responses lasting for less than 6 months, and for longer periods in some cultural contexts, should not be regarded as meeting this requirement. **Criterion D:** The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Research has shown that PCBD, comorbid post-traumatic stress disorder (PTSD), and depression

after a sudden or violent loss (i.e., traumatic loss), such as RTCs, are higher than after a death due to

illness (Djelantik et al., 2020; Lundorff et al., 2017). PCBD and PTSD can be delineated on several

criteria; a core underlying characteristic of PCBD is 'yearning for the deceased', whereas

'anxiousness' and 'depressed mood' are central to PTSD. Furthermore, PCBD is more associated with

difficulties in daily life than bereavement-related PTSD (Djelantik et al., 2020).

       1.4.2.5 Post-Traumatic Grief Disorder. Historically, a diagnosis of PTSD was associated with

catastrophic events well out of the experience of everyday life; as such, PTSD was considered rare in

non-military cohorts (Hepp, Moergeli, Buchi, Bruchhaus-Steinert, Kraemer, Sensky & Schnyder,

2008). Epidemiologic surveys have suggested that PTSD may be much more prevalent than

previously recognised; as a result, the DSM-IV has been amended to include a wider variety of

stressors (Atwoli et al., 2017). In a study of 350 newly bereaved widows and widowers, a diagnosis of

PTSD was made two months after the spouse's death. Ten per cent of those whose deceased

spouses died after a chronic illness met the criteria for PTSD, and 36% of those whose spouses died

from "unnatural" causes (suicide or sudden traumatic death) had PTSD. These results further suggest

that PTSD may occur after sudden traumatic bereavement (Zisook et al., 1998).

PTSD and depression from grief may be mediated by negative cognitions and avoidance behaviours

in people who have experienced sudden or violent loss (Lenferink et al., 2020). Avoidance

behaviours can be expressed through various 'strategies'; these include depressive avoidance and

anxious avoidance. Depressive avoidance refers to withdrawing from social, recreational, and work

activities because they no longer seem meaningful. Anxious avoidance involves the prevention of

confrontation with the reality of death (Boelen et al., 2015). Avoiding confrontation with the reality

of loss can lead to a focus on angry thoughts and feelings, such as anger at police, courts,

perpetrators, or administrators (Foa, Riggs, Massie & Yarczower, 1995; Lenferink et al., 2020). These

avoidance strategies appear to be frequently used by bereaved people after traffic accidents and are

strongly related to PTSD (Lenferink et al., 2020). This avoidance then interferes with the loss

becoming integrated into autobiographical knowledge, resulting in grief reactions persisting (Boelen,

2010). Difficulties integrating the loss into the autobiographical knowledge refer to the challenges of

connecting factual knowledge that the loss is final with existing information about the self and the

relationship with the deceased person stored in autobiographical memory (Lenferink et al., 2020).

Because factual knowledge regarding a sudden or violent bereavement may not be integrated into

autobiographical knowledge, memories related to the death may lack the context of time and place,

causing the death to be experienced as unreal (Boelen, 2010). Drawing on the Cognitive Stress

Theory of Lazarus & Folkman (1984), the belief that one is capable of coping with stressor-related

thoughts, emotions, and behaviours (e.g., 'I can usually handle whatever comes my way') has also

been identified as an essential factor in coping with traumatic stressors (Benight & Bandura, 2004).

Conversely, diminished self-efficacy, negative cognitions and insufficient integration of the

bereavement may contribute to increased sensitivity to loss reminders or secondary stressors

following a traumatic loss (Smid, Kleber, de la Rie, 2015. Specific circumstances of sudden deaths

caused by RTCs may explain the elevated risk of grief-related distress and PTSD (Lenferink et al.,

2020). For instance, multiple losses, witnessing the collision, court trials, and financial consequences

are proposed to exacerbate grief-related distress (Boelen, Keijser & Smid, 2015). Bereaved people

are subject to many loss reminders due to on going investigations, court trials, media coverage and

passing the location of the RTC (Tehrani, 2004). These experiences may hold bereaved people in the

loss-orientated coping phase with repeated exposure to loss reminders (Stroebe & Schut, 2010).

The literature suggests that people bereaved by RTCs may be at elevate risk for PTSD. Additionally,

the circumstances of sudden death, such as involvement with police, courts etc, may exacerbate

grief-related distress. Avoidance behaviours may further exacerbate grief-related distress and lead

to a more elevated risk of PTSD. Given that there is no state-provided specialist RTC bereavement

service in the UK, do charities have the available skills to support people bereaved by RTCs with

PTSD?

1.4.3 Critical Realist Position on Diagnosis

The research discussed thus far refers to diagnostic categorisations of various expressions of human suffering and distress, namely PGD/PCBD and PTSD, both included in DSM and ICD diagnostic manuals. The medicalised position of mental illness is derived from a positivist position which critical realists would critique as reductionist (Bergin, Wells & Owen,2008). The research into mental illness fails to account for the inequalities and complexities of the social world (Williams, 2003). Therefore, positivists confuse prediction with both the causation and explanation of mental health (Bergin et al., 2008).

For the critical realist, the cause of mental illness may be biological, psychological, or social, a position compatible with a bio-psycho-social model (Rogers & Pilgrim,2014, p.14). This permits an individual with a mental illness to understand their biological experiences while also allowing for experiences in the social realm (Bergin et al. 2008). This offers an understanding of 'illness [that] varies across time and place, but does not suggest any denial of the material reality of the phenomena that come to be constituted as disease or disorder... whilst also recognising the importance of the social processes...' (Busfield, 2001p. 5). In the case of PCBD and PTSD, unlike other psychiatric diagnosis, there is an identified antecedence, in the case of this research a sudden death of a family member. Therefore, PCBD and PTSD diagnoses incorporate socio-environmental contextual elements.

Pilgrim (2022) argues that reductionist, positivist views are focused on what is wrong and, by extension, what ought to be correct, or that 'abnormality implies normality and disorder implies order' (p.87). This is also at odds with the aims of this research to find what supports people to find hope to rebuild their lives. As such, I accept the researchers have, through their diagnostic tools, captured a description of psychological distress, and understand it in the context of their participant's sudden unexpected bereavement, but I do not accept that the participants' distress is

inherently pathological. Rather it can be understood in terms of the socio-economic environment in which the bereaved find themselves after the sudden death of a loved one.

1.4.4 Support Services for Road Traffic Collisions Related Bereavement

Despite the well-documented impact of mental illness resulting from the impact of RTCs on survivors, very little research has focused on those bereaved by RTCs, the accessibility of psychological services following RTC bereavement, or the efficacy of such services (Papadatou et al., 2018; Chatukuta et al., 2021). Research has shown that many people impacted by RTCs do not receive the appropriate follow-up support or referrals for psychological therapies following an RTC (Smith, Mackenzie-Ross & Scragg, 2007; Mayou & Bryant, 2002). Research by Tehrani (2004) highlights a gap in service provision for those impacted by RTCs in the UK. Those bereaved by RTCs report that the limited support received was insufficient and that they were not even signposted appropriately to potential support (Attwood et al., 2022).

Gaps in service provision for people impacted by RTCs have been noted in other countries. Breen & O'Connor (2012) were commissioned by the Western Australia (WA) Department of Health to research the provision of post-RTC support. Their research resulted in recommendations for establishing a road trauma support service in WA to provide sustainable peer support and professional counselling for road trauma victims, family members, witnesses, and others adversely affected by road trauma events. Their report provides a comprehensive list of twenty-two recommendations on how an effective road trauma support service should operate (Breen & O'Connor, 2012, p. 8). They recommended establishing a dedicated road trauma support service to provide non-specialist and professional support. This road trauma service should be a 'one-stop shop' for everyone impacted by RTCs. This research was instrumental in establishing Road Trauma Support WA in November 2013, an organisation providing support for those affected by RTCs in Western Australia.

While Breen & O'Connor's (2012) research was specific to Western Australia (WA), there are valid

reasons to consider how their findings can be applied to a UK context. Firstly, their

recommendations are based on a review of a variety of pre-existing service delivery models offered

in a multitude of contexts in Australia with different approaches to service delivery. This variety

suggests that Breen & O'Connor (2012) have considered a good breadth of possible models of

service delivery. Secondly, Breen & O'Connor (2012) based their recommendations on best practice

guidelines for supporting bereavement (Aoun, Breen & O'Connor, 2012; NICE,2004). While these

guidelines are over ten years old, they are supported by more recent research, which calls for

comprehensive services offering care based on need (Harrop, 2020; Lee, 2022).

In the UK, dedicated and specific support for people impacted by RTCs is provided by the charity

sector. Some national and regional organisations in the UK support those impacted by RTCs. These

include; Aftermath, Brake, RoadPeace, SCARD, and Road Victims Trust (RVT) (Savigar-Shaw, Turner &

White, 2022). Brake offer signposting services, directing people to other services that provide

counselling in their region. Road Peace offers practical support and peer- and group-based support,

while SCARD offers practical support and counselling.

In contrast, RVT provides practical support and counselling through an in-house service. Of the

services in the UK, the RVT is the organisation most similar to the model proposed by Breen &

O'Connor (2012) for a sustainable road trauma service (see Appendix A). They are providing their

clients with a dedicated counsellor and supporting clients with practical needs to address the

primary and secondary stressors associated with an RTC-related bereavement. Such comprehensive

support marks RVT as a suitable service to explore what supports people bereaved by RTCs to build

hope.

RVT offers emotional and practical support to anyone living in the East of England (Bedfordshire,

Cambridgeshire, Hertfordshire, Norfolk and Suffolk) affected by a serious road collision. A severe

road collision is considered an RTC where there has been life-altering injury or death. This support is

offered to bereaved families, witnesses and drivers involved in serious road collisions. Practical

support includes providing information and explaining how to plan a funeral, and benefits, notifying

authorities of the collision, legal procedures, police investigation and support during an inquest or

criminal case. Throughout these procedures, RVT continues to keep their service users updated on

what is happening and explain what part the service user may be expected to play in these

procedures. RVT offer emotional support that is tailored to the individual. RVT has specialist

bereavement and trauma counsellors trained to deliver expert emotional support. Support from RVT

is free, confidential, and includes weekly one-hour face-to-face or telephone counselling sessions for

as long as it is deemed necessary.

Most referrals to RVT come through a unique service agreement with the Police Road Collision Unit

within the operational counties. The police referral of a collision can contain between one and thirty

individuals affected by that collision. The remaining referrals are self-referrals and referrals from

other agencies, such as Brake and the NHS. According to RVT's annual reports (2013 – 2021), the

profile of people using their service is; family members (50 – 60%), witnesses (27 – 35%), persons

with life-altering injuries (2 – 5%) and drivers (≈ 10%), this includes people who allegedly caused the

collisions and other drivers.

While RVT meets many of the recommendations set out in Breen and O'Connor (2012) and has a

referral system direct from the regional police, the efficacy of the service has yet to be evaluated by

independent research. The RVT provides practical and emotional support for those impacted by

RTCs but does not know what aspects of their work have the most impact.

RVT is uniquely positioned to fill a gap in service provision identified in research (Mayou & Bryant,

2002; Smith et al., 2007) in the East of England. By conducting research with the RVT and its former

clients, the opportunity exists to understand better what makes for a supportive and effective

service for those impacted by RTCs, and where service development might be recommended. While

the Breen and O'Connor (2012) model of service provision led to the creation of a designated road

trauma service, no research has followed up to assess if or how supportive this service is for the people who use it.

Research into bereavement, grief, and PTSD has demonstrated that there may exist a specific grief experience for those who are bereaved by sudden and unnatural causes of death (Djelantik et al., 2020; Lundorff et al., 2017). The literature so far discussed has considered models of grief and bereavement and the impact of violent and unnatural deaths on grief (Bowlby, 1960; Kübler-Ross, 1997; Stroebe & Schut, 1999; Lenferink, 2021; Lundorff, 2017). This research shows that those bereaved by violent or unnatural deaths may be more at risk of experiencing prolonged grief and or post-traumatic stress disorder (Lenferink, 2021; Lundorff, 2017).

Road traffic deaths are unnatural and sudden deaths that could fall into the category of bereavement, which can put people at risk of PCBD or PTSD (Lenferink, 2021; Lundorff, 2017). Furthermore, the research covered thus far highlights that people in the UK may not receive the aftercare to support them in their time of need (Mayou & Bryant, 2002; Smith et al., 2007; Tehrani, 2004). People bereaved by RTCs are at greater risk of mental health distress and may not receive adequate support. A systemic literature review exploring the psychological impact of RTCs on bereaved people and the recommended support they should receive is required. A better understanding of the knowledge base and conduct further research to develop recommendations for services to support people bereaved by RTCs.

2.0 Systematic Literature Review

2.1 Aims of the Systematic Literature Review

This systematic review is intended to assess and critically synthesise the peer-reviewed literature on the experience of, and the psychological support available to, family members whom road traffic collisions have bereaved. Deaths from RTC remain a serious problem globally, representing the leading cause of death for people aged 5-29 worldwide (UNECE, 2021). Department for Transport (DfT, 2022) reported that 1558 (1211 male) people died on UK roads in 2021. Sudden and traumatic deaths can be complicated, and people seek support from family, friends, support groups, counselling professionals, and the church (Hewison, Zafar, & Efstathiou, 2020). For services to be skilled and best placed to support those bereaved by RTC, we must understand the nature of their grief and distress.

2.2 Search Strategy

Database searches were conducted in January 2023 using different databases: Scopus, PubMed, APA PsychNet, and Google Scholar. These databases were chosen after consultation with the librarian as they include psychology, sociology and public health journals. Terminology for road traffic collisions has varied dramatically across regions and time, so the search was designed to capture the widest variety of these terms. The terms used in the search are shown in Table 1 and were decided upon following consultations with supervisors, EbEs, RVT, and after an informal search of the literature. The relevant studies found in the databases, meeting the inclusion criteria, were included in the review. Each article's reference and citation lists were also searched to ensure no studies were missed in the primary searches. Alerts were assigned for newly published articles that meet the search criteria.

Table 2 Search Terms for Literature Search

(psych* OR counsel* OR therapy) AND (fatalit* OR Death OR bereav*) AND (("road traffic

collision" OR "road traffic crash" OR "road traffic incident" OR "road traffic accident") OR ("motor

traffic collision" OR "motor traffic crash" OR "motor traffic incident" OR "motor traffic accident"))

NOT injury

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources
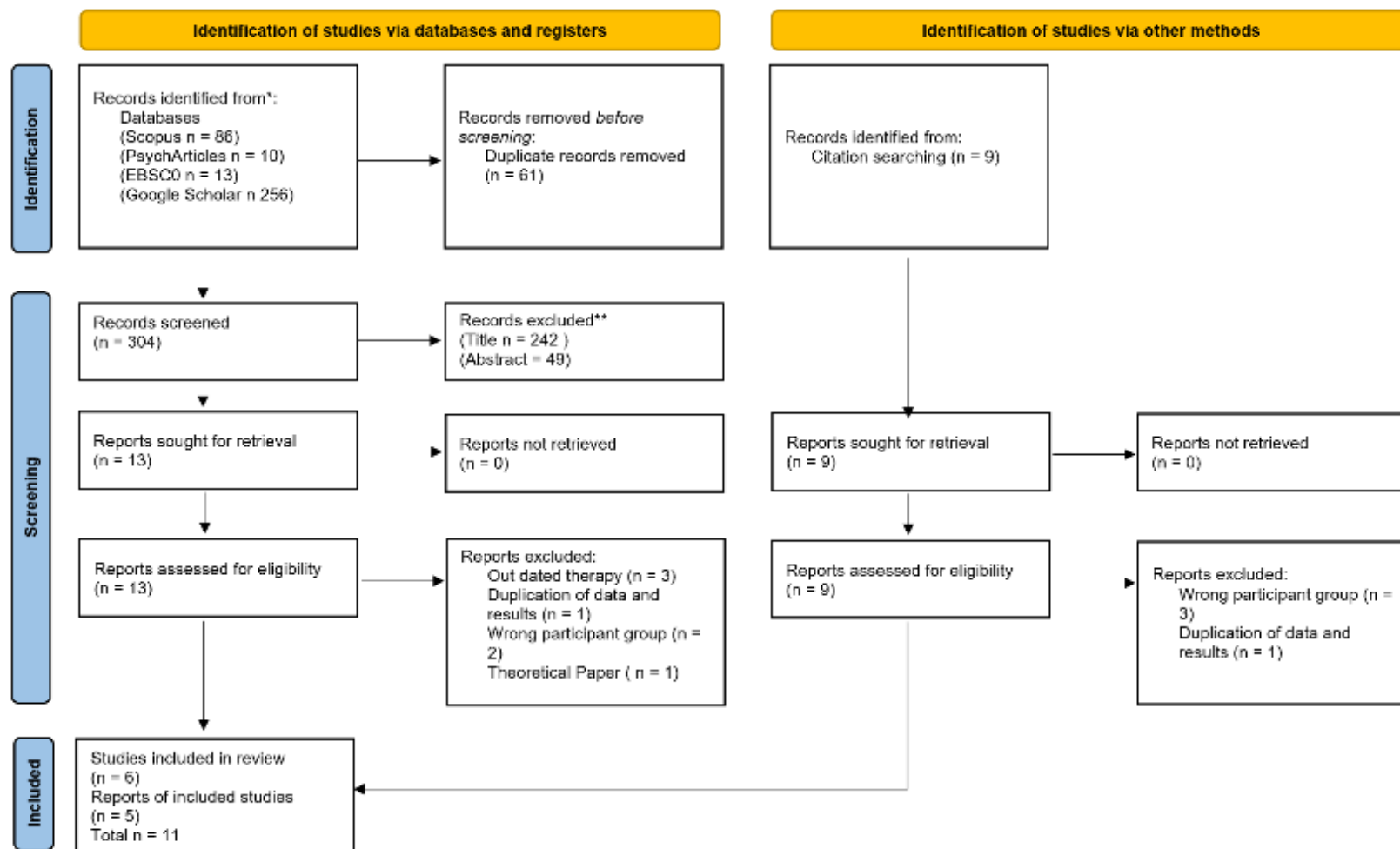
Figure 1: PRISMA flowchart of the review process (Moher et al., 2009)

The initial search yielded 365 papers fitting the search terms. Papers were then screened by title and were excluded if: the focus was on the cause of RTC, if the population was those injured in RTCs if the study investigated the role of alcohol in RTC, or if the research was on medical trauma in an RTC. Duplicates were identified and removed, leaving 304 article abstracts to be reviewed and considered against inclusion and exclusion criteria.

Papers were excluded if they did not research the experiences of family members who have been bereaved by an RTC, assess psychological treatment for family members whom an RTC has bereaved. Family is defined as "People related by marriage, birth, consanguinity or legal adoption, who share a common kitchen and financial resources on a regular basis" (Sharma, 2013). For the purposes of inclusion family is considered any partner (spouse, cohabiting couples or divorced) or any parent, child, sibling relationship (consanguinity, adoption, step relationship, or cohabitation) also considered are grandparents (consanguinity, adoption, step relationship, or cohabitation).

The vast majority of excluded papers researched RTC survivors (PTSD, quality of life); others researched the role of alcohol and drugs in RTCs, emergency medical interventions, driver behaviour in causing RTCs and road safety policy. The remaining 13 papers were read in full, and reference lists were read to identify any other relevant articles not identified by the database search. The literature search ultimately generated ten journal articles for review; a flow chart summarising the search process is shown in Figure 1. The ten articles were quality assessed using Critical Appraisal Skills Programme (CASP) Qualitative and Quantitative checklists. A modified form of framework-based data synthesis was undertaken (Hewison et al., 2020), and key themes were identified and will be discussed below. A summary of the findings, strengths, and weaknesses of each article can be found in Table 2.

Table 3 Summary of Studies Included in Systematic Literature Review

Authors & Title	Aims of study	Participants	Method (sampling, data collection, data analysis)	Key findings and conclusions	Main strengths and limitations
Attwood et al. (2022) *"We are the forgotten grievers": Bereaved family members' experiences of support and mental ill-health following a road traffic collision* **UK**	To explore the experiences of individuals who have been bereaved due to an RTC involving a family member	14 Adults who had been bereaved by an RTC, losing a family member.	Participants recruited by social media campaign with Brake charity, and follow up snowballing. Data collected by semi structured interview Data were analysed using Thematic Analysis	Participants reported that their bereavement experience negatively impacted their mental health and their relationships	(+) Gives voice to bereaved family members (+) Data collected in a manner sensitive to the participants needs (-) Ethical issues not discussed
Bolton et al (2013) *Parental Bereavement After the Death of an Offspring in a Motor Vehicle Collision: A Population-based Study* **Canada**	Mental, physical, and social outcomes experienced by parents who had an offspring die in a RTC	1458 parents with children who died in RTC, along with 1458 nonbereaved parent controls	Data used in the study came from the Population Health Data Repository in the Faculty of Medicine of the University of Manitoba. Data were analysed using structural equation regression models.	Bereaved parents had increases in the risks of depression and anxiety disorders and marital break-up in the 2 years after the death.	(+) Balanced representation of males and females (+) Matched control group (+) Longitudinal (-) Based only on database information
Breen & O'Connor (2009) *Acts of resistance: breaking the silence of grief following traffic crash fatalities* **Australia**	To explore the various acts of resistance to the dominant grief discourse engaged in by people bereaved through the death of a family member in a traffic crash.	21 adults aged 24 to 71 years. Sixteen were women and five were men. Time since bereavement 13 months to 23 years	Participants were recruited from mutual-help groups, road safety activist groups and media advertisement. All interviews were conducted at participants homes. The researchers used a Grounded Theory approach to data collection and data analysis	Researchers identified how their participants resisted 'normative grief discourses, narrow definitions of normal grief and how their experience of grief being at odds with the norm could be distressing. They raise the questions of how services could support bereaved people and how the bereaved want to be supported.	(+) Gives voice to bereaved family members (+) Data collected in a manner sensitive to the participants needs
Breen & O'Connor (2011) *Family and social networks after bereavement: Experiences of support, change and isolation* **Australia**	To explore the role of family and social support networks on grief experiences following the death of a family member in a crash	21 adults aged 24 to 71 years. Sixteen were women and five were men. Time since bereavement 13 months to 23 years	Participants were recruited from a mutual-help group and a road safety activist group. Interviews were conducted in participants home. Data were gathered and analysed using a Grounded Theory methodology.	The findings highlight that participants undermine many assumptions held by services. First that people who may need support know they are in need of help and know where to get it. They identified a disparity between current grief literature and dominant grief discourse held by lay people and service providers.	(+) Gives voice to bereaved family members (+) Data collected in a manner sensitive to the participants needs
Hardt et al. (2020) *Complications in Bereavement Following Motor Vehicle Crash Fatalities in a Sample of Young Adults* **USA**	The psychological outcome for individuals who identified RTC bereavement as their worst or only type of loss experienced.	70 participants recruited from a larger study, they identified a RTC bereavement as their worst or only loss. 58 female 12 male.	Participants were recruited from a larger study on bereavement, Correlation analyses were run to examine relationships between demographic and loss related variables, those that were significantly associated with mental health outcomes were entered as independent variables in a series of regression analyses with mental health outcomes modelled as dependent variables.	Losing a close friend or family member to a RTC is quite commonplace for young adults in the United States Peritraumatic emotional reactions remained uniquely associated with PGD symptoms after controlling for other factors. History of repeated bereavement was associated with lower risk of PTSD.	(+) Students / young adults the focus. Generally underrepresented in research on RTCs (-) Recruitment was not well defined so cohort was heterogenous in terms of RTC bereavement (-) Confounds were not considered

Authors & Title	Aims of study	Participants	Method (sampling, data collection, data analysis)	Key findings and conclusions	Main strengths and limitations
Lehman et al. (1987) *Long term effects of sudden bereavement marital and parent child relationships* **USA**	This paper explores the effects of losing a spouse or child in a RTC.	a) 39 individuals who had a spouse die in a RTC 4 - 7 years (39 matched controls) b) 41 parents who had children who died in RTC (41 matched controls)	The bereaved respondents were randomly selected from a file that contains a record of every motor vehicle fatality that occurred in the state of Michigan between 1976 and 1979. Data were gathered by telephone interview, questions that assessed depression, well-being, social functioning, physical health and employment and financial status	In the spouse study, there were significant differences between bereaved and control respondents on effective coping and adjustment, depression and other psychiatric symptoms, social functioning, psychological well-being and future worries and concerns. Comparisons between bereaved and control parents also revealed significant differences on depression	(+) Randomised selection for bereaved and control groups.
Lenferink et al (2021) *Treatment gap in bereavement care: (Online) bereavement support needs and use after traumatic loss* **Netherlands**	This research focused on the needs and use of bereavement care for RTC bereaved people.	273 (206 Female) people who had been bereaved by RTC 206 Female	Participants were recruited from people who had contacted the Victim Support organization in the Netherlands. Standardized Instruments were used to assess PGD other measures included Internet-based Interventions Acceptability Questionnaire. Logistic regression models were built to examine needs and use of services after bereavement	63% of participants had used (one or more) bereavement care services (psychotherapy, pharmacotherapy, and/or support group) Being younger, having a higher educational level, having experienced the loss longer ago, having obtained psychological support prior to the loss, and reporting higher pathological grief levels significantly increased the likelihood of the self-reported need for or use of psychotherapy	(+) Assessed barriers to treatment (+) Assessed past use of psychotherapy (+) Detailed statistics in results including standard error (-) Little consideration of confounding variables (-) Mean age of participants 50yrs and heavily female
Lenferink (2022) *Associations of Dimensions of Anger With Distress Following Traumatic Bereavement* **Netherlands**	To assess 5 factor model of anger and regression of model to Prolonged Grief Disorder and PTSD	209 adults whose spouse/ family member had died RTC where a perpetrator was blamed for the death	Participants were recruited from people who had contacted the Victim Support organization in the Netherlands. Participants completed the Posttraumatic Anger Questionnaire, Traumatic Grief Inventory Self-Report Plus and the PTSD Checklist. Factor analysis was conducted on the PAQ, to examine the associations between posttraumatic anger factors and PGD and PTSD levels	The five factor model for anger was supported by the analysis. Anger toward oneself was the only anger domain that was significantly associated with symptom levels of PGD. Anger toward oneself and a desire for revenge were both significantly related to PTSD levels.	(+) Perpetrator in RTC is under researched (+) Anger in bereaved is under researched
Sprang (1997) *PTSD in Surviving Family Members of Drunk Driving Episodes: Victim and Crime-Related Factors* **USA**	The study has a particular focus on PTSD after bereavement from a RTC caused by drunk drivers.	186 adult family members of individuals who had been killed by a drunk driver and 106 non-victim controls.	Participants were recruited from Mothers Against Drunk Driving and bereavement-support groups. Participants completed the Mississippi Post-Traumatic Stress Disorder scale along with data related to their relationship with the deceased, extent of injuries, satisfaction with criminal justice system. A set of univariate analyses was conducted comparing the two groups on identified dependent variables.	Female victims report significantly higher levels of PTSD than male victims and their nonvictim counterparts. People more dissatisfied with criminal justice system were more likely to be symptomatic for PTSD	(+) Perpetrator (drunk driver) in RTC is under researched (-) Some participants possibly involved in RTC. Are PTSD findings from involvement in RTC or death of loved one?

Authors & Title	Aims of study	Participants	Method (sampling, data collection, data analysis)	Key findings and conclusions	Main strengths and limitations
Tehrani (2004) *Road victim trauma: an investigation of the impact on the injured and bereaved* **UK**	This research investigates the impact of RTCs on two groups, people injured in RTCs and people bereaved by RTCs who approached RoadPeace	46 (33 females) people who had been injured in RTCs

57 (48 were female) who have been bereaved | The participants contacted RoadPeace helpline and were invited to complete a self-assessment questionnaire

Impact of events scale, questions regarding responsibility for the crash, 11 associated psychological symptoms, and with measures of the social impact, physical impact of the road crash and quality of support provided by the emergency services together with the follow up support. | 74% of injured participants and 67% of bereaved had scored reaching clinically relevant scores for PTSD. The injured experienced more anxiety and depression regarding financial problems than the bereaved.

The bereaved experienced high levels of anxiety and depression related to relationship problems. | (-) Unclear research goals (-) Recruitment created confounding cohorts (some participants injured, some bereaved some both) (-) Mostly correlational analysis |

2.3 Summary of Studies

Of the ten papers included, seven were quantitative studies, and three were qualitative studies.

There was considerable variation in the scope and scale of the quantitative studies, with sample

sizes ranging from 46 to 2916 and 14 to 21 in qualitative studies. Except for one article (Bolton,

2013), there was a disparity in female and male participants, with female participants outnumbering

males by significant margins. Perhaps this is a consequence of the disparity of male deaths

outnumbering female deaths in RTCs. These studies were primarily conducted in western English-

speaking nations Australia (2), Canada (1), Netherlands (2), UK (2) and USA (3). Four key themes

were identified from the findings in the articles; these were: the interaction of Posttraumatic Stress

and Prolonged Grief Disorder, the impact on family relationships, treatment models and barriers to

treatment, understanding of grief and the criminal justice system.

2.3.1 Posttraumatic Stress and Prolonged Grief

Posttraumatic stress was present across five articles and is a critical variable in how qualitative

researchers seek to understand grief following sudden traumatic bereavement, emphasising

understanding the distress of those bereaved by RTCs from a diagnostic perspective. For example,

researchers set out the case that bereavement from an RTC is a particularly traumatic experience

that leaves the bereaved at risk of pathological grief reactions (Lenferink et al., 2021), that these

risks can be impacted by interpretations of the blame for the crash (Lenferink et al., 2022; Sprang,

1997), satisfaction with the criminal justice system (Sprang, 1997; Tehrani, 2004), and various

demographic variables such as gender and level of education.PTSD symptomology was assessed in

four articles; however, three different instruments were used to assess PTSD across four articles. The

PTSD Checklist (PCL-5; Weathers et al., 2013), a 20-item self-report measure of PTSD symptoms, was

used by Hardt et al. (2020) and Lenferink et al. (2022). Tehrani (2004) used the Impact of Events

Scale (IES, Horowitz, Wilner, & Alvarez, 1979), a 22-item self-report measure (for DSM-IV) that

assesses subjective distress caused by traumatic events. Sprang (1997) used The Mississippi

Posttraumatic Stress Disorder (M-PTSD, Keane, Caddell,& Taylor, 1988), a scale developed for

military veterans but adapted for civilian use.

Prevalence of PTSD varied across the articles, with Hardt et al. (2020) reporting 30%, Tehrani (2004)

reporting 67.7%, and Sprang (1997) reporting 68.9% of their sample reaching clinically relevant

symptoms of PTSD. The Hardt et al. (2020) sample can be differentiated from the others as it

included participants who had friends (58.6%) die in RTCs, whereas Sprang (1997) and Tehrani

(2004) had direct family members die in RTC. This disparity would suggest that familial relationships

can impact the intensity of the grief reaction. Data from Lenferink et al. (2022) would support this

interpretation; the death of a spouse or child was significantly associated with both PGD and PTSD.

Contemporary research (Hardt et al., 2020, Lenferink et al., 2021,2022) has begun to assess PGD

since its inclusion in the DSM-5 text revision (DSM-5-TR; American Psychiatric Association, 2020) and

International Classification of Diseases (11th rev.; ICD-11; World Health Organization, 2018). To

assess PGD, Lenferink et al. (2021;2022) used the Traumatic Grief Inventory Self-Report Plus (TGI-

SR+, Boelen & Smid, 2017), and Hardt et al. (2020) measured PGD with The Prolonged Grief–13 (PG-

13; Prigerson et al., 2009). Lenferink (2021) found that, of their sample, 46% reached clinically

relevant levels of pathological grief. While for Hardt et al. (2020), only 10% reached clinically

relevant levels of pathological grief. Again, this lower score could be due to the high rate of people in

the cohort who had friends rather than family members die in RTC. Higher levels of PGD were

associated with help-seeking; Lenferink (2021) reported that higher PGD levels increased the

likelihood of the self-reported need for or use of psychotherapy and support groups. However,

Lenferink (2021) did not consider the use of social support networks such as friends and family.

Two articles assessing PGD analysed the comorbidity of PGD with PTSD. Hardt et al. (year) found that

in their sample of those who screened positive for PTSD, 30% screened positive for PGD and all who

screened positive for PGD screened positive for PTSD. Using a structural equation model, Lenferink

(2022) assessed associations between posttraumatic anger, PGD and PTSD symptom levels. They

found a distinction between anger in PGD and PTSD; specifically, anger toward oneself was the only anger domain significantly associated with symptom levels of PGD. Anger toward oneself and a desire for revenge significantly relate to PTSD levels. While Hardt et al. (2020) demonstrate overlap in PGD and PTSD, Lenferink (2022) demonstrate that the two can be differentiated by understanding the nature of anger the bereaved person holds and whom it is directed towards.

Along with PGD, researchers sought to understand associations between PTSD and other mental health outcomes, including depression, anxiety, and anger. Two articles reported a strong correlation of depression with PTSD (Hardt et al., 2020; Tehrani, 2004). Tehrani also reports a strong correlation between anger with PTSD. Different expressions of anger were explored by Lenferink (2022). It was found that mean levels of anger at perpetrators were higher than anger at the criminal justice system, anger at third persons, anger at oneself, and a desire for revenge. However, they found that anger at the justice system was not associated with PGD or PTSD. Sprang (1997) reports a moderate negative correlation between satisfaction with the criminal justice system and PTSD.

Gender appeared to be associated with PTSD across three articles where it was assessed. Sprang (1997) reported that 68.9% of the participants who reached clinical levels of PTSD were female. ANOVA determined that female victims report significantly higher levels of PTSD than male victims and their nonvictim counterparts. Lenferink (2022) reported that female participants were significantly more likely to reach clinical levels of PTSD and PGD. In contrast, Hardt et al. (2020) report weak correlations of gender with PGD, PTSD cluster B (intrusion) and cluster E (Arousal and Reactivity) but not with PTSD.

Across the theme of PTSD and PGD, the limited research has been mostly consistent, with one article reporting contradictory findings (Hardt et al., 2020). The picture that emerges from the research is that people who have a family member die in an RTC do appear to be at risk of developing PTSD and, to a lesser extent PGD, along with other mental health outcomes, such as depression. It would appear that the death of a direct family member is a more significant risk factor for PSTD than the

death of a friend, and this could explain the discrepancy between Hardt et al. (2020) and the other articles. Being female was also significantly associated with PTSD. People's interpretation of their anger and where it is directed appears to play a role in developing PTSD and PGD. While PTSD and PGD appear to share similarities, such as anger at self and can be comorbid, a potential desire for revenge can be more indicative of PTSD.

Further qualitative research is warranted to establish how the bereaved understand the nature of their distress and grief. Do they view their bereavement as traumatic or their grief as a disorder? Furthermore, the research reviewed here adds to the evidence that people bereaved by RTCs experience intense distress that can be categorised as PTSD or PGD; what is not addressed is how and when to offer support.

2.3.2 Impact on Family Dynamics

Another theme identified in the literature is the impact of RTC on family functioning, with the papers investigating family functioning from different perspectives. Some research investigates how families support one another after a bereavement. In comparison, others explore the experience of bereaved spouses and parents. This was present across four articles that specifically focused on the impact of RTC on family functioning. Two articles used qualitative methodologies: grounded theory (Breen & O'Connor, 2011) and thematic analysis (Attwood et al., 2022), and their participants had lost family members, including spouses, children, siblings, and parents. The two articles, Bolton et al. (2013) and Lehman et al. (1987), used quantitative methods. Bolton et al. (2013) focused solely on parents who had a child who died in RTC, while Lehman et al. (1987) assessed the experiences of both people who had a spouse die and separately people who had a child die. The results of these studies demonstrate that families are impacted in various ways, from difficulties in supporting one another, strains on relationships, divorce, and financial impacts. This suggests that grieving families may struggle to support one another, and external professional support may play a role in maintaining relationships following an RTC bereavement.

Families turn to one another for support after a loss; however, research shows that the support they seek may not always be available in family networks. Breen & O'Connor (2011) suggest that following the death of a loved one, families may work together, but bereavement may precipitate long-term estrangements within families. Attwood et al. (2022) refer to the ripple effect the RTC death had on their family dynamic and the strain the bereavement placed on their relationships. It becomes difficult for people to find support from their families as other family members are also grieving (Breen & O'Connor, 2011). This pattern was also noted by Attwood et al. (2022), who found that their participants expressed the strain this placed on some of their relationships, *"I think the hardest thing definitely between myself and my sister is our relationship has been quite challenging."* The cause of the challenges can be due to different ways of grieving, especially regarding emotional expression, remembering and talking about the deceased loved one, and seeking professional help; people quickly recalled instances where their families were not supportive (Breen & O'Connor, 2011). People who had a sibling die reported feeling overlooked, excluded and unheard by their parents, leading to resentment.

Death, in many cases, serves to exacerbate existing issues and problems within a couple's relationship (Breen & O'Connor, 2011). Participants described instances where they fought, usually verbally but sometimes physically, with their spouses because they felt they were not supported or understood by them, or they blamed each other for the circumstances that led to their loved one's death (Breen & O'Connor, 2011). Female participants discussed situations where they were in a long-term relationship with a man who was not the father of their deceased children; their grief was disenfranchised due to their partner appearing unable to understand and unwilling to talk about the deceased child or their partner's experiences of grief. Women reported bearing the weight of supporting family members after being bereaved. They report that they have taken on a critical supportive role in maintaining a semblance of normality in the extended family unit (Breen & O'Connor, 2011).

The quantitative data also supports the impact of a child's death in RTC as potentially destabilising a relationship. Bolton et al. (2013) report that parents were more likely to be single after their child's death than they were in the two years before the death. Similar findings by Lehman et al. (1987), who report in their parent study that 8 of the 41 bereaved participants had divorced since their child's death, compared to the control group, where only one out of 41 had been divorced during the same period. Bereaved parents appear more likely to divorce after their child dies in an RTC due to a lack of support, fighting and uneven distribution of responsibilities (Breen & O'Connor, 2011).

The research also identifies a financial impact and potential strain on familial relationships. In their spouse study, Lehman et al. (1987) found that the mean family income reported by the bereaved respondents was $22,000 compared to a mean of $29,500 for controls. This may be expected when a family lose an adult. However, Lehman et al. (1987) found a similar rate of financial impact in their parent study, where the mean family income reported by the bereaved respondents was $22,300 compared with a mean of $29,200 for controls.

The available evidence suggests that families may face many extra challenges following a bereavement from an RTC. Grieving family members may face challenges dealing with their grief and that of other family members, and this responsibility seems to fall on women (Breen & O'Connor, 2011). This may strain relationships, and bereaved siblings may feel that their parents ignore them; married couples are at greater risk of divorce, and family finances can come under pressure. Many elements highlighted are worthy of further research to better understand how to support bereaved people when their family network is also grieving. The issue of grieving family members needing support and not finding it within the family is particularly relevant. Where can they turn if they cannot find emotional support in the family?

2.3.3 Service Models and Barriers

Four articles emphasised service models and barriers to accessing services. Two directly researched issues related to models of service provision and provided recommendations (Breen &

O'Connor,2012; Lenferink et al., 2021). The remaining two make recommendations based on

research on people bereaved by RTCs (Breen & O'Connor, 2011; Tehrani, 2004).

Lenferink et al. (2021) conducted a quantitative feasibility study of online self-directed CBT for adults

bereaved by RTCs. In seeking to establish if people bereaved by RTCs would find online CBT

acceptable for service provision, Lenferink et al. (2021) surveyed 273 people who had contacted the

Dutch support service Victim Support. It was found that 149 (54.6%) of their sample had received

psychotherapy for their bereavement care. In Tehrani's (2004) research with the support service

RoadPeace, of 114 participants, 45 (39.5%) received psychotherapy for their bereavement care.

Lenferink et al. (2021) established that, of their sample, 33.1% felt that they did not need any

treatment. The remaining 12.1% had not received treatment but would like to; when Lenferink et al.

(2021) considered only those with clinically relevant PGD, this goes up to 16% of those who would

like to receive treatment. Lenferink et al. (2021) also assessed predictors of help-seeking. The factors

that predicted support seeking include being younger, having a higher educational level, having

experienced the loss longer ago, having obtained psychological support prior to the loss, reporting

higher pathological grief levels, and significantly increasing the likelihood of the self-reported need

for, or use of, psychotherapy.

Table 4 Barriers to Support Services (Lenferink et al., 2021)

Barriers to accessing support services	% agreement
No emotional problems	31.4
Problems will naturally disappear	23.5
No one can help	17.6
It too painful to talk about the loss	13.7
Difficult to find help	11.8
Uncomfortable discussing with other	9.8
Transport concerns	5.9

When asked about barriers to support, participants in Lenferink et al.'s (2021) research who reported

clinically relevant PGD reported the barriers presented in Table 3. Breen & O'Connor (2011) noted

that services assume that people who require help are aware that they need help and are willing and

able to seek help; they support this with reference to other research identifying the very experience

of grief reduces the likelihood of recognising a need, asking for and receiving help, and being able to

find a suitable service (Prigerson et al., 2001). This may explain why bereaved people who meet

clinical levels of PGD do not feel they need to seek support.

Where Lenferink et al. (2021) explored the provision of a specific modality of treatment (online CBT),

Breen & O'Connor (2012) conducted a review of road trauma services in Australia. Breen & O'Connor

(2012) proposed 22 recommendations for the development and operation of a comprehensive road

trauma support service in Western Australia (WA) (Appendix A). Breen & O'Connor (2012)

researched various service provisions, both regional and national, in Australia for people impacted by

RTCs (injured, bereaved and witnesses) combined with the literature on trauma and bereavement

support. While these recommendations are made for WA, they are informed by practice and

research links and potentially apply to other contexts.

The findings and recommendations from these articles highlight still unexplored areas of research,

such as bereavement service links with Family Liaison Officers (FLOs). Furthermore, there is sparse

research on bereavement support for people bereaved by RTCs.

2.3.4 Understandings of Grief

Two articles discussed variations in the understanding of grief by professionals and lay people. A key

theme in the bereavement literature is that every grief experience is unique and dependent on many

variables. These articles discuss the impact these inconsistent discourses around grief can have on

those recently bereaved. Growing theoretical and empirical evidence demonstrates the limited utility

of 'normal' grief to capture all grief experiences (Breen & O'Connor, 2009). Through their research,

Breen & O'Connor (2009;2012) have identified the dominant discourse of grief, including:

- Grief follows a relatively distinctive pattern regardless of the circumstances of the loss, as
  though 'grief is grief.'
- Grief is short-term and finite.

- Grief is a linear process characterised by shock, yearning and recovery stages.

- Grief is a process that needs to be 'worked through', which entails grieving in a certain way with the appropriate emotional expression.

- Grief culminates in detachment from the deceased loved one, and the continued attachment to the deceased is abnormal, even pathological.

Overall Breen & O'Connor found that their participants resisted these pervasive conceptualisations that construct grief as a stage-based and short-term phenomenon with pathological variants. They wanted to be listened to rather than being told what to do or what they needed. Many of the participants found ways to normalise their grief experience by recognising cultural norms; many of the participants were able to accept their grief experience as normal and no longer judged themselves by a grief 'standard' (Breen & O'Connor, 2009). Others resisted dominant grief discourses and described their grief as oscillating rather than linear, consistent with the Dual-process Model (Stroebe & Schut, 1999).

Bereaved people can potentially encounter these unhelpful discourses of grief from family, friends, and the media. These findings suggest a need for well-trained and skilled professionals who can support people bereaved by RTCs in a sensitive manner and formulate grief collaboratively with their clients.

2.3.5 Criminal Justice System

Post-crash experiences may further compound the psychological impact of bereavement from an RTC. These experiences may include interactions with police, hospital personnel, mortuary attendants, coroners, or magistrates. For many, interactions with police and the criminal justice system can be a new and daunting experience. The bereaved may find that the justice process does not follow as expected (Attwood et al., 2022). Thus, in addition to family bereavement, the justice system, sentencing, and related processes pose further social and mental health challenges. For

example, the experience of a court trial leaves family members with the sense that the victim feels less important than the perpetrator (Attwood et al., 2022).

As previously discussed, anger at the criminal justice system was not associated with PGD or PTSD. However, Sprang (1997) reports a moderate negative correlation between satisfaction with the criminal justice system and PTSD. While satisfaction with and anger toward the criminal justice system are different questions, these results appear contradictory. Family members may view the different components of the criminal justice system as separate entities and be less angry with one element than another. Tehrani (2004) found that bereaved family members rated their satisfaction with police at 45%, while Crown prosecution rated at 25% and the courts at 16%. Police have multiple roles when it comes to RTCs, including; Investigating Officer, Coroner's Officer, Forensic Collision Investigator and Family Liaison Officer (FLO) (College of Policing, 2023a). These roles cannot be captured by asking about satisfaction with 'police' given the many and varied roles. FLOs work with the family to ensure their rights to receive all relevant information connected with the enquiry, subject to the needs of the investigation (College of Policing, 2023b). The supportive role of FLOs leads Breen & O'Connor (2012) to recommend re-establishing a Family Liaison Officer in WA Police's Major Crash section.

2.4 Quality of Papers

The Critical Appraisal Skills Programme (CASP) Qualitative and Quantitative Checklists (2017a, 2017b) were used to assist in the assessment of quality in the 11 papers identified in the literature review. CASP checklists are critical appraisal tools developed to help health professionals assess the quality of research in order to ensure that medical guidelines are evidence-based. The quantitative checklist covers twelve critical criteria for judging the quality of a piece of quantitative research (see Appendix B), whilst the qualitative checklist covers ten critical criteria for judging the quality of a piece of qualitative research (see Appendix C).

The review of each article against the quality checklists disclosed that the research reviewed was generally of good quality, with a few articles lacking rigour. Only one article (Bolton et al., 2013) satisfied every criterion included (12 on the quantitative checklist). Another four articles meet most of the criteria and offer rigorous and credible research which can contribute to understanding the experience of people bereaved by RTCs (Lehman, 1987; Lenferink et al., 2021; Lenferink et al., 2022; Sprang, 1997). The remaining two articles (Hardt et al., 2020; Tehrani, 2004) had limitations in the quality of research design, data collection and analysis, and recognition of confounding variables. Limitations included; not addressing a focused issue (trying to address too many research questions), clarity around the sample population (inclusion/exclusion criteria), needing more accurate measurement (use of unvalidated questionnaires), and not identifying confounding variables. Overall the findings from the reviewed research offer insight into the experiences of those bereaved by RTCs. However, the literature review has highlighted the lack of research focusing on those bereaved by RTCs.

A limitation shared by the two articles was the inclusion of two research cohorts (Lehman, 1987; Tehrani, 2004). Considering two cohorts in one article leads to answering multiple research questions in one paper. Lehman et al. (1987) dealt with this more successfully, and the article remained clear in its aims and findings. However, Tehrani (2004) reported two cohorts (people injured and bereaved by RTCs) with some crossover between the cohort's presentation of analysis and results communicated by the cohort or entire sample, confounding the results.

A review of the quantitative articles discloses that the research was generally of a high quality overall with some limitations. None of the qualitative articles satisfied all criteria included in the checklist, with the consistent limitation of needing more self-reflexivity of the researcher. Two articles failed to address ethical issues (Attwood et al., 2022; Breen & O'Connor, 2012). Apart from self-reflexivity and ethical issues, the four quantitative research articles meet all other criteria and offer rigorous and

credible research which can make a valuable contribution to understanding the experience of people

bereaved by RTCs.

The current body of evidence was primarily based on the experience of white, well-educated,

heterosexual men and women from Australia, Europe, and North America.

2.5 Summary of Research Literature and Clinical Relevance

Reviewing and synthesising the literature suggests that people who have had a family member die in

an RTC may have an elevated risk of PTSD and PGD, along with comorbid depression and anxiety.

Social and emotional support from family may be difficult to access from other family members who

are also grieving, making access to professional support services essential to fulfil that need.

However, people are not often aware of how to access support, or grieving people may not know

that they need support. Grieving is an experience unique to each individual; this can lead to friction

in families when ways of grieving clash. Societal understandings of grief based on outdated research

may be the dominant discourse of grief that bereaved people come into contact with and does not

fit with their experience of grief. Contact with police and courts can be a new and stressful

experience for the bereaved; the research demonstrates that satisfaction with the criminal justice

system is a factor in the distress the bereaved experience. Recommendations have been made as

the elements required in effective support service for road trauma. These recommendations address

many of the issues that arise in the literature. In brief, these recommendations are, establishing an

organisation that provides a free region-wide service with appropriately trained therapists that

works with police FLOs.

2.6 Research Aims

In 2021, a total of 1558 people died in RTCs on roads in the UK, more than double those killed in

homicides and terrorism combined (DfT, 2022). As a result, a considerable cohort of the UK

population will be bereaved; these bereaved people are children, spouses, parents, and siblings

(Savigar-Shaw, Turner & White, 2022). Many bereaved individuals experience intense grief that may result in PTSD or PGD/PCBD. For those seeking support for their grief, services in the UK operate at national and regional levels, such as Aftermath, Brake, RoadPeace, Road Victims Trust, and SCARD (Savigar-Shaw et al., 2022). However, there are inconsistencies in the support available across the UK, with some terming it a postcode lottery (Savigar-Shaw et al., 2022).

 Given the findings from the literature, there is a need for support for people who RTCs bereave, but the question remains, what is good support? There is a need to evaluate the support offered and develop a context-specific evidence base (Attwood et al., 2022; Hewison et al., 2020). RVT is well placed for research to understand what supports people whom RTCs have bereaved in dealing with their grief. In light of the above, the main aim of this research is:

> *To understand what supports people who RTCs have bereaved to build hope and continue.*

- *What aspects of counselling are considered by RVT clients to be effective in supporting them with their grief?*

- What practical support is considered by RVT clients to be effective in supporting them with their grief?

3.0 Methodology

3.1 Overview

This chapter begins by describing Grounded Theory and the rationale for its use in this research. Data collection strategies when reviewing annual reports, feedback, and interviews are explained, and details of the participant recruitment process are provided. Ethical considerations for this research are discussed, along with steps taken to ensure participant safety. Consultation with Expert-by-Experience (EbE) is also discussed. The data analysis process is described detailing how data were interpreted and how constructions of the data developed over time. Finally, the decisions and actions taken to ensure the quality of this research are discussed with emphasis on steps taken to ensure the rigour and credibility of the findings.

3.2 Design

3.2.1 Critical Realist Grounded Theory

Discovered by Glaser & Strauss (1967), Grounded Theory is a research methodology that aims to develop theory through an inductive process of synchronous data collection and analysis. The goal is to develop a theoretical understanding which is 'grounded' in the data. The grounded theory researcher aims to systematically proceed from categorising data related to the subject of an investigation to linking data into categories. Through this process, an explanation of the context-based subject will emerge (Glaser & Strauss, 1967).

Grounded theory has evolved in methodology and epistemology (Chun Tie, Birks & Francis, 2019). From its earliest inception, Grounded Theory took a critical realist position from which new theory was thought to 'emerge' from data, implying the discovery of properties of underlying reality (Willig, 2016). Critical Realism posits that reality, including the social world, is a layer-open system of emergent structures (Vincent & O'Mahoney, 2018), such as social realities as constituted by humans that participate in events and make sense of them (Willig, 2013). Critical realist grounded theory

addresses both the event itself and the meanings made of it (Oliver, 2011). Because of the unique

methods utilised in Grounded Theory research, it is possible to identify instances where Grounded

theory is indicated (Birks & Mills, 2015); these include:

- When little is known about the area of study

- The desired outcome is to generate a theory with explanatory power

- The phenomenon of investigation contains a process we seek to construe

This project meets all the criteria indicating Grounded Theory as an appropriate research

methodology. More qualitative research needs to be conducted on assessing how dedicated services

for people bereaved by RTCs support and nurture people to build hope and continue living

successfully. Granted, there exists a body of empirical papers that seek to understand how people

bereaved by sudden or violent events experience grief. This research literature does not specifically

focus on RTC-related bereavement or how to support the bereaved. We seek a theory to explain how

RVT's actions support their service users. Therefore, Grounded Theory is an ideal research method

for this project by building a model for effective bereavement support based on data from those

receiving the support.

3.2.2 Consideration of other methods

Consideration was given to Interpretative Phenomenological Analysis (IPA). Phenomenological

research explores how participants make meaning of their lived experiences (Willig, 2013). This is

achieved by the researcher identifying the underlying assumptions in the person's account of their

experiences and making these explicit (Willig, 2013). Although an IPA method was considered for the

present research, it was ruled out as it requires participants to provide a detailed verbal account of

their experiences, which could be more difficult for people bereaved by RTCs. People who have had a

loved one die often report intense and unexpected emotions during research interviews when

questioned about the death (Williams, Woodby, Bailey & Burgio, 2008). Furthermore, IPA does not

focus on processes within an experience, so it may have been less helpful in generating a theory of what helps people bereaved by RTCs.

Narrative Analysis originated from narrative psychology and is concerned with how people construct stories about their lives and the societal discourses they draw from to tell them (Squire, Andrews & Tamboukou, 2013). This method would have been valuable in the present study in analysing how people make sense of their stories of transitioning from sudden and traumatic bereavement to living a full life, how they construct those stories, and to what effect (Willig, 2013). However, the Grounded Theory methodology was more suited to the goals of the present study as a means of exploring a sparsely-researched area and generating a theoretical understanding of peoples' experiences.

3.2.3 Sources of Data

The first source of data in this research was annual reports published annually by RVT from 2012 to 2023. As a charity, RVT is obliged by law to publish annual reports explaining its charitable purposes and what it has done during the year to carry out those purposes (The Charity Commission, 2013). RVT's annual reports include data on referrals, a message from the chief executive, and feedback from past service users regarding their experience of RVT—a core tenet of grounded theory that 'all is data' (Glaser, 1998). More broadly speaking, Charmaz (2014) states that data should be gathered so that it captures a range of contexts and provides rich detail. Having diversity in data used strengthens the credibility of the Grounded Theory (Birks & Mills, 2015). These reports offer insight into the organisation's views of itself, an overview of the organisational structure, and insight into the feedback shared with the public. It should be acknowledged that there may be bias in the information presented in these reports.

Across the reporting period 2012 – 2023, RVT has published service user feedback and stories of fifty-five clients in their annual reports. This was the first source of data to be coded. Another source of data was individual interviews. Interviews have been a useful data-gathering method in various methods of qualitative research (Charmaz, 2014). Through dialogue with the participant, the

interviewer seeks to understand the topic by hearing about their experiences (Charmaz, 2014).

Interviewing lends itself well to interpretive inquiry; it facilitates the researcher building rapport with

the participant and as it enables in-depth exploration of a topic (Charmaz, 2006, 2014). Therefore,

semi-structured interviews were chosen, allowing the flexibility and structure to move iteratively

between data gathering and analysis, which is essential to Grounded Theory (Charmaz, 2014). Semi-

structured interviews permit data gathering in stages, beginning with open explorations of

participants' experiences, and later, allowing for following theoretical leads, interviews may be

adapted to gather more focussed data.

RVT annual reports also publish statistics on referrals by gender, ethnicity, and relationship to the

RTC. These data will also be considered in this analysis.

3.3 Ethics

3.3.1 Ethical Approval

This study was approved by the University of Hertfordshire research ethics committee protocol

number: LMS/PGR/UH/05131 (see Appendix D). Ethical practice throughout the research was

informed by the Code of Human Research Ethics (British Psychological Society [BPS], 2014).

3.3.2 Ethical Considerations

3.3.2.1 Informed Consent. Interviewing the bereaved about experiences related to a loved

one's death can compromise respondent privacy and dignity by evoking painful disclosure, sad

memories, and overwhelming emotions (Williams et al., 2008). Researchers investigating

phenomena adjacent to death must be aware of this and ensure their participants fully know what

they consent to. Participants who expressed interest in the study were sent an email information

sheet explaining the study's goals, potential risks and benefits, and their right to withdraw (see

Appendix E). Participants were given time to read the information and ask questions via email or

phone. Before interviews commenced, the researcher discussed with the participants the study's

goals, potential risks and benefits, and participants were asked to sign a consent form (see Appendix F).

3.3.2.1 Managing potential distress. Due to the topic's sensitive nature, participants were informed that they could take a break during the interview, skip any questions they were uncomfortable answering or end the interview at any time.

3.3.2.2 Role confusion. Role conflict can occur in interview research on emotive topics where researchers can be mistaken for clinicians (Williams et al., 2008). From the participant's perspective, a face-to-face interview with an attentive and empathic researcher is difficult to distinguishable from counselling. In order to maintain professional boundaries while attending to potential help-seeking behaviour from respondents, it is communicated to participants in advance that counselling support may be sought both in pre-briefing and debriefing. Interview guides were designed so that participants were not asked direct questions about their bereavement.

3.3.2.3 Confidentiality and Anonymity. The participant information sheet described how anonymity and confidentiality would be maintained, including removing any identifying information, using pseudonyms, and storing data in password-protected files.

3.3.2.4 Access to Participation in Research. Ethical and methodological implications of the interview setting have been considered in the literature (Williams et al., 2008). Qualitative researchers typically adhere to one mode of communication for interviews. However, with technological improvements, growing options for researchers wishing to conduct interviews are available. Online interviews permit face-to-face, real-time conversation and sharing of some non-verbal communication. Different data collection methods will appeal to different people and may improve access to participation in research (Heath, Williamson, Williams & Harcourt, 2018). I discussed this with my EbE, and they reported that giving participants a choice of venue would be the best option because people impacted by RTCs may have a phobia of travel by road, and this

opinion is supported in the literature (Tehrani, 2004). Therefore, interviews were offered online (MS

Teams), face-to-face in an RVT office or at the person's home.

3.3.2.5 Safety Precautions. During interviews at RVT offices, RVT staff were in the

building. A lone working procedure was employed for face-to-face interviews in participants'

homes, in line with the University procedures. This included establishing a checking-in and

checking-out procedure by SMS message with a colleague to ensure someone was always aware

of the researcher's location during interviews.

3.4 Consultation with Experts by Experience

An Expert-by-Experience was recruited for the project by contacting RVTs Ambassadors and asking

for people to consult on the project. One person agreed to act as a consultant; they had used the

services of RVT after their spouse was killed in an RTC. They were consulted on the appropriateness

of the questions and the language used, and adaptations were made accordingly. They also gave

feedback on aspects of research design. The feedback was taken on board and applied to aspects of

design and materials.

3.5 Procedure

3.5.1 Participants

3.5.1.1 Recruiting participants. Participants were recruited online through social media platforms

LinkedIn and Twitter, with the support of RVT social media. A poster advertisement was posted on

these platforms with contact details for the principal researcher. Inclusion criteria included being a

United Kingdom resident, over 18, and having used the services of RVT after being bereaved by an

RTC (see Appendix I). Based on the data it was deemed necessary to interview RVT counsellors. Two

RVT volunteer counsellors and an RVT coordinator were also interviewed. They had between three

and six years of experience working with RVT. All were White British females and non had personal

experience of RTC bereavement.

3.5.1.2 Inclusion exclusion criteria. Participants were adults who had used the services of RVT following the death of an immediate family member (spouse, parent, child, sibling, or grandparent) in an RTC, RVT counsellors and coordinators. Due to the focus of the research on bereavement, people who used the services of RVT having been involved in an RTC as an injured person, a driver, or a witness were excluded. People under the age of eighteen were not considered eligible for this research due to the impact of trauma in children depending on the life stage and bereavement interventions for adults and children differing (Krupnick, 1984).

3.5.1.3 Demographics of participants. Feedback from fifty-five people who used the services of RVT from 2013 to 2022 was analysed. This feedback was given anonymously. Four people who were bereaved by RTCs were interviewed; three were female. The participants were all close family relations to the person who died (a mother, a father, a daughter and a wife). All were White British and aged between 40 and 50.

Two RVT volunteer counsellors and an RVT coordinator were also interviewed. They had between three and six years of experience working with RVT. All were White British females. Based on the data, efforts were made to recruit an FLO to interview. While contact was made with an FLO and multiple dates for interviews were set, no interview could be conducted. Various challenges resulted in cancellations, such as illness, shift work and the FLO picking up new fatal RVTs to work.

3.6 Data Collection

3.6.1 Evolution of the interview guide

Within a Grounded Theory methodology, data collection and analysis occur concurrently (Charmaz, 2014). An interview guide was developed following an analysis of textual data in the RVT Annual Reports. The interview was grounded in the data from the RVT service user feedback and the research question; questions covered the experience of people bereaved by RTC in using the services of RVT. The initial interview guide comprised open-ended questions to elicit an initial broad view of

key aspects of participants' experiences of using the services of RVT. Questions were asked slowly,

with clarifying fillers offered to prompt participants' reflections and directions (Charmaz, 2014). As

concepts and categories were developed, the interviews became more structured to explore

particular aspects of participants' experiences further. Having written a research proposal, met with

an EbE, and conducted a systemic literature review, I had preconceived ideas about what participants

may discuss. In an attempt to keep the initial interview schedule grounded in the research question

and protect my knowledge and constructions of the topic, the initial interview guide was open, and

attempts were made to follow participants' leads to gather information related to their own

experiences.

The initial interview schedule was used for the first three interviews. Each interview was analysed,

and the key ideas developing were influential in subsequent interviews. The concepts that emerged

from these early interviews informed the questions and topics of subsequent interviews. For

example, a possible conflation between the roles of counsellor and FLO emerged in the first round of

interviews. Based on this finding, it was decided to attempt to recruit and interview counsellors and

FLOs. The interview guide was adapted and evolved throughout the research as leads were followed

up, adapted, or dropped from the developing model. Following the analysis of the interviews with a

counsellor, six tentative categories of experiences were identified. The subsequent interviews aimed

to ask questions about these developing ideas whilst remaining open to understanding unique

experiences.

       3.6.1.1 The interview process. Interviews were conducted in various formats, face-to-face in

participants' homes, in RVT offices, or online via MS Teams. Before each interview, I introduced

myself and gave a briefing about the research project. Time was given for any questions or concerns

the participants may have about the research or interview process. On completion of the interview,

participants were debriefed and given the opportunity to reflect on the interview process and ask

any questions. They were reminded that they had my details on the Information Sheet and could

contact me or my research supervisor with any questions or concerns. All participants were asked if

they would like a summary of the final report.

I recorded my initial thoughts and reflections in a reflective diary following each interview.

Reflections included topics that piqued my interest, the tone of the interview, the ease of

establishing rapport, and any feelings the interview may have evoked in me, in addition to initial

thoughts and ideas about the interview process. These notes served to add context to the interview

and interpretations of the data.

3.7 Data Analysis

The data were analysed using the principles and guidelines for critical realist Grounded Theory

(Oliver, 2011, Kempster & Parry, 2011). The process of analysis within this model begins with line-by-

line coding of the data, in which reflections and memos are written soon after the interview has

taken place. Interviews are then frequently revisited to familiarise oneself with the data. This

involves repeatedly reading transcripts or listening to recorded interviews. Memos are written

throughout the process, noting the meanings in codes and categories, dimensional aspects to

categories, what remains unsaid, and what draws the researcher's attention. Interviews are then

transcribed before analysis is performed. The critical aspects of the analysis process are outlined

below, with examples in the appendices.

3.7.1. Initial coding

I conducted initial coding on NVIVO 12 of the fifty-five feedback vignettes from RVT annual reports

(Appendix H). Each sentence was coded using a line-by-line process. I examined each line to assess

the data's potential theoretical importance and used gerunds as codes (Charmaz & Henwood, 2017).

This process involves analysing the data to reflect the processes underlying the excerpt rather than

just labelling a description of what has been stated. Memos were recorded to capture the meaning

of the code (Appendix I). Early detailed line-by-line coding is intended to 'break open the data to

consider all possible meanings' (Corbin & Strauss, 2008, p. 59) and to move the researcher away

from their preconceptions. The coding begins to make an analytical sense of what is happening in the

data. Grounded Theory initial coding generates hundreds of initial codes, some examples of

categories identified in initial coding include, Criminal Justice System, Tools to Cope, Being on a

Journey, Expressing Gratitude to RVT, Outpouring of Grief, Intrusive Thoughts, Counsellor being

Objective Person, Normalisation, etc.

3.7.2. Interviews

Following each interview, a reflective account of the interview process was written, and memos were

created around critical parts of the interviews that felt important or meaningful. Interviews were

then transcribed verbatim.

3.7.3. Focused coding

Focused coding takes the most significant initial codes to study, sort, compare, and synthesise the

data (Charmaz & Henwood, 2017). A document was created of comparative focussed codes across

the textual data, and for the first three interviews, focused codes were also created for each

interview. Codes from interviews were compared to identify similarities and differences in categories

(Appendix J). Memoing was used to try and illuminate the processes that emerged from codes. I

created a document with focused codes, initial codes, memos, and quotes from the data ensuring

that I understood processes as they related to the data. Focused coding allowed me to begin to

develop key ideas about what I felt was happening in the data.

Using an MS Excel spreadsheet, I sorted initial Codes into columns where the codes had similar

meanings (Appendix K). The columns represented focused codes that would become tentative

categories to explore and analyse. This involved reviewing initial codes that occur frequently or codes

which appear significant in portraying meaning. The initial codes generated across textual data from

feedback and the first three interviews were reviewed, and important or frequent codes were pulled

up to focussed codes. Once focussed codes were developed, they were used to analyse the

remainder of the interviews; the codes were constantly refined and developed as the interviews

were analysed against these codes. Thus, the process of analysis involved constant comparisons across data sets.

Throughout this process, I wrote a reflective diary; this was especially helpful in the focused coding stage as I needed to maintain awareness of influences on category creation. Having completed the literature review and having engaged with RVT prior to the research, I gained some knowledge of what may influence participants' experience. The reflective diary and supervision helped to check these influences on coding (Appendix L).

3.7.4. Developing and Defining Categories and Subcategories:

Once I had completed coding 55 service user feedback submissions and six interviews, I began to synthesise focused codes into tentative conceptual categories and subcategories and aimed to identify the theoretical direction of the results. This involved looking at how focused codes fit together under higher conceptual categories, which helped in how I constructed what was happening in the data. Focused codes that I felt explained key ideas or processes were elevated to categories or subcategories at this stage. For other clusters of focused codes, a category was developed to give a theoretical description of the codes and data.

3.7.5. Theoretical coding

I sought to identify links between codes and form them into higher-level categories where necessary. This involves relying on a process of constant comparison where the researcher compares information between and within categories to interrogate how the properties and dimensions of each category vary under different conditions (Glaser & Strauss, 1967). Theoretical coding is an advanced level of coding that follows the codes selected for focused coding and the categories developed from these (Charmaz, 2014). It involves describing how categories relate to one another as predictions to be integrated into a theory. The idea of these codes is that they integrate the data that has been constructed in order to tell a coherent analytical story (Charmaz, 2014). In doing this,

relationships between categories are identified under theoretical concepts, which help to explain the

data.

In some instances, codes could fit multiple categories; this creates overlaps between categories and

can highlight where categories should collapse into super-ordinate categories. I created tables in

Excel to show where focused codes overlapped across categories. These tables highlighted where

categories may overlap and form part of a super-category and when there may be a relationship

between categories, but they are separate entities. Identifying relationships between categories

helped in identifying interactions and the direction of interactions if they were bi-directional or

unidirectional.

These codes are aimed at explaining processes. The move to theoretical coding was aided by

returning to memos and developing new memos that began to consider hypotheses about the

processes involved in participants' experiences of RVT and how these related to how they rebuilt

their lives. Once categories could no longer be collapsed or no new categories could be identified in

the data, I explored how the relationships between categories could inform a model to explain how

people bereaved by RTC could move from grief to rebuilding their lives.

I drew out the higher-level codes and drew diagrams of the conceptual connections between

them (Appendix M). My initial analysis was shaped by the timeline of events for people

bereaved by RTCs beginning with getting the news of the death, being referred to RVT, and

receiving counselling. This approach gave more weighting to aspects of the client's experience

that did not address the research question. By centring on the grief of bereaved people, the

model could be constructed to show the impact of RVT support and counselling on grief while

also incorporating other environmental impacts such as police investigations and courts. This

stage of analysis culminated with a model outlined in the Results chapter.

3.7.6. Memo writing

Memos were used throughout the analysis and marked an essential process of Grounded Theory. Throughout this research, I wrote memos documenting the process, and my thoughts following the interview, during transcribing and while coding. Memo-writing involves the researcher writing notes throughout the research process to identify tentative categories, define data collection gaps, outline categories, and engage reflexively in the research process (Charmaz & Henwood, 2017). An example of my memos can be found in Appendix XX. This process is described by Glaser (1978, p. 83) as the 'bedrock of theory generation'. Memoing enabled me to reflect on what I brought to the research, capture my emotional reactions, note new information, reflect on patterns in the data, and make comparisons between participants. Memos were helpful in comparing and contrasting ideas across interviews and guided the theoretical direction of the analysis. Memos also served as a data trail for developing ideas and theories constructed throughout the research.

3.8 Quality Assurance

3.8.1 Quality assurance

It has been argued that in the quest to evaluate the quality of qualitative research, qualitative researchers have mistakenly used the standards of quantitative research as a metric (Elliot, Fisher & Rennie, 1999). As a result, some qualitative researchers have sought to develop quality standards to assess qualitative research in a manner more suited to qualitative research. The goal of developing these standards is to provide guidelines for identifying high-quality research that is rigorous in its methodology and credible in its findings. To assess the quality of this research, I will use the CASP tool used to assess the quality of the research in the Systemic Literature Review.

3.8.2 Awareness of my own perspective

Reflexivity is one of the quality indicators of qualitative research; it enables readers to understand the research process and findings in the context of the researcher's position (Elliot et al., 1999; Tracey, 2010). Another indicator of good qualitative research is openness to other perspectives in the

analysis. At each stage of analysis, consultation with EbE, peers and supervisors aided in opening my

mind to new perspectives on the data, new questions to explore and checking my assumptions.

Member checking the model with an EbE ensured the model was general enough to incorporate

various experiences. Grounded Theory workshops with other grounded theory researchers during

both the coding and theory-building stages of analysis opened up new ways to understand the data.

People who have been bereaved by RTCs are given a Brake Pack by the police officers who inform the

family of the death (College of Police, 2023b), or as participants named it, the "Green Book". I could

not get a hard copy of the Brake Pack, so I accessed it online. Reading the pack gives an insight into

the scale of practical challenges facing bereaved people, from dealing with police, insurance

companies, solicitors, financial difficulties, courts and planning funerals. While this does not capture

the emotional toll of bereavement, it helped me to gain some insight into the challenges bereaved

people face.

Supervision, peer support, a reflective journal and memos were essential tools in reflecting on

emotional and analytical responses to the research process. While the interview schedule was

designed to not ask specifically for details of bereavement, participants who had been bereaved

would speak about the death and the person who died. Supervision helped in both planning ahead

for how and when to respond to the death. Peer support and memo writing aided in debriefing after

interviews which often resulted in emotional reactions to the content of the interviews.

I found that the process of conducting a systemic literature review concurrently with data collection

brings new ideas and concepts that become salient in thinking about this research. Discussions with

my supervisor helped me to assess if my thinking about the research was being influenced by my

own preconceptions, by the existing literature or by the data.

4.0 Results

4.1 Overview

This chapter presents an interpretation of the data and proposes a model that represents the aspects of RVT's work that participants who have been bereaved by RTCs believe supported their regaining hope to build new lives. After presenting the model as a whole, I will then go on to describe the individual categories and processes representing different aspects of the model. I will use participant quotations to illustrate the model's categories and processes. Providing a range of quotations allows readers to check their credibility when considering the material presented. These quotes may be edited where appropriate to protect anonymity, for clarity or ease of reading.

4.2 Introduction to the Model

The model presented represents my understanding of the journey people bereaved by RTCs take when supported by RVT to build hope. The red dashed line represents the direct purview of RVT in helping people bereaved by RTCs by providing a counsellor. Counselling for grief is not a linear process, and clients can cycle through varying states of grief depending on their relationship and other external factors (Stroebe & Schut, 1999). Possibly the most impactful external factors are the slow investigation process of RTC, the long time for legal cases to come to trial and the outcome of a court trial.

In many cases, people bereaved by RTCs believe that they are well supported by FLOs who keep them up to date on development in the investigations and help prepare them for court cases. However, this is not always the case. Many bereaved reported feeling that the FLOs do not provide the support and communication they expect. These expectations appear to stem from bereaved people wanting to know as much as possible about the circumstances of their loved one's death.
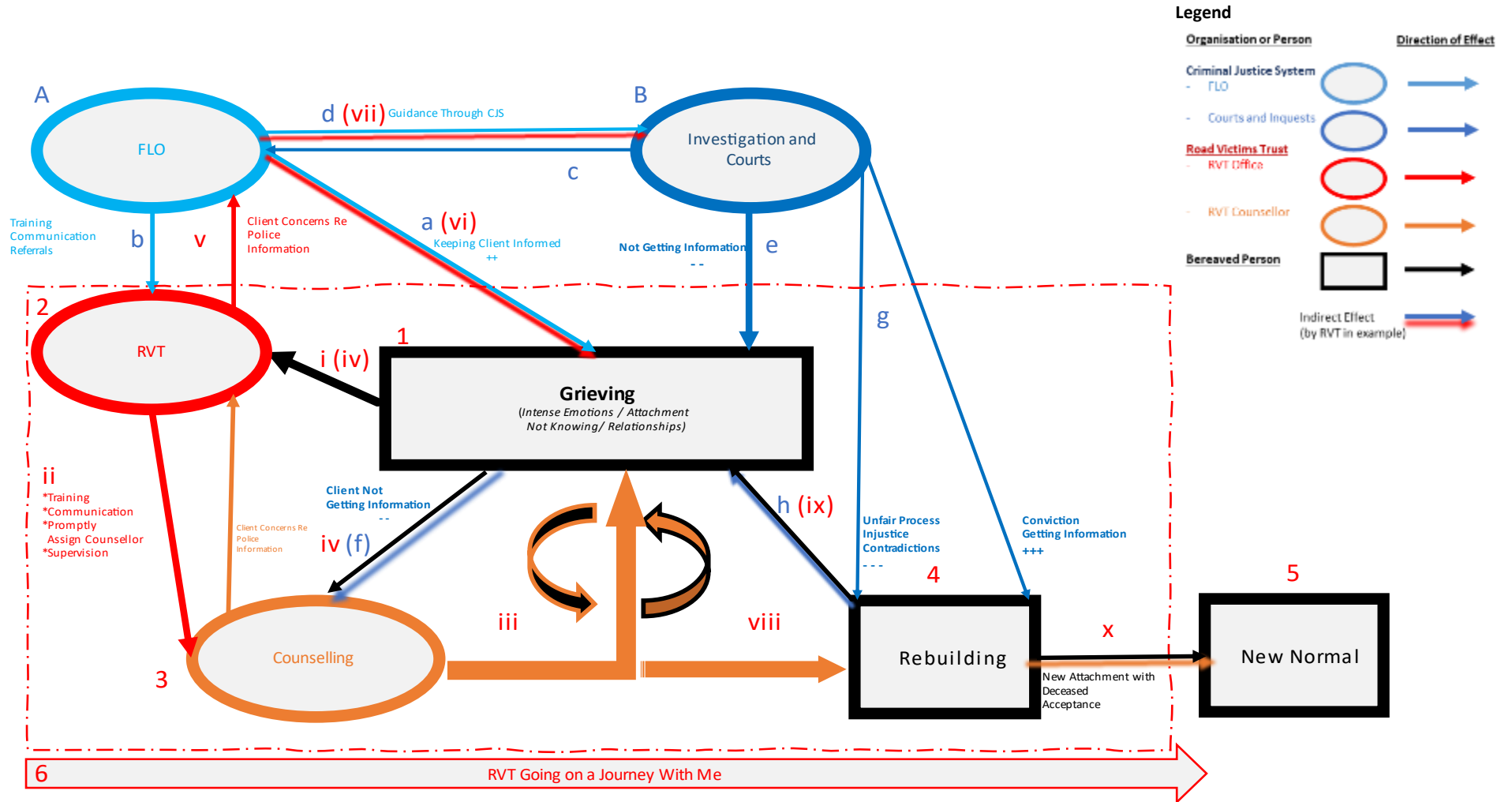
Figure 2: Model of Bereavement Support from RVT
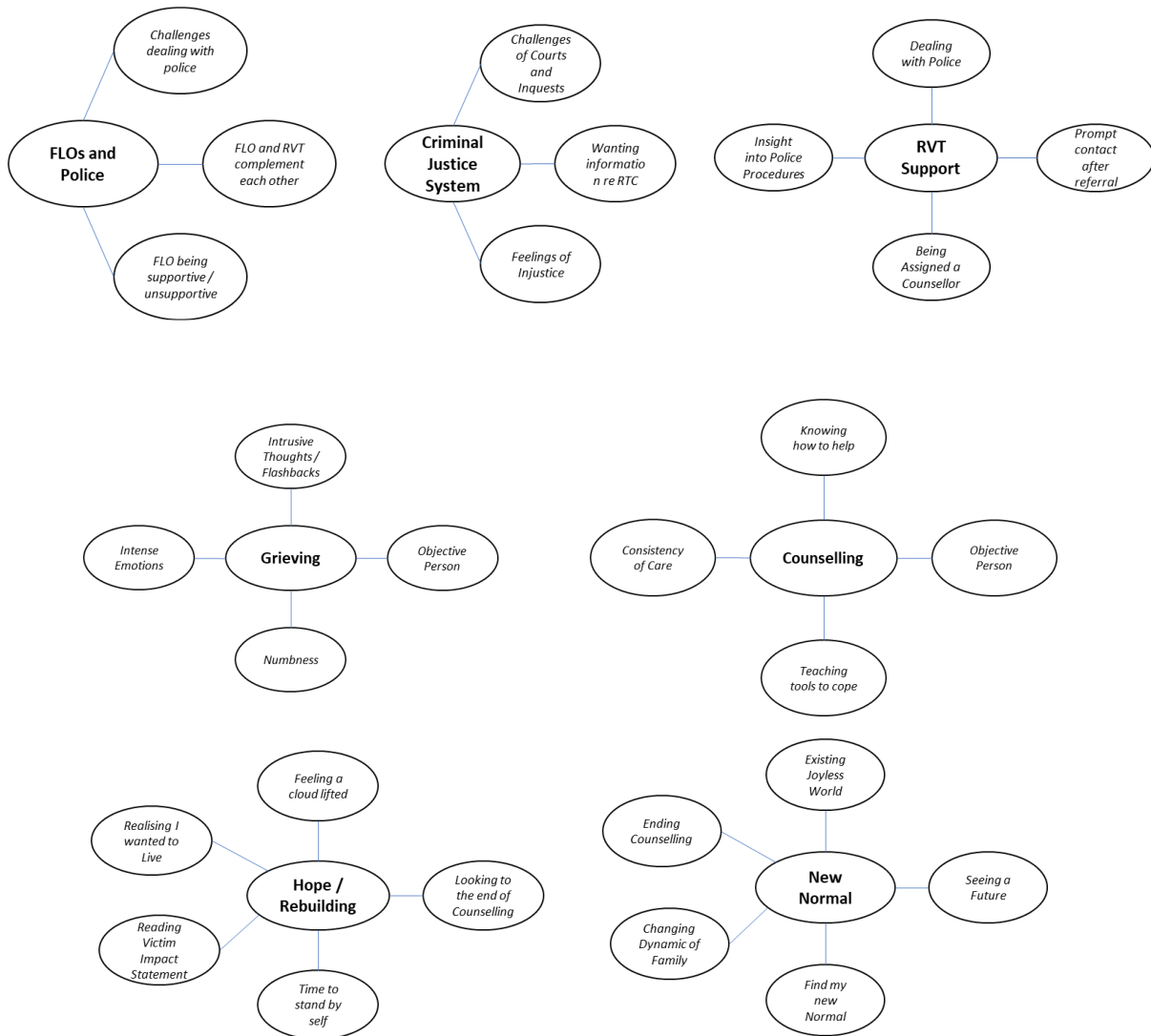
Figure 3 Developed thematic map, showing main Categories and Subcategories

For bereaved people, challenges with communication with the FLO and getting information about

the investigation or court processes can be distressing. These distressing difficulties can impact the

grieving process and be brought to counselling. Black arrows with blue shadows represent these. In

the case where RVT support the bereaved person with the practical matters of managing their

communication and relationship with police, these are represented by the blue arrows with red

shadow.

Throughout these processes, participants feel that RVT accompanies them from their darkest time to

rebuilding a new life between practical office support and counselling.

4.2.1 Bereaved Person RVT Interaction Pathways

Some pathways in the model are considered to overlap. Where overlaps occur, there will be a repetition of the pathway descriptions below.

1	The bereaved person is experiencing extreme emotions, feelings they don't recognise, suffering with the loss of a close attachment, they yearn to know how their loved one died and may be struggling with other relationships.
i	The bereaved person receives the 'Green Book' from police when they are informed about the death of their loved one. FLO makes the referral, or the bereaved person makes a self-referral to RVT.
2	RVT coordinator is assigned and contacts the bereaved to take an assessment of and offer counselling to the bereaved person. RVT-trained counsellors, who receive ongoing CPD and supervision, provide bereaved persons with counselling that meets their needs. Counsellors' training includes learning about grief processes, police investigations, prosecutions, trials, and inquests. RVT coordinators can take requests from counsellors or bereaved persons to resolve issues of communication and frustration with police. For some bereaved persons, speaking with the coordinator may be enough to vent the anger directed at the police.
ii	RVT coordinator assigns a counsellor and sets an appointment for the first counselling session.
3	Counsellors meet weekly with bereaved persons in the early stages; they use their counselling and RVT training to support bereaved persons. This includes having knowledge of grief, being there to listen, helping the bereaved person move at a comfortable pace, and having knowledge of police terminology and procedures.

iii During counselling, the bereaved person and counsellor navigate grief, perhaps cycling through aspects of grief, managing relationships and expectations of the criminal justice system.

iv The bereaved person may bring their frustrations with the criminal justice system to counselling or their RVT coordinator. When the bereaved person brings criminal justice system issues to counselling, the counsellor may pass these on to the RVT coordinator.

v RVT coordinator passes the bereaved person's concerns regarding getting information from police onto FLO.

vi Regular contact with families and keeping them informed helps families to process what happened and can help in managing expectations regarding future legal processes. RVT can support this process by acting as an intermediary when families cannot contact FLO (due to demands of work, sick leave, or annual leave).

vii Along with providing information to families regarding investigations, FLOs can support families by educating them on the legal process and what happens in court or inquests. This is not always possible, and in some cases, RVT fulfils this role.

viii Counsellor highlights to bereaved persons how they have made changes in their life that they never thought possible again (e.g., wearing make-up, dressing well, going out, returning to work, changing jobs, moving house). The bereaved person then begins to notice they have hope for the future.

4 With this knowledge, the bereaved person begins to rebuild their life. If a court case is still pending, they may feel that they cannot move on just yet.

ix If the bereaved person had previously finished counselling, they may return to sessions for the duration of a trial. Trials can be challenging and leave some bereaved persons

feeling that the process is unfair; the defendant's legal team may make claims about their loved one that they find hurtful and may not get the justice they hoped for.

x   When bereaved persons have come to an acceptance of the death of their loved one and or the end of the legal procedures, they are ready to begin living their lives.

5   While they begin to live their lives, bereaved persons are aware that this is a new normal and not the world as it existed for them before the death of their loved one.

6   Bereaved persons speak about RVT being on the journey with them. In their journey through grief, bereaved persons see RVT as a consistent and reliable presence in their lives, one that is with them weekly but also available when other supports around them fail.

4.2.2 Bereaved Person and Criminal Justice System Interactions

A   Bereaved families rely on FLOs to inform them of developments investigating the cause of their loved one's death. They work long hours, can have a large caseload and do not always have access to the information families seek.

a   Regular contact with families and keeping them informed helps them to process what happened and can help in managing expectations regarding future legal processes. RVT can support this process by acting as an intermediary when families cannot contact FLO or feel they are being shut out.

b   The police have a direct referral and data-sharing partnership with RVT; this streamlines the referral process and supports cooperative partnership. FLOs also provide training for RVT counsellors.

B   The police investigation, prosecution, and trials are processes that many bereaved families find frustratingly slow. They long for information about the circumstances of their loved ones' death and justice.

c   Where appropriate, information regarding the investigation and prosecution is shared with FLOs to pass on to family members. Some information held by investigators and prosecution is privileged and will not be made available to be shared with families. Privileged information is preserved for trial.

d   Along with providing information regarding investigations, FLOs can support families by educating them on the legal process and what happens in court or inquests. This is not always possible, and in some cases, RVT fulfils this role.

e   Many families yearn to know the circumstances of their loved one's death. When they are not receiving information, this leaves families feeling that they are out of the loop and frustrated. They can become angry with the police.

f   The bereaved person may bring their frustrations with the criminal justice system to counselling or their RVT coordinator. When the bereaved person brings criminal justice system issues to counselling, the counsellor may pass these on to the RVT coordinator.

g   Events in court, such as perceived preferential treatment of the defendant over the bereaved family, offence taken at statements made about the deceased, and unsatisfactory verdicts, can be complicated for bereaved people to cope with. When bereaved people believe that some level of justice has been achieved, or at the end of a trial, they can begin to rebuild their lives.

h   If the bereaved person had previously finished counselling, they might return to sessions for the duration of a trial. The trials can be challenging and leave bereaved persons feeling that the process is unfair; the defendant's legal team may make claims about their loved one that they find hurtful and may not get the justice they hoped for.

4.3 Detailed Data Analysis

Each category of the model will be presented by considering the subcategories that constitute the

super-category. Each category will be accompanied by quotations allowing readers to check their

credibility. Where a quote comes from an interview, it will be attributed to a pseudonym; where the

quote is taken from feedback, it will]be attributed to initials where present and anonymous with the

year the feedback was provided.

4.3.1 Grieving

Participants described the grief they experienced in the aftermath of the collision. Their memories of

events in the initial aftermath of the collision are vague and "foggy", with an experience of being on

"auto-pilot". They describe the intensity of the emotions they experienced as taking over their lives,

memories and flashbacks of the events triggered by everyday situations. Dealing with the challenges

of everyday life has become too much, and people have begun to avoid driving or going to work.

Grief is impacted by secondary problems such as not getting information about what happened to

cause the collision and struggling with people who do not understand what they are going through.

4.3.1.1 Being in a Fog.

Participants described how they don't remember much after their bereavement. During this time,

the bereaved feel like they are just getting by each day, as Niamh and KH say when trying to recall the

events around that time:

> *I mean, a lot of those first weeks are a bit of a blur. I think, you know, you're just in shock and*
>
> *you're just going through the motions* **– Niamh**

> *The rest is a blur. I just remember the physical pain, the shock, the numbness, the complete*
>
> *and utter despair* **- KH**

For others, this period described discovering their loved one had died as the beginning of a

nightmare:

> *We were taken to the hospital by the police to discover that he had been killed in a road traffic accident. Our nightmare then began* **- CF**

For others, the emotional experience of bereavement became all-encompassing, and they believed it dominated their life.

> *… death was all encompassing; it just took over life in a way I would never have imagined life could be taken over* **- Sean**

Other participants recall the confusion they felt in the aftermath of their bereavement:

> *We often referred to being in a fog; a confusion of madness* **- CD**

4.3.1.2 Intensity of Emotions.

Participants described how grief caused them to be overwhelmed by emotions after learning of their loved one's death. These descriptions include how their grief was expressed physically and emotionally, leaving them feeling incapacitated:

> *I just remember the physical pain, the shock, the numbness, the complete and utter despair* **- KH**

> *At this time, emotionally paralysed, our life stopped* **- CD**

When discussing counselling very soon after her parent's death, Niamh describes how she needed some support coping with her emotions:

> *Although some people probably think you know oh counselling, you know you've only lost them a week. You know, I think in those circumstances, there's so many other emotions* **– Niamh**

Counsellors report that in the early days of their grief, their clients are overcome with intense emotions that feel beyond their control.

> *Everything really. Certainly, in the early days, it's everything. I suppose they're shocked,*
>
> *um, in denial. It can, I guess, for them, it feels really overwhelming. And, disbelief, anger.*
>
> *It's like a massive part of their life has been ripped out. So, everything feels*
>
> *unmanageable; everything feels unbearable -* **Maura**

4.3.1.3 Difficulties Living Life.

Grief also impacted on the participants' ability to function. Participants discussed having difficulties

participating in regular everyday activities; for some participants returning to work was challenging.

> *So, the doctor, in the end, when I did eventually go to the doctor, it was quite a long time*
>
> *after… he signed me off for a few weeks. Then, because they, like, because we were working*
>
> *from home, they increasingly wanted me to go back in, but I couldn't cope, I didn't want to*
>
> *go back in -* **Sean**

Clodagh attempted to continue working but following advice from a nurse at her GP practice, she

took time off.

> *But I'd gone to the nurse and because I'd not seen a doctor in all that time, I just ended up*
>
> *spilling it all out. And she said to me that she felt like I needed to take time out from work* **–**
>
> **Clodagh**

Working from home helped some cope with challenges everyday life brought up such as fear of loud

noises, driving, or passing the scene of the crash.

> *And then, I had a lady working for me and she was very overpowering. And I couldn't cope*
>
> *with her. I could do the job. At home. Because obviously with COVID we'd been sent home as*
>
> *well* **– Clodagh**

While time off work and working from home helped some bereaved people to grieve by maintaining their normal routine, others needed time off work and credited the support of RVT in supporting their return to work.

The support I received from the RVT was crucial to me and being able to return to work **– ET**

Driving was another common difficulty for people after being bereaved by an RTC. Some participants requested face-to-face interviews at their homes so they wouldn't have to drive anywhere. Driving was a particular challenge for some participants as it can be a trigger for them to recall memories.

Some of the trigger points to driving again, so he. There was lorries involved in the accident, there was a tractor involved and initially, you know, seeing those would trigger memories **– Niamh**

Parenting was a challenge for some participants who reported not knowing how to do what was needed each day.

Whilst all of this was going on I still had to be a parent. I had to get out of bed every day and that was becoming very hard…..I knew that I had to create a new life for my daughter, but I had no idea how to even begin that process **- KH**.

Counsellors notice that their clients bring these issues to therapy. Phobias of travelling by car and fear responses to driving have impacts on how people report living their lives.

And sounds and bangs, loud bangs, loud crashes and driving as well when, you know, if they start to drive again, they're like hyper-vigilant. Or they won't drive past the collision site; they'll go all the way around the world to avoid it **- Maura**

4.3.1.4 Needing to Know About the Collision.

Participants discussed the need to know as much about their loved one's death as possible. They seek the information and believe they cannot move on until they have received answers to their questions. For some, this does not come until after an inquest or trial.

> *And I don't actually think you're really in a bit sort of no man's land until you've got to that point.* **Niamh**

Participants discussed *"yearning for information"* **(Clodagh)**, wanting as much as possible, and every piece of information being essential to them.

> *My way of trying to deal with it was I had to know every single detail of events leading up to it, after it I think it's just, you know, you hang on to every single word that you're told and when things then don't materialise from that, it just gives you sort of even more stress -* **Niamh**

> *That's why I think the trial was particularly hard because there's a lot of stuff that came out that we didn't know -* **Clodagh**

When getting information about the investigation seemed slow, participants felt frustration with the police and the process.

> *Yeah, I suppose because we'd been, not messed, I dunno, it felt like we were being messed about, but we weren't. It's just because, you know, there's only a certain amount of things that they were allowed to tell us -* **Clodagh**

> *There was actually the actual circumstances leading up to the crash he gave us wrong information -* **Niamh**

> *When you're told that a time frame of when something's gonna happen that you sort of, so that's in your mind, and when that, when things don't happen in that time frame it just creates extra stress.*

Counsellors notice that their clients can often feel left out of the loop regarding investigations and want answers from the police more promptly. This can often be due to impatience with the slow pace of investigations and the criminal justice system.

> *I think it's not knowing, and it's being left out of the loop. And yeah, not knowing what's going on, and then wanting it to be quicker than, certainly some elements of wanting justice, I guess. And wanting it sooner rather than have to wait* **- Maura**

4.3.2 Counselling

Participants discussed many aspects of the counselling they received, such as how they knew they needed support, how they came to trust and build rapport with their counsellor, how they knew it was time to end counselling and bringing their frustrations with the criminal justice system to counselling.

4.3.2.1 Needing support.

Participants commented that bereavement counselling was often only available after six months; this was too long to wait for them, so they needed help immediately. The fact that RVT were there for them immediately was necessary for these participants.

> *I'm not sure I would be happy to wait six months. I, I needed someone's help immediately. I just needed somebody to talk to that wasn't my family or friend. I needed to talk to them individually. And RVT were there for that. If I'd had to wait six months, I'm not sure how I would have got through those six months* **- Sean**

For Sean, he wanted to speak to people who were not family or a friend; he did not want to burden his kith and kin with his grief as they were grieving too.

RVT state that they offer support for as long as is needed. Endings are achieved through negotiation between the client and counsellor. From the counsellor's perspective, clients end sessions when they begin to notice that they have made changes in their lives (moving house, changing jobs etc). This

can occur before a trial has taken place. Participants often have anxiety about the trial as there is uncertainty that they will get the justice they are seeking. Participants will then pause their counselling sessions and reengage when needed; for other participants, stressful life events may precipitate them returning to counselling. The reasons people reengage with counselling vary, but overall, participants are grateful that they can return and will not be waitlisted.

> *When I stopped having the sessions with them and then you know. Sort of six months later, we were having later. We were then hit by COVID and lockdown, and that for me some ways was good in some ways wasn't so good because I had too much time in my hands to think about things. So yeah, I mean, it probably was a good year or so before I those thoughts didn't really enter my mind anymore.* **- Niamh**

Secondary factors impact the experience of grief; feeling that other people don't understand what they are going through is a common experience reported by participants.

> *As much support as I can because it also feels like quite a lonely time because lots of people have suffered loss, but not so many have suffered loss in this way* **- Niamh**

Counsellors notice that their clients struggle with family and friends when there are contrasting styles in grieving.

> *Sometimes anger, like if people are grieving differently and, sort of, down the line when a period of time is passed, and maybe family and friends because they feel they're insensitive* **- Maura**

In terms of seeking support for other agencies people discussed going to their GP or NHS talking Therapies. For some participants, their GP was not seen as helpful in supporting them with their grief.

they just said, oh, you know, you're in shock, you know. Just, you know, just go with that kind

of thing **– Niamh**

4.3.2.2 Speaking to an Objective Person.

Participants often commented on needing to speak to someone outside the family "…*because*

sometimes you can't say what you want to say to the people you love" (**Clodagh**). This could be for

various reasons, including not wanting to burden their loved ones with their grief or wanting to have

an objective person to speak with.

> *I said all the things to him that I couldn't say to my friends and family and slowly, week by*
>
> *week, I could see that there could be a new chapter, some light in our future* **- KH**

> *It is easier to talk to a stranger because you know talking to family and friends will upset*
>
> *them… The counselling takes the burden away because you can talk and it is in total*
>
> *confidence. The grief journey has a lot of ups and downs and it was really helpful to have an*
>
> *objective and empathetic person to support me during what has been a tough 2 years* **- CF**

4.3.2.3 Getting it.

For many of the bereaved, it is difficult to speak with others who don't understand the impact of

deaths from RTCs, or the language that police use because it is complex; especially when they are

grieving. In contrast, many RVT service users reported that their counsellors understood the difficulty

that they were talking about, because *"…they specialise in dealing with loss in the way that [their*

service users have] suffered it" **(Niamh)**, which was very supportive.

I still felt really connected to her ah because I think, yeah. She obviously has had a lot of first-hand experience and like I said …. everyone's sort of grieving process is different. And so she's obviously worked with lots of different and supported lots of different people and I guess that probably, you know, sort of moulded her into to sort of the great support that she was **- Niamh**

So I don't feel I have to explain any of the terminology or what the police have said to us. They already know all of that and that has made a massive difference. To know when I've been talking to anybody else I can use terms that the police use **- Sean**

From counsellors' perspectives, they find that they draw on the training RVT organises with the FLOs to help them understand the processes involved in police investigations of RTCs and the time it takes for cases to come to court.

In our training, and that, we had to draw on that, it was so obvious why we were trained in that, because it really impacts a client, and their grieving and moving on, and a lot of them can't move on - I've witnessed it - until they've got past that legal process **- Siobhan**

4.3.2.4 Counsellors Skill Set and Knowledge.

Participants discussed the qualities their counsellors had shown that help them to trust and feel emotionally supported. These qualities include being caring and compassionate. The participants point to behaviours such as listening and being present with them as evidence of these qualities.

So I don't know her personally, but she's seems like a caring person. And it feels like she wants to help, rather than it's her job to help **- Sean**

Um, yeah, she's listened to me sob for an hour, she's listening to me when I'm angry for hours. She's listening to everything, and she's just been there; compassionate and caring.

So it wasn't first-hand experience, ah but you know, even though she hadn't felt the same emotions as me, I still felt really connected to her **- Sean**

For some participants, they reported their counsellors teaching them about models of grief helping them to gain an understanding of what they were going through.

>   *so she sent me a couple of diagrams one time and, I'm trying to think as it was so long ago now. It was, like, I think it was a circle. And a circle in the middle and the middle bit was that when it first happens and how slowly, slowly you get to function again* **- Clodagh**

For others, counsellors thought grounding skills helped them to cope when their emotions became overwhelming.

>   *Breathing is a good one…And, I never realised that breathing could be an issue, but, I see, just slowing it down, um and tapping, I love to tap my feet when I'm anxious, so if I'm tapping my feet while we're talking. Erm, and in the same way as tapping, just clicking my fingernails, something I can discreetly do, something I'm aware of, and I suppose the routine of that just allows me to bring myself back. I'm here. I'm safe* **- Sean**

Most participants have had no prior knowledge of inquests or trials. In some cases, families will be supported in learning about courtroom procedures by their FLO. This is not always possible, and RVT fulfils this role. Participants report that their counsellors helped them to understand what happens in a courtroom, who is likely to be present and what they can and cannot do in the room.

>   *When we got the dates for the inquest, the counsellor took us over to the coroner's court just so we knew what to expect* **- CF**

>   *She just prepared me, so I've never been to an inquest before. Ah She sort of prepared me as to like who was likely to be. There you know what to expect. You know that I could leave the room at any point if there was something I didn't wanna hear or didn't wanna see* **- Niamh**

Counsellors don't always attend trials with their clients; an RVT coordinator can sometimes fulfil that role. However, counsellors note that attending a trial can have a positive impact on the relationship.

I can think of two examples where it was absolutely right, that I'd be there with them

and was not detrimental to the relationship and was actually deepen the relationship

and the sense of trust, and didn't negatively impact the work **- Siobhan**

4.3.2.5 Frustration with Police Investigation.

As discussed under grief, the need to know what happened in the RTC impacts the bereaved persons

grieving process. When participants feel that they are not getting information about the RTC or

progress in the investigation, they feel frustrated by the slow pace of the process. They bring this

frustration to counselling. They discuss how they can still offer support, although the counsellor

cannot advise them on this process.

But then I guess as well, you know, looking at the experience I guess when there are

questions that come up and you know sort of processes that form part of the police

investigation, I guess that the relationship then between them and their understanding is still

quite important **- Niamh**

And actually, she helped me because it was getting very close to the inquest date we hadn't

received anything from the police. So, she did actually help me to chase that up to get that

through **- Niamh**

Yeah. She couldn't, like, give me the information that I wanted, but she was a sounding board

for my frustrations, I suppose. Because it was frustrating like, the last two and a half years

have been horrendous really **- Clodagh**

Participants often expressed frustration with getting information from the police in their counselling

sessions. Counsellors understand some of this frustration with police as a place to direct their anger.

Yeah. It's always, yeah; it's frustration And maybe with the police, or maybe that things take

so long. And, quite often there's not a lot of contact with the police because they're doing

their investigation and there's nothing new to share. But that's really difficult for the client.

They think nothing's going on, but it is; it's just it takes time **- Maura**

4.3.3 Support From RVT Office

While bereaved people come to RVT for counselling, there are aspects of their experience of dealing

with RVT coordinators that participants reported offered support and gave them confidence in the

organisation. Gaining confidence in RVT begins with the participant's first interactions with RVT. This

is usually due to getting a quick referral and not being waitlisted. Prompt communication from RVT is

appreciated by participants and contrasted with slow contact with the police. Another area where

participants greatly value the Support of RVT office staff is in communication with the police where

they feel there has not been contact for some time or they want more information.

4.3.3.1 Referral to RVT.

Participants talked about the different referral pathways they had to RVT. Their FLO directly referred

some. Others heard about RVT through other means, such as solicitors. Others made direct contact

with RVT. All participants remarked on how they received a prompt reply. Having flexibility with

referrals and not having a waiting list are essential factors in why participants come to RVT and a

point of difference with other available services.

Well, the fact that I don't have to, like, go through a process of being referred. Because that's,

in that respect, I've been fortunate in that I've been able to get instant help **- Clodagh**

Two officers came and came and gave us a green folder with all the details and said, you

know, we can put you in touch with the RVT and I immediately said yes. So I started with the

RVT almost from weeks after Jacob's death **- Sean**

Um, and so I sent an email in the middle of the night. I was quite desperate at that point

…and then like within about a half eight in the morning I got an email back from RVT and

they had somebody ring me, I think, more or less straight away, like later that day **- Clodagh**

Ray went to local solicitors in Baldock and the lady he spoke with there asked if we had been

in contact with RVT. Up until this point we had never heard of them – and so our RVT journey

began **- CF**

4.3.3.2 RVT Being Responsive.

While participants' primary contact with RVT is with their counsellor, this is not always the case;

there are times when they feel the need to access further Support from RVT. Participants remarked

on the prompt responses they received from RVT; this is often contrasted with difficulties in

attempting to contact the police.

I'd say the vast majority of the help has been via my counsellor because that's who I'm

speaking to week in week out. Um, again, I suppose our situation may be a bit different

because I'm more aware of the office **- Sean**

And I felt like sometimes the communication was like; there was a long time between

communication with them [police], whereas with RVT it was exactly when, exactly on the dot

when she said she was gonna phone. Yeah, it was important to me. **- Clodagh**

4.3.3.3 Support with FLO or Police.

Along with the perception from participants that communication with police can be slow,

participants also commented on how RVT supported them in overcoming these communication

challenges, from getting information about inquests or trials to asking questions about police

procedures and other difficulties. This area of support with maintaining or improving communication

channels with the police is seen as a significant area where RVT support their clients.

At that point, RVT came into themselves, via my counsellor, she relayed it to the office. Um, I suppose the question, you know, just to find out, is any of this normal practice? What should we be doing? Um, and the office were good. I mean, they relayed back, they actually called me at one point, and they also relayed back via my counsellor, that his wasn't normal, no. And that allowed us to move forward and put in an official complaint with the police, which has been actioned and the FLO has been stood down **- Sean**

When clients bring frustrations with FLO or police to counselling, it is often taken back to the RVT coordinator to contact the police.

It does. I can take that back to the office, I ask the client, would you like me to see if we can contact the FLO and find out information for you or, you know, try and help that way? And so, I would, and if I have their permission to, excuse me, if I have permission from them, I will contact either my supervisor or the coordinator on that particular case **- Siobhan**

4.3.4 Rebuild a New Life

This refers to participants moving from being overwhelmed by grief to realising that a new life is possible. When participants make these statements, they emphasise that life has not become easy. Participants were expressing a new perspective they achieved in coping with their grief, expressed as flashes of colour, being happy and enjoying the simple things.

And I'm not gonna say life is getting easier because it's not easy. It's becoming more manageable. So I can see things are improving. So, as that goes on, I think I will probably see a point where, okay, I think I'm in a good enough place to stand firm myself now. **– Sean**

They made me realise I wanted to get better, to get on with my life, and show people you can be happy again after terrible things have happened. **Anonymous B 2016/17**

When I existed in a joyless grey world, you helped me experience flashes of colour and this

encouraged me to edge forward, taking my grief with me. **- Anonymous A 2016/17**

RVT state that they offer counselling for as long as it is needed. This open-ended offer of counselling

is appreciated by their clients, but how counselling sessions are brought to an end is unspecified.

Counsellors and their clients have different perspectives on how endings come about.

4.3.5 Finding a New Normal

When participants receive Support from RVT, they speak about their gratitude for the Support RVT

provided. They talk about beginning a new life or new normal, a reflection that life will never be as it

was before but is different.

I needed just to try and sort of find that new me and that new normal for me **– Niamh**

The fantastic help I received made me feel relaxed and confident when speaking to RVT and

helped set me up for my new normal life **- JS**

You know, you will accept the loss. You will get used to the feeling that you have because of

the loss. But you know that life does go on. And you can find a new normal **- Niamh**

While bereaved people discuss changes that lead to them finding a new normal, counsellors

comment that sometimes these changes need to be highlighted or named by the counsellor to bring

it to awareness.

And what do you remember from last year and, you know, going into this year, so that can

sometimes that can sometimes do it, you know, that can kind of indicate to them how

differently they feel; or not as the case may be. Other changes that come in their life, maybe

like a change of job or a house move or something that can precipitate an ending, you know,

that how, how they've managed it, how they're going forward from this point? **- Siobhan**

4.3.6 FLO

Participants generally speak positively about the support they received from FLOs. They commented on how their FLO kept them informed about the progress of investigations and supported them with preparing for court or inquest and even on the day of the case; however, this is not always the case. When participants felt they were not being kept informed, RVT was available to support them in these situations.

4.3.6.1 Quality Support from FLO.

There were varied perceptions amongst participants regarding the quality of support they received from FLOs. For the most part, participants believed their FLOs to have been very supportive from the first meeting up to and including at trial. As discussed in section 4.3.1.5, needing to know about the Coalition participants are *"yearning for information"* and greatly appreciate having an FLO that keeps them informed.

> *Our liaison officer would always, prepare us and say you know, it's so fluid, you know, the whole process takes forever; getting information* - **Clodagh**

> *Um, and she was great and we were getting updates from her, and sometimes she was having to …. get updates, but she was on our side* - **Sean**

For other participants, the FLOs were perceived to have given them incorrect information or not provided any information regarding the RTC.

> *His Sergeant told us, you know, the events leading up to it and what we were about to see. And that was nothing like what we've been told previously by our by our FLO. So again you know that sort of made us sort of doubt his, you know his I don't know his ability to be able to deal with us and our needs* - **Niamh**

> *And at that point, our first FLO was stood down and were given a new FLO, who wouldn't tell*
>
> *us anything* **– Sean**

These excerpts highlight the importance participants place in sharing information regarding the

investigation. The relationship can be undermined if participants perceive that the FLO has given

them incorrect or is withholding information.

4.3.6.2 When the FLO is busy.

Although participants generally speak positively of their FLOs, the relationship is not without some

frustration. Participants report that there are times when the family are waiting for new information

or struggling with the slow progress pace; they want an update from the FLO. However, the FLOs are

not always available when wanted due to many reasons. While participants acknowledge these

reasons, it does not permanently alleviate their anxiety.

> *But obviously, he's on shift. He's got shift patterns. And in the beginning, he used to give me a*
>
> *shift pattern, so I knew exactly when he was there. But a few times I was feeling impatient. I*
>
> *was impatient* **- Clodagh**
>
> *Also, they've got other families and, you know, you think, yeah, they've got other accidents*
>
> *that are happening all the time that take them off to other jobs. You're not the only person*
>
> *that needs help* **- Clodagh**

4.3.6.3 RVT Communication to FLOs.

When participants are having difficulties with slow progress or contacting their FLO, it can cause

frustration that they bring to counselling. Counsellors can feed these frustrations back to the office,

where contact can be made with the family liaison team. This level of communication and

relationship between Police, FLOs and RVT is understood by participants as a critical factor in the

support they receive.

So, she did also feedback to whoever their contact is within the police and the family liaison team **- Niamh**

It was reassuring to know that she actually trained up RVT staff, so that connected. Although she's police, they're RVT, it felt that they were together. It's probably the best way I can describe it. They weren't they weren't working against each other **- Sean**

4.3.7 Investigation and Courts

Along with participants needing to know the details of the RTC in which their loved ones died, they also want to see justice done. However, the slow pace of investigations and time for court cases to be heard can frustrate the bereaved. Many commented on the length of time for court cases to be heard.

The driver was charged with death by dangerous driving, it took two years to go to court **- KH**

Added to this frustration of a slow legal process, participants commented on a sense of unfairness when witnessing the defendant's treatment in court.

I felt like he was getting treated better than we were, not, but, obviously we were treated well because we had Ashley sitting beside us, but in the court, it's like, you know, they're asking him how he is, and to me it doesn't seem fair **- Clodagh**

Many participants commented upon the length of sentences handed down to those convicted, often believing these too lenient.

I will never get over the loss of her or agree with the light sentence for taking her life **- RW**

The criminal justice system, including coroners' inquests and magistrates courts are a source of frustration for participants. While in some cases participants have had an FLO to support them and

their families through this process, for these people, their RVT counsellor was still available to help

them after hearings.

>   *I felt like we had enough support at the court, but I felt like [counsellor] was there for the*
>
>   *support if I wanted to offload it afterwards* **- Clodagh**

However, having an FLO supporting a family in court was not universally reported, and for others,

RVTs were available to help clients at an inquest.

>   *I literally saw her every week after that she came with me to the inquest* **- Niamh**

In some cases, this support was not possible during the COVID-19 pandemic, but RVT counsellors

supported clients by telling them what to expect in court.

>   *I didn't have support at court due to Covid, but it was the first time for me. S helped me*
>
>   *understand what to expect. Very helpful* **- JC**

While the criminal justice system is a source of frustration and anxiety for bereaved families, some

are supported by FLOs. In these cases, RVT continues to help clients discuss their experiences of the

trials and difficulties it brings. Other times RVT have stepped in and attended inquests and trials to

support their clients in the courtroom. Participants greatly appreciate this support at a challenging

time for them.

4.3.8 Going on a Journey with Me

People bereaved by RTCs commented on how RVT was with them at a challenging time as they

journeyed from intense grief to building a new life. Some talk about RVT going on a journey with

them. This perception of travelling with the bereaved is not limited to the counsellor but extended to

office staff and the RVT organisation.

>   *Thank you, you were there when I needed you the most. In the shock, in the dark, in the pain*
>
>   *- JS*

And even when my counsellor is not there, I know I can call the office. And yeah, it just feels

like you've got somebody on your side. And that's what. That makes a huge difference **- Sean**

Over the last two and a half years you have journeyed with me through the darkest of times **–**

Anonymous A 2016/17

4.4 Summary of Additional Findings

4.4.1 Counsellors Training

The bereaved explicitly mentioned the training their counsellors received; they recognised their

counsellors' depth and breadth of knowledge. Participants commented on how the counselling was

general and specific to their situation. The counsellors themselves also commented upon this

observation. Counsellors commented on how although they were qualified counsellors, the specific

training provided by RVT was essential for them to do their RTC bereavement work. Before beginning

their role as an RVT counsellor, they receive an additional six weeks of training. This training was

reported to cover everything to do with RVT, including legal details of what our clients go through,

such as sudden bereavement, shock trauma and grief. The training covered the practical experience

of the bereaved; counsellors attended an inquest and visited undertakers and crematoriums. RVT

also provide teaching about the uncertainty that the bereaved experience for a long time, through to

police investigations, inquests, court procedures, and sentencing. FLOs and solicitors provide some of

the training regarding police and legal processes. Following the initial six-week training, counsellors

also receive ongoing CPD thrice yearly. Counsellors report that they can make suggestions for the

training they would like to receive, and they report it to be focused on meeting the needs of the

counsellors and their clients. For example, During the COVID-19 pandemic, training on MS Teams was

offered when all counselling had to move to virtual sessions.

4.4.2 Who Does RVT Serve

RVT keep track of referrals and acceptance rates by ethnicity, gender and relationship to RTC; these

have been reported in the annual reports from 2017 to 2023 (summarised in Appendix N and O).

Over this period of reporting, RVT received between 404 to 588 referrals (M = 493, SD = 67). For each incident, RVT attempt to contact all referred people. This is not always possible; uncontacted people are considered to decline the service. Across the period 2017 to 2023, the overall acceptance rates for all referrals have ranged from 41% to 56% (M = 48%, SD = 6%). A trend noticed in the reported statistics is that witnesses to RTCs are least likely to accept the offer of counselling, as were male drivers (driver refers to a person who might be culpable) and those who were seriously injured. Other people referred to RVT tend to be families of people killed or seriously injured in the collision (parents, offspring, spouses/partners, children and siblings).

Most referrals for the period are for White British (67%), with an approximate acceptance rate of 52%. Approximately 7% of referrals are for Other White and White Irish, with an approximate acceptance rate of 43%. The remaining referrals are for Indian, Pakistani, Bangladeshi, Chinese, Caribbean and African people. Over the reported period, Other White, Pakistani, and Indian Bangladeshi all have below-average acceptance rates. While RVT reports the ethnicity of the people referred, they are not broken down by the person's relationship to the RTC. Therefore, acceptance rates by ethnicity when there are low numbers may be more explained by the people being in the lower acceptance rate relationships to RTC rather than RVT not meeting the needs of the community. For all offers of counselling, RVT offers the service of an interpreter to reduce language as a barrier to the service.

5.0 Discussion

5.1 Overview

This chapter states the aims of the research and summarises the key findings that address those aims. Furthermore, I will explore how the findings of the research link to and expand past research on support for people bereaved by RTCs; I will then discuss the clinical implications of the findings. Reflection on the research's strengths, limitations and implications will lead to future research recommendations.

5.2 Summary of Findings

This project researched the support work of Road Victims Trust in order to explore the following aims.

To understand what supports people whom RTCs have bereaved to build hope and continue.

Support services include referral, contact with case managers and counselling. The research produced a model that encapsulates the experience of people whom RTCs have bereaved in using the services of RVT. The model depicts two separate systems people bereaved by RTCs interact with. These are RVT and the criminal justice system. RVT provide practical and emotional support in the form of accessible case coordinators who can support dealing with police and legal procedures and counsellors who meet with their clients weekly and support the bereaved for as long as is deemed useful. The criminal justice system is represented by FLOs, investigators, prosecutors, and the courts (magistrates and coroners). Understanding the criminal justice system and how it impacts people bereaved by RTCs, sets the context for much of RVT's work in practically and emotionally supporting their clients.

5.3 Relations to Previous Research

5.3.1 Grief

Grieving is central to the proposed model for how people who have been bereaved by RTCs are

supported in getting hope and continuing their lives. The grieving process is impacted by a variety of

factors, such as counselling and interactions with police and courts. This section summarises how the

findings from this research relate to past research. Participants described the intense grief emotions

they experienced in the aftermath of learning of the death of their loved one in an RTC. Their

memories of events in the initial aftermath of the collision are vague and "foggy", with an experience

of being on "auto-pilot". They describe the intensity of the emotions they experienced as taking over

their lives, memories and flashbacks of the events triggered by everyday situations. Dealing with the

challenges of everyday life has become too much, and people have begun to avoid driving or going to

work. Grief is impacted by secondary problems such as not getting information about what

happened to cause the collision and struggling with people who do not understand what they are

going through.

5.3.1.1 Dual Process Model of Grief. Previous research and theory concerning grief and its processes

have yielded stage models of grief and dual process models. Stage models propose grieving as a

process of stages, each to be worked through and reworked until it is manageable and efficiently

carried out (Kübler-Ross, 2005). The DPM conceptualises loss and restoration orientations. Loss

orientation concerns appraising and processing aspects of the loss, such as searching for the lost

person (Stroebe & Schut, 2010). Restoration orientation concerns adapting to a world without the

deceased person (Stroebe & Schut, 2010). Both are sources of stress and are associated with distress

and anxiety. DPM suggests that grieving persons oscillate between loss and restoration orientations

in a dynamic process that changes over time (Stroebe & Schut, 1999; 2010).

Many participants noted that grief also impacted the participant's ability to function in various social

contexts, such as work. Some participants discussed how they had difficulties with regular everyday

activities; for some participants, returning to work was challenging. Those who needed time off from work credit the support of RVT for supporting their return to work. Counsellors notice that their clients bring these and other issues to therapy. Difficulties with re-engaging in regular everyday activities fit with the restoration orientation stressors. Phobias about travelling by car and fear responses to driving impact how people report living their lives. These fears are often linked to worries about being confronted by reminders of death and fit with loss orientation stressors.

In this research, participants struggled with comments from family, friends and wider society; participants discussed how these comments led them to seek objective support from professionals who normalised their grief. This is similar to experiences reported in other research that has suggested that bereaved people encounter unhelpful discourses of grief from family, friends, and the media, such as grief being a staged process that one proceeds through linearly. RVT Counsellors noticed that their clients would often ask if they were grieving correctly or in the correct stage of grief. RVT clients who participated in this research commented on how helpful they found the counselling to be in the early sessions when the counsellor would normalise their grief and explain how unique grief is to each person. For Breen & O'Conner's participants, they sought ways to normalise their grief (Breen & O'Connor, 2009). Others resisted dominant grief discourses and described their grief as oscillating rather than linear, consistent with the DPM of grief (Stroebe & Schut, 1999). When considering people bereaved by RTCs, Breen & O'Connor (2009, 2011) found their participants resisted conceptualisations that framed grief as stage-based. They wanted to be listened to rather than being told what to do or what they needed.

The bereavements of the cohort studied in this research are sudden and unexpected. Participants in this research reported feeling that their loved one was killed. They yearn to know how their loved one died and also want justice for their loved one. Past research has shown that sudden and violent deaths can make sense-making difficult. Sense-making has been considered important in helping the bereaved to accept death as part of life (Currier, Holland, & Neimeyer, 2006). Needing to know how

their loved one died can be understood as part of sense-making. Police investigations, prosecutions

and trials complicate grieving and may compound their loss (Herman, 2003; Currier et al., 2006).

Many of the bereaved from this research appear stuck in their grief until their quest for information

and justice is resolved. Participants discussed the need to know as much about their loved one's

death as possible. They seek the information and believe they can only move on once they have

received answers to their questions; for some, this only comes after an inquest or trial. Ongoing

complications of grief caused by investigations and court trials may impact the loss orientation within

the DPM. Until the facts of the death are established, then the bereaved may not be able to process

the death. Loss orientation is concerned with the processing of aspects of the loss, particularly with

respect to the deceased person (Stroebe & Schut 1999).

5.3.1.2 Complicated Grief. Symptoms of PGD include a pervasive yearning for the deceased, or

persistent preoccupation with the deceased, accompanied by intense emotional pain (World Health

Organization, 2016). A duration criterion of six months is proposed prior to diagnosis to ensure that

natural grief reactions in the acute state following bereavement are not confounded with the

syndrome of PGD (Prigerson et al., 2009). Researchers have found symptoms of PGD to be associated

with impairment of the bereaved person's familial, social, and occupational functioning and to be on

a level with other mental disorders, e.g., depression and post-traumatic stress disorder (Jordan &

Litz, 2014; Maercker et al., 2013; Prigerson et al., 2009; Shah & Meeks, 2012).

There are three main symptoms specific to PGD. These are intrusive memories, persistent avoidance,

and persistent symptoms of increased arousal (Dyregrov & Dyregrov, 2008). Intrusive memories may

consist of distressing thoughts or dreams and intense psychological distress when exposed to

reminders of the event. Persistent avoidance is associated with avoiding anything associated with the

death (places, people), thoughts, feelings or conversations linked to the death, and less participation

in activities (Dyregrov & Dyregrov, 2008). Participants in this research report difficulties with the

challenges of everyday life, leading them to avoid driving or going to work.

Persistent symptoms of increased arousal are associated with sleep difficulties, mood swings, difficulties concentrating, and hyper-vigilance (Dyregrov & Dyregrov, 2008). Participants in this research reported experiencing all of the symptoms mentioned above and seeking support for these symptoms from their counsellors. Some participants described how they do not remember much in the days following their bereavement. For others, the emotional experience of bereavement became all-encompassing, and they believed it dominated their life. Participants described how grief caused them to be overwhelmed by emotions after learning of their loved one's death. These descriptions include how their grief was expressed physically and emotionally, leaving them feeling incapacitated.

Pathological forms of grief are only diagnosed after six months (APA, 2022). Therefore, it is recommended that bereaved people are assessed during the first six months before intervention. From the participants' perspective in this research, some believed they needed support for their grief very soon after bereavement. Participants explicitly stated that they could not have waited six months for support with their grief. Dyregrov & Dyregrov (2008) make recommendations more in line with the express will of the participants in this research. Dyregrov & Dyregrov (2008) state that because sudden deaths can have long-term impacts on many people, they recommend professional help early and automatically for all sudden deaths such as accidents, suicide, and murder.

5.3.2 Service Provision

Services for people who have been bereaved by RTCs have been researched in various contexts with widely differing models of service provision, from comprehensive needs-based service (information, peer support and 1:1 therapy) and online CBT for bereavement. Participants reported the various ways RVT supported them with their grief; they listed easy referrals, no waiting lists, counselling, and support in dealing with police and courts as the main aspects of the help they received. Participants' first contact with RVT is usually with a coordinator who offers support and gives them confidence in the organisation.

Research in this area has suggested that people bereaved by RTCs face many challenges in accessing support from families, friends, or external agencies (Breen & O'Connor, 2011; Dyregrov & Dyregrov, 2008). In interviews with family members bereaved by RTCs, Breen & O'Connor (2011) reported a mixed picture regarding receiving support from their family and friend networks; similar findings are reported by Dyregrov & Dyregrov (2008). In published research, bereaved people report receiving support from families, friends, colleagues, neighbours etc., particularly in the weeks following a death (Dyregrov & Dyregrov, 2008; Breen & O'Connor, 2011). Despite the positive experiences, research shows that network support can become insufficient or harmful (Dyregrov & Dyregrov, 2008). Breen & O'Connor (2011) found that their participants reported the challenges of grieving and getting or providing support to family members. Different ways of coping with grief could become contentious. This research supported these findings where the bereaved struggled with people in their network not understanding their grief. Participants often commented on needing to speak to someone outside the family for various reasons, including not wanting to burden their loved ones with their grief or wanting to have an objective person to speak to.

In their recommendations, Breen & O'Connor (2012) made four recommendations specific to therapeutic support for bereaved people (recommendations 2,3,4, 7 & 20 in Appendix A). Recommendations 2-4 & 7 relate to different aspects of a needs-based service. A needs-based service is based on NICE (2004) recommendations for bereavement. A three Component Model of Bereavement Care is recommended; this specifies the type of support to be offered, who should receive this support and who should provide that support. At level one, it is recommended that all bereaved people should receive information about bereavement and sources of support. For Level Two support, approximately 33% should receive non-specialist support from trained volunteers, mutual-help groups, and other community supports. And finally, at level three, 10% would need professional psychotherapeutic interventions.

The participants in this research reported recognising how family members were grieving and did not want to burden them with their grief. These challenges of other people's grief and not understanding what they are going through were given as a reason for seeking the support of RVT. Some participants reported that they hoped to meet people who have been through a similar experience; for others, it was 1:1 therapy that they were seeking. Aoun et al. (2019) defined peer support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient". In a systemic review of the literature, Hay et al. (2022) found that most of the bereaved people studied rated informal support (friends, family, religious/spiritual communities, peer support groups) as more helpful than formal support (counselling). Peer support is not without its challenges. In some instances, people may feel that for that, 'the personal chemistry does not work' or be 'overwhelmed by the grief of others' (Dyregrov & Dyregrov, 2008). Furthermore, the difference in contexts when groups are not differentiated enough, and people perceive too much variation in instances of death within the group (Dyregrov & Dyregrov, 2008).

Throughout this research, participants discussed the ease of access to services with RVT. Considering these findings in the context of previous research reveals the strengths and weaknesses of RVT. When asked about barriers to support, participants (Aoun et al., 2015; Lichtenthal et al., 2015) reported believing that professional support was not required, that their problems would naturally subside and that no one could help them. Breen & O'Connor (2011) noted that there exists an assumption in services that people who require support are aware that they need and are willing and able to seek help. This is supported by other research linking the experience of grief to a lack of energy, resources or initiative or because they do not believe that others will understand the situation or a reduction in the likelihood of recognising a need for help (Prigerson et al., 2001, Dyregrov & Dyregrov 2008). Lenferink et al. (2020) reported similar barriers to accessing services and transportation concerns as the main physical barrier to services.

As presented in the additional findings, the vast majority of RVT service users are White British. Acceptance rates for support from RVT are above the mean of 48.5% for people identifying with White and Black ethnicities and below the mean for people identifying with Asian ethnicities. This raises numerous questions. Do people who do not accept the offer of support from RVT perceive cultural, religious or language barriers? Or do they believe that they have sufficient support from their social networks (family, friends, church or community)?

In the UK, those who have been informed by the police of the death of a loved one receive a Brake pack that informs them of sources of support and information. The Police policy of giving bereaved families the "Green Book" or Brake Pack (College of Policing 2023b) provides them with information about available supports. Furthermore, all those impacted by an RTC in RVTs operational area are contacted by an RVT case coordinator and will be given further information or referred to other services if they do not accept the offer of counselling from RVT. In the East of England, between Police and RVT, most people impacted by an RTC should receive the recommended information contained in the Brake pack.

As previously mentioned, for 33% of bereaved people, Peer Support is the recommended intervention (NICE 2004). 'Peer support' occurs when the bereaved meet with other bereaved people through bereavement support groups (Dyregrov & Dyregrov, 2008). Dyregrov & Dyregrov (2008) report that in their research, bereaved people find that others with similar experiences of loss are in a unique position because they 'have been in their shoes'. Some participants in this research commented on how they would like to meet others in the same situation via peer support. RVT does not provide a peer support service. Therefore, RVT does not offer a fully comprehensive Three Component Model needs-based service as NICE (2004) and Breen & O'Connor (2012) recommended. Despite not receiving Peer Support, participants remained positively disposed to RVT and felt they benefited from the 1:1 counselling they received.

The final tier of the Three Component Model of needs-based service provision is specialist 1:1 psychotherapy. Dyregrov & Dyregrov (2008) report that from their research, bereaved people would like to receive help as early as possible and to receive help not only from their family and friend networks but also from professionals. They want stability and continuity of care from qualified people that are flexible and adapted to the individual (Dyregrov & Dyregrov, 2008). This is the type of service RVT provide for their clients. The participants in this study discussed how they found counselling to be helpful in their grieving process. They appreciated that RVT was available to them immediately after their loved one's death, as they felt they needed support immediately. Participants in this research commented on how they received help when they asked for it, the professionalism of RVT coordinators and counsellors, and gave examples of the flexibility of RVT in providing a service that is adapted to their needs (changing therapist, moving to face-to-face meetings). An additional finding is the participant observation that counsellors' specialist training in grief and police procedures was a significant factor in the help they received. They also appreciated that their counsellors understood the impact of a road traffic collision death and the language the police use. Many participants also appreciated that their counsellors helped them understand that investigations can be a slow process and the courtroom procedures involved in inquests and trials. Some participants found it helpful to learn about models of grief, while others found grounding skills to help cope with their emotions.

Since the COVID-19 pandemic, RVT has moved to provide 1:1 sessions for their clients by video conferencing (Microsoft Teams). This provision was welcomed by many of the participants and counsellors. However, one person reported that she did not have a private space at home for her sessions. RVT provided a room for face-to-face meetings between counsellor and client. Where a client does not have English as a first language, RVT report that they will provide an interpreter for counselling sessions. By offering support directly to the bereaved person and offering easy access to the service, RVT removes many barriers to support. However, the participants in this research self-selected to participate in a project aimed at understanding what it is that RVT does that supports

rebuilding hope. It was not possible to include in this research the opinions of those who turned

down the offer of counselling. As previously mentioned, some who accepted 1:1 counselling wanted

to receive peer support. Could the lack of peer support hinder people from feeling that RVT can offer

the service they need?

Breen & O'Connor (2012) recommend that road trauma support services be complemented by best-

practice death notification established relationship with Family Liaison Officers. RVT have an

established relationship with local police in the East of England with a unique information-sharing

agreement and referral process. FLOs refer all identified people impacted by a fatal RTC to RVT

through this agreement. This data-sharing agreement and subsequent follow-up by RVT ensures

referral and removes many barriers to support for the bereaved. This is not the only referral pathway.

RVT accept self-referrals and referrals from GPs. Participants appreciated the different referral

pathways to accessing help from RVT. Having flexibility with referrals and not having a waiting list are

essential factors in why participants come to RVT and a point of difference with other services such

as NHS Talking Therapies.

This established relationship between RVT and the local police is a strength and enables RVT to

support people who have been bereaved when having difficulties with the police. Prompt

communication from RVT is appreciated by participants and contrasted with difficulties in contacting

the police. Along with the perception from participants that communication with police can be slow,

participants also commented on how RVT supported them in overcoming these communication

challenges, from getting information about inquests or trials to asking questions about police

procedures and other difficulties. When clients bring frustrations with FLO or police to counselling,

the counsellor uses their training and experience to normalise these frustrations, explain the

challenges facing police and then offer these frustrations to the RVT coordinator to contact the

police. This presents a challenge for counsellors in maintaining boundaries and a focus on

therapeutic goals. The option to pass frustrations with FLO or police to coordinators can help to

maintain the therapeutic relationship and permit RVT to support the client with their frustrations.

People bereaved by RTCs commented on how RVT was with them at a challenging time as they

journeyed from intense grief to building a new life. Some talk about RVT going on a journey with

them. This perception of travelling with the bereaved is not limited to the counsellor but extended to

office staff and the RVT organisation.

5.3.3 Criminal Justice System

Previous research has highlighted how post-crash experiences may further compound the

psychological impact of bereavement from an RTC. For people bereaved by RTCs, the experience of

interactions with police and the criminal justice system can be daunting and a secondary source of

stress (Tehrani, 2004). The bereaved may find that the justice process does not follow as expected

(Attwood, 2022). Thus, in addition to family bereavement, interactions with police, solicitors, courts,

sentencing, and related procedures pose further mental health challenges (Attwood, 2022). The

Criminal Justice System impacts bereaved families through its many and varied agents. When

considering the impact of the criminal justice system on the bereaved, previous research

conceptualises the criminal justice system as a singular entity (Sprang, 1997, Tehrani, 2004, Lenferink

et al., 2021).

The criminal justice system comprises the police (FLOs, investigative officers), Crown Prosecution

Service, Magistrates and Coroners Courts. For bereaved family members, their interactions with each

of these aspects of the criminal justice system should be considered separately rather than as a

whole. In this research, participants discussed the impact the various elements of the criminal justice

system have had on their experience of grieving. But they spoke about each element of the criminal

justice system as separate entities.

For many participants, the first contact with the criminal justice system is with the police, who inform

them of their loved ones' death in an RTC (Tehrani, 2004; McGrath, 2020). Following this, their

primary contact with the police is their FLO until the end of legal proceedings (McGrath, 2020).

Participants' primary expectation from the FLO was to keep them informed about the progress of investigations. Participants in this study generally spoke positively about the support they received from FLOs.

However, some felt that they needed more information about the progress of the investigation or believed that they had been given incorrect information. This can undermine the relationship between the FLO and the family. Participants raised issues of difficulty contacting their FLOs; this can be frustrating for families waiting for updates or struggling to cope with the slow pace of the investigation. When participants felt they were not being kept informed or getting incorrect information, they could lose trust in the FLO. Participants became frustrated with FLOs when they were difficult to contact, especially when the family was waiting for new information or struggling with the investigation's slow progress. While FLOs may not be investigating officers, they are the contact between families and police (McGrath, 2020) and tend to be the target of frustrations, at least for participants in this research. FLOs are not always available when wanted due to annual leave, shift patterns, workload, and taking on new cases. While participants acknowledge these are valid reasons, it does not alleviate their anxiety or frustration. Despite some of the challenges listed here, participants generally held positive views toward their FLO. The trust between families and FLO was built through support in getting information, returning the deceased belongings, and support in court. Overall, the findings of this study suggest that FLOs play an important role in supporting families of victims of road traffic collisions.

Furthermore, participants commented on the importance of connecting the FLOs and RVT in communication, data sharing and training. Breen & O'Connor (2012) recommended establishing close links between bereavement support services and local police. It is clear from this research that RVT and police in the region have a good working relationship that bereaved families appreciate. Despite some challenges, the participants in this study felt that the communication and relationship between the police, FLOs, and RVT were critical to the support they received.

While the slow pace of investigations can frustrate the bereaved, it can also take longer than

expected for court trials to be heard. Families bereaved by road traffic collisions want to see justice

done. Seeing justice done may have a Sense-making function for the bereaved to accept death

(Currier et al., 2006). Court trials are a significant source of stress for people bereaved, and many of

those interviewed remained in counselling until after the completion of a trial related to the RTC in

which their loved one was killed. Attwood et al. (2022) described participants in their study reporting

worsening mental health during court proceedings. Participants discussed needing to know the

details of the RTC in which their loved ones were killed. It is at trial where the full details and facts of

the RTC are publicly revealed, and families may learn of new details that had to be withheld from

them during the investigation. Some participants discussed how they want justice done in the trial;

certain elements of the trial process can frustrate their perceptions of justice and this varies between

individuals. Participants commented on a sense of unfairness when witnessing the defendant's

treatment in court, believing the accused is given more rights than the victims or that the sentences

are too lenient. This finding was also reported by Attwood et al. (2022). Many participants

commented upon the length of sentences handed down to those convicted, often believing these

too lenient. RVT counsellors can be important in supporting families through the criminal justice

system. They can help families understand the process, prepare for court, and cope with the

experience's emotional challenges. In some cases, RVT counsellors have even attended inquests and

trials to support their clients in the courtroom. This can be a very important source of support for

families when they feel vulnerable and alone. Previous research has identified that court trials are

challenging for bereaved families due to legal proceedings taking preference over the needs of

families (Currier et al., 2006).

Not all aspects of the legal process are seen as stressful for participants; many believed their FLO to

be very supportive, kept them informed and helped with practical issues such as returning loved

ones' belongings. At court, participants reported how giving a Victim Impact Statement was very

important for them. While difficult at the moment, it helped them gain a sense of justice because they got to tell the accused about the harm they had caused.

5.4 Clinical Implications

Some participants reported that their GP informed them that they were in shock following their bereavement and it would pass. Such advice may be grounded in the complex grief models recommending six months before accessing bereavement care. The NICE (2004) recommendations for the three-component model of bereavement care would recommend that all bereaved people be offered information about the experience of bereavement and how to access other forms of support. GP services, as primary care providers, should offer their bereaved patients information regarding locally available services and provide basic psycho-education about the experience of bereavement.

Previous research recommends that not all bereaved people need 1:1 psychological therapy; peer support networks may be a more appropriate level of support (Dyregrov & Dyregrov, 2008; NICE, 2004). RVT does not facilitate peer support; instead it adopts a model of providing 1:1 counselling for their clients. Some participants in this research have said they would have liked to speak to people with similar experiences. The request by participants for peer support is aligned with established research (Breen & O'Connor, 2012; Dyregrov & Dyregrov, 2008) and should be considered. Perhaps RVT could consider establishing a peer support system to complement its existing services. Such a system should involve a robust assessment and screening process so clients are appropriately assigned to peer support or 1:1 therapy based on need (Dyregrov et al., 2014).

Furthermore, group leaders should be trained in group processes and consideration given to organisational and structural factors on group needs (Dyregrov et al., 2014). In previous research, people who have participated in peer support groups have stated that homogeneity of group composition is important for bonding. Homogeneity in peer support groups concerns the same type of death, close in age, and relationship to the deceased (Dyregrov et al., 2014).

Participants in this research were expressly clear that they believed that the specialist nature of the counselling they received from RVT was essential in supporting the process of their grief. Some participants compared other forms of therapy they received, such as six sessions of CBT which they believed was too short and not specific to sudden loss. This suggests that specialist services for RTC-related bereavement are important in supporting people with their grief. Given that regionally based charities provide such services, there is a postcode lottery across the UK for whom can access such services.

5.5 Methodological Reflections

5.5.1 Consideration of the Quality

The systemic literature review used the CASP quality review proformas to analyse the quality of the literature reviewed. I will use the same tool, the CASP Qualitative Research tool, to analyse the quality of this research.

5.5.1.1. Was there a clear statement of the aims of the research? The research aims were stated and informed the design of the research. The aim of this research was to understand what supports people RTCs have been bereaved to build hope and continue.

•   What aspects of counselling are considered by RVT clients to be effective in supporting them with their grief?

•   RVT clients consider what practical support is effective in supporting them with their grief.

This topic was considered important because limited specialist services are available for people whom RTCs have bereaved. Charities provide those that do exist in the UK. As a result, there is inconsistency in service provision across the UK. Limited research in the literature assesses the services of people bereaved by RTCs. This research addresses a gap in the literature and provides insight into what bereaved people want and believe to be supportive in managing their grief.

5.5.1.2. Is a qualitative methodology appropriate? Grounded Theory is a qualitative research methodology that aims to generate a model grounded in the data that explains a phenomenon. Instances, where Grounded Theory is indicated (Birks & Mills, 2015) include:

• When little is known about the area of study

• The desired outcome is to generate a theory with explanatory power

• The phenomenon of investigation contains a process I seek to construe

This project meets all the criteria indicating Grounded Theory as an appropriate research methodology. There is a dearth of research specifically exploring specialist services available for people whom RTCs have bereaved. This research aims to generate a theory explaining how a service supports its clients in coping with their grief. The interaction of a person who has been bereaved by an RTC, the charity RVT and the Criminal Justice System is a complex interconnected system with various processes. Such research goals can be explored using qualitative methods that allow participants to bring their lived experiences and perspective to the research.

5.5.1.3. Was the research design appropriate to address the research aims? I have explained in section 3.2.2 why Grounded Theory was chosen over other qualitative research methods. Both IPA and Narrative Analysis were considered as potential alternatives.

5.5.1.4. Was the recruitment strategy appropriate to the aims of the research? I have explained how data were collected and how participants were recruited in the methodology section. I believe these were the most appropriate people to get this knowledge from. Grounded Theory research is conducted in stages; the previous stage informs each stage. Analysis of service user feedback in annual reports suggested that clients of RVT would be the most appropriate people to speak to. After analysing the interviews with bereaved people, they gave insight into what their counsellor did that helped them. However, certain aspects were not discussed. Bereaved people did not name their emotions; they had

a certain perspective on how the ending of counselling came about. These were topics that led me to seek to interview counsellors.

Interviews with both bereaved people and counsellors strongly suggested that FLOs play an important role in the experience of people bereaved by RTCs. I sought to interview an FLO, but after making contact with an FLO who agreed to participate in the research an interview could not be arranged due to the demands of the FLO's job. FLO's are assigned to work with families impacted by homicide, road fatality, mass fatality or other critical incident (College of Policing, 2023b), therefore a FLO can be assigned a new case whenever there is a homicide or road death. This was the case for the FLO who agreed to interview, resulting in the interview being cancelled at short notice. I felt that this experience of attempting to arrange an interview with an FLO mirrored that of people bereaved by RTCs in contacting their FLO. Similarly, it offered some insight into the difficulties and demands of the FLO role, trying to balance supporting families with the uncertainty of when a new case will be assigned.

5.5.1.5. Was the data collected in a way that addressed the research issue? Grounded Theory research involves a recursive and iterative process of data collection, analysis, data collection, etc. The analysis informs each round of data collection of the previous rounds of data to ensure that each subsequent stage of data collection is grounded in the data. I made efforts to ensure that data were collected in a manner that was led by the research question and grounded in the data. Memoing and keeping a reflective journal (Appendix L), along with supervisory meetings, helped me to explore if questions I believed to be important were grounded in the data rather than as part of my assumptions or from the literature.

RVTs annual reports were a useful source of data; they gave the researcher a perspective on how the organisation views itself, its relationships with other agencies (e.g., police, councils etc.) and how service users perceive the organisation. I had to remember that these reports, service user interviews, and RVT counsellor interviews must be viewed as potentially holding a bias in favour of RVT.

The research question and the data from RVT annual reports informed the decision to interview people bereaved by RTCs. The research aimed to understand what supported them in building hope, so service users were the most important source of data.

Following interviews with people bereaved by RTCs, questions arose about whether a single perspective on the counselling experience was being shared by participants with similar views/experiences. The interviews provided one version of emotional expression after bereavement, managing difficulties with police and how endings with FLOs and RVT are managed. Getting another perspective on this seemed like a logical next step, intending to check the final answers with people bereaved by RTCs. Gaining more diverse perspectives from past RVT service users may have been compromised by challenges in recruitment. The project relied on social media recruitment strategy, with the project's reach being amplified by RVT social media. It is possible that those who had negative experiences would be less likely to interact with RVT social media.

The data also suggested that it would be important to interview FLOs. However, this proved to not be possible. While this is regrettable, the process of attempting to arrange an interview with an FLO seemed to mirror the experience of bereaved people. It offered the researcher an insight into the difficulties they face in contacting their FLO.

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

In the report, I have discussed how data collection decisions were made, the potential biases in the data, and efforts made to protect against my biases, such as using supervision and a reflective diary. The wording of questions and use of terminology was carefully considered in supervision and in meetings with EbE. Careful consideration was given to the phrasing of statements relating to existing relationships between organisations such as RVT and the police. These relationships are viewed as important by RVT, EbE and participants, and so where there are critiques of organisations at times, attempts were made to present these as such and not as areas of contention.

5.5.1.7. Have ethical issues been taken into consideration? The University of Hertfordshire ethics committee conferred ethical approval for this research. I have discussed the ethical considerations required for conducting this research. Ethical topics considered included informed consent from participants, managing the potential distress of interviewees, role confusion where researchers can be mistaken for clinicians, confidentiality and anonymity, access to participants and safety precautions for me as the researcher. Being an outsider in this research, I was observing existing processes and relationships and had to be mindful of the impact this work could have on those relationships.

5.5.1.8. Was the data analysis sufficiently rigorous? I have presented a model based on analysing the data gathered from annual reports and face-to-face interviews. In conducting analysis, efforts were made to ensure rigorous data analysis by Memoing throughout the research. Memos of the meaning assigned to categories were noted and reassessed when creating super-ordinate categories. Categories were compared between interviews and between stages of interviews to ensure constant comparison (Appendix J).

5.5.1.9. Is there a clear statement of findings? The findings are presented in a model showing the super-ordinate categories' interactions. The model is labelled and annotated. Furthermore, the super-ordinate categories are broken down and discussed in terms of their sub-ordinate categories accompanied by relevant quotes. This presentation should make the findings clear and accessible to the reader.

I plan to disseminate the findings of this research by providing a report to RVT, offering to present to their counsellors at a CPD day and offer another presentation for service users. It is anticipated that I will publish the findings of this research in a peer-reviewed journal.

5.5.1.10. How valuable is the research? I have considered how the research relates to certain aspects of the research literature related to this topic. Specifically, how the experience of people bereaved by RTCs relates to models of grief, prolonged Grief Disorder, service provision and the Criminal Justice System. This research has highlighted that existing models for bereavement support, which are often

based on natural deaths, may not be fit for people who have suffered sudden bereavement, such as

from RTCs. Furthermore, I have discussed how this research can inform clinical services, such as

primary care's role in supporting people's grief following an RTC bereavement. I discussed the role

peer support may play in supporting people who have been bereaved by RTCs and the potential pitfalls

of such an approach. RVT does not provide peer support, but it is worth exploring as participants have

brought it up. Finally, I have made recommendations for further research (below) based not only on

the findings of this research but also on the limitations of the research.

5.5.2 Strengths

Grounded Theory is a research method that allows for the development of models or theories for

understanding areas with limited published research. Therefore, it was a suitable methodology for

researching a service for people bereaved by RTCs. The model generated by this research was

grounded in the data and presented two overlapping and interconnected systems (RVT and the

Criminal Justice System) that impact people bereaved by RTCs. It illustrates how following an RTC

death, the bereaved have a long process of grieving that is impacted by ongoing police investigations

and court trials. This is a difficult period of meaning-making and uncertainty about the final outcome.

The consistency of support from RVT appears to offer the bereaved an opportunity to express their

emotions, understand what they are going through and normalise their experience with people who

have the knowledge to support them. Furthermore, by grounding the findings in the data, it has

been highlighted that the criminal justice system should not be considered one system as it has been

operationalised in previous research. Rather the criminal justice system is a system of organisations

with separate roles. Furthermore, within each organisation, there are separate roles; for example,

after an RTC, the FLO is the contact with the family, and crash investigators must remain impartial to

the family and establish the facts as they relate to the RTC. Previous research has asked bereaved

families about their satisfaction with the police without regard to the very different roles within the

police service (Sprang, 1997, Tehrani, 2004, Lenferink et al., 2021).

Accessibility was a strength in this research; every effort was made to accommodate participants' needs so that they could access and participate in the research. Interviews were conducted face-to-face in participants' homes, office spaces, and online. Each participant chose an interview medium that suited their needs. Some wanted face-to-face interviews but found travel by road too difficult since their bereavement. This flexibility in the interview medium ensured that people were not denied access to participation in research (Heath et al., 2018).

5.5.3 Limitations

A limitation of this research was a strong self-selection bias; this is expressed in the sources of data from feedback in annual reports and in the bereaved people who participated in this research. RVT provided the researcher with the raw feedback data. From that I could see that the feedback published in annual reports is an accurate reflection of the feedback the organisation receives. There was an absence of any critical feedback and so only certain perspectives on RVT were available. People who submitted feedback to RVT may have self-selected to do so based on their positive experiences with RVT.

Similarly, those who came forward to participate in this research did so due to their positive experience with RVT. There were no participants or feedback in annual reports that were critical toward RVT. It is worth mentioning that the project title may have played a role in this bias toward the self-selection of people who are more positively disposed to RVT.

Grounded Theory research is strengthened by collecting data from many data sources and perspectives. In this research, I have sought to get data from various perspectives, not only from people RTCs have bereaved but also those who support them. FLOs play an important role in supporting people bereaved by RTCs; they are the main contact between families and police, train RVT counsellors and make referrals to RVT. I attempted to interview a FLO for this project, but it proved unsuccessful. I believe the difficulties in arranging an interview mirrored the difficulties families have in making contact with their FLO. FLOs were slow to respond to contact, often due to shift working and

heavy workload. One interview was arranged but was cancelled because the FLO had been assigned to work on a fatal RTC. This speaks to the unpredictable nature of the FLOs job and the emotional challenges of working with families of those killed by homicide or RTCs.

Recruitment for this project proved challenging. RVT have a policy that their service is free and does not come with any obligations. For this reason, RVT will not directly contact current or former clients to ask for anything, including participation in research. RVT provided support in recruitment by sharing recruitment literature on their social media platforms (Twitter and LinkedIn). Further limitations to data sharing between researcher and RVT were due to RVT's enhanced data protection policy. RVT have a data sharing agreement with local police which they place as a high priority and therefore have a conservative data protection policy to ensure the security of their service users and the data sharing agreement.

All data from past service user feedback and bereaved participants spoke to a positive experience with RVT. This is unlikely to be reflective of everyone's experience with RVT, but difficulties in recruitment and the title of the project may have biased the perspectives of people who choose to participate.

5.6 Suggestions for Further Research

Research suggests that people who have had a sudden and shocking bereavement may not know they need support to cope with their grief (Dyregrov & Dyregrov, 2008). It has been reported by participants in this research (the bereaved and RVT coordinators) that contact is made with bereaved people with an offer of support within weeks of a referral being made. The possibility exists that the offer of support from RVT may come too soon for some bereaved people. Following a death, there can be many practical considerations, such as dealing with emergency services, police, planning funerals and inquests. Future research could assess the timing of an offer of support to ensure that those who may benefit from support are in a position to accept.

By extension to the previous recommendation to further research, there may be people who do not accept support regardless of the timing of an offer. Future research could focus on those who reject

the offer of bereavement support following an RTC to understand why people do not accept it. Some

may believe that nobody can help them, as found in Lenferink's (]2021) research. For others, they

may have family and friend network support that meets their needs. Understanding what constitutes

a supportive network would add to the literature, given that many participants in this research

sought support because they believed their support network did not understand their grief.

FLOs' role is to provide support to families sensitively and compassionately and to ensure that the

bereaved family are given information in accordance with the needs of the investigation (College of

Policing, 2023). That FLOs give information in accordance with the needs of the investigation would

suggest that some information will be withheld from families. Families report that they are yearning

for information about the RTC. Not receiving information makes bereaved people frustrated with the

police, and the FLO may be the person toward whom this frustration is directed. Future research

could explore the role of an FLO and the impact the challenges of managing the expectations of

families with the demands of an investigation have on their ability to manage workload and stress.

Although previous research recommends that support for bereaved people be provided based on

need, peer support networks may be a more appropriate level of support for many (NICE 2004).

However, there are also concerns regarding peer support groups (Dyregrov & Dyregrov, 2008). Peer

support groups are not without challenges; quality and content can vary greatly and lack therapeutic

focus (Dyregrov & Dyregrov, 2008; Dyregov et al., 2014).

Models of complicated grief in the literature and subsequent treatment models propose that

complex grief be diagnosed after six months (ICD 11, Eisma et al., 2020). Following this, psychological

intervention is recommended only after at least six months following bereavement. Participants in

this research reported experiencing such intense levels of acute distress following their bereavement

that they needed support as soon as possible, even referring to the recommended six-month

timeline as unreasonable. Dyregrov & Dyregrov (2008) also present evidence of immediate provision

of support for people impacted by sudden and shocking bereavements such as RTCs. A contradiction

exists between these recommendations; on the one hand, complex grief and PTSD interventions are

both recommended six months post-event before intervention (ICD 11, Eisma et al., 2020). On the

other hand, our participants believe they needed professional support immediately, and Dyregrov &

Dyregrov (2008) also argue for immediate provision of support. Further research is required to

establish if people who have been suddenly bereaved should receive psychological intervention and

what form it should take.

5.7 Conclusions

This research sought to understand what supports people whom RTCs have bereaved to build hope

and continue with their lives. The findings suggest that people who were bereaved by RTCs face

many challenges in coping with their grief; these include interactions with police and courts, other

people and services not understanding their grief experience. RVT service users report that their

counselling with RVT was specialised and designed to support them with their grief and the many

challenges of being bereaved by an RTC. RVT clients talk about the criminal justice system, which can

sometimes be supportive but is generally a source of stress; this is contrasted with RVT, which is

construed as a source of consistency and stability in their grief journey. Services like RVT offer a

model of care for people bereaved by RTCs and are only available in the East of England.

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Appendices

Appendix A

Breen & O'Connor (2012) Recommendations (20 adapted for UK context)

	Aftermath[1]	Brake[2]	SCARD[3]	RoadPeace[4]	RVT[5]
1. The support service be funded by Government	×	×	×	×	×
2. The service is comprehensive and provides services region-wide	×	×	×	×	✓
3. A peer support services be promoted region-wide	×	×	×	✓	×
4. The service be delivered according to service need (stepped care)	×	×	×	×	×
5. The service should be provided with no charge to clients.	✓	✓	✓	✓	✓
6. The service provides preventative education services.	×	✓	×	✓	×
7. The service links with appropriately trained in trauma to provide professional psychotherapeutic interventions.	×	×	✓	×	✓
8. The service facilitates appropriately trained volunteers to provide non-specialist supports	×	✓	✓	✓	✓
9. The service includes complementary direct and indirect services.	×	×	×	✓	✓
10. The service be established as a non-profit organisation	✓	✓	✓	✓	✓
11. The service be governed a Board of Management / Trustees	✓	✓	✓	✓	✓
12. The service utilise a high-profile and appropriately sensitive Patron;	×	×	×	✓	✓
13. The road trauma support service has a core salaried staff.	✓	✓	×	✓	✓
14. The service be situated in community-based premises accessible by public transport.	×	×	✓	×	✓
15. The service be complemented by information packages, a brochure, and a website.	✓	✓	✓	✓	✓
16. The service has an initial annual budget and ongoing funding	✓	✓	✓	✓	✓
17. The service has an evaluation and reporting framework.	✓	✓	✓	✓	✓
18. The service be linked and work in partnership with other services and supports.	✓	✓	✓	✓	✓
19. The service meet the access needs of underserved groups	✓	✓	✓	✓	✓
20. The road trauma support service be complemented by best-practice death notification established relationship with Family Liaison Officers	✓	✓	×	✓	✓

[1] Email with Aftermath, Aftermath website and Charity Commission. [2] Brake website and Charity Commission, [3]SCARD website and Charity Commission , [4]RoadPeace website and Charity Commission, [5]Emails with RVT, RVT website and Charity Commission.

Appendix B

CASP Quantitative Research Assessment Tool

CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
• what was the goal of the research
• why it was thought important
• its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
• Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
• if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal
Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal
Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal
Skills Programme

8. Was the data analysis
sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement
of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix C

CASP Qualitative Research Assessment Tool

CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal
Skills Programme

		HINT: Consider
4. Was the recruitment strategy appropriate to the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	• If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

		HINT: Consider
5. Was the data collected in a way that addressed the research issue?	Yes ☐ Can't Tell ☐ No ☐	• If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal
Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal
Skills Programme

8. Was the data analysis sufficiently rigorous?	Yes		HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Yes

Can't Tell

No

Comments:

9. Is there a clear statement of findings?	Yes		HINT: Consider whether

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Yes

Can't Tell

No

Comments:

CASP
Critical Appraisal
Skills Programme

Section C: Will the results help locally?

10. How valuable is the
research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix D

Letter of Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Tomás Walsh
CC	Jennifer Heath
FROM	Dr Rebecca Knight, Health, Science, Engineering & Technology ECDA Vice Chair
DATE	20/10/2022

Protocol number: **LMS/PGR/UH/05131**

Title of study: Does Practical and Emotional Support for Those Bereaved by Road Traffic Collisions Give Hope to Rebuild Lives?

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Matt Staton – Field Supervisor

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 03/11/2022

To: 20/02/2023

Appendix E

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

1   **Title of study**

Does Practical and Emotional Support for Those Bereaved by Road Traffic Collisions Give Hope to Rebuild Lives?

2   **Introduction**
You are being invited to take part in a study. Before deciding whether to do so, you must understand the study being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is unclear or for any further information you would like to help you decide. Please take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

(after accessing this website, scroll down to Letter S, where you will find the regulation)

Thank you for reading this.

3   **What is the purpose of this study?**
This research fulfils the requirements for the principal researcher's doctoral course in clinical psychology. We wish to understand how the Road Victims Trust help those bereaved by road traffic collisions rebuild their lives.

4   **Do I have to take part?**
Whether you decide to participate in this study is entirely up to you. If you decide to participate, you will be given this information sheet to keep and asked to sign a consent form. Agreeing to join the study does not mean you must complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time or not to take part at all will not affect any treatment/care you may receive (should this be relevant).

5   **Are there any age or other restrictions that may prevent me from participating?**
        We want to speak with people who have used the services of the Road Victims Trust as an
        adult (over the age of 18)

6   **How long will my part in the study take?**
        If you choose to participate in this study, you will be conducted for interview. Interviews will
        be conducted face-to-face at an agreed venue or via Microsoft Teams. They should last
        around 45-60 minutes. I will ask you questions about your experience of being supported by
        the Road Victims Trust.

7   **What will happen to me if I take part?**
        The first thing to happen is being asked to read this information sheet and complete the
        following consent form.

8   **What are the possible disadvantages, risks or side effects of participating?**
        We believe there are no known risks associated with this research study. However, we will
        discuss your experiences from a difficult period in your life.

We do not anticipate that you will find any of the questions upsetting. However, if you need support
        following completion, we recommend you contact your GP. The Samaritans can be contacted
        at 116123. I have additionally provided signposts to potential support networks below:

        MIND: https://www.mind.org.uk/

9   **What are the possible benefits of taking part?**
        Some people might find that reflecting on their experiences is helpful. Whilst there might be
        no direct benefit to your participation, the findings will be novel for the community of people
        who have. Unfortunately, they will be impacted by road traffic collisions in the future. To
        date, minimal research has explored the experiences of people impacted by road traffic
        collisions, particularly in the United Kingdom. It is hoped that the research will highlight the
        strengths of offering bespoke services specifically geared toward the needs of people
        impacted by road traffic collisions. This may result in service changes to make them more
        accessible and improve liaison between statutory services and road safety charities.

10   **How will my taking part in this study be kept confidential?**
        We will follow ethical and legal practices and handle all information confidently.

Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible. Any information that you provide will be anonymised for confidentiality reasons and stored on the secure University of Hertfordshire One-Drive.

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular research areas. All personal information that could identify you will be removed or changed before the information is shared with other researchers or results are made public.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses provided.

11   **Audio-visual material**

If you would like to take part in a follow-up interview at a later date, we will meet online via Microsoft Teams. This interview will be audio-visual recorded.

12 **What will happen to the data collected within this study?**

- The data collected will be stored electronically, in a password-protected environment, for 18 months, after which time it will be destroyed under secure conditions;
- The data will be anonymised prior to storage.
- You will be asked to sign a 'Contributors' Release Form' to allow the transmission of the audio/visual material to which you have contributed
- Password protected electronic copies of anonymised transcripts will be kept for two years, since the study will be written up for publication

  The results will be used for the write up of my major project that forms part of the Professional Doctorate in Clinical Psychology qualification.

13   **Will the data be required for use in further studies?**

Password protected electronic copies of anonymised transcripts may be re-used or subjected to further analysis as part of a future ethically-approved study; the data to be re-used will be anonymised.

14   Who has reviewed this study?

This study has been reviewed by The University of Hertfordshire Health, Science, Engineering & Technology Ethics Committee with Delegated Authority

The UH protocol number is

15   Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16   Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, Tomás Walsh (Trainee Clinical Psychologist) by email at tw20aau@herts.ac.uk or you can contact my primary research supervisor Dr Jen Heath at j.heath@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix F

Participant Consent Form

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned [please give your name here, in BLOCK CAPITALS]

....
of [please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]

....
hereby freely agree to take part in the study entitled: Does Practical and Emotional Support for Those Bereaved by Road Traffic Collisions Give Hope to Rebuild Lives?

....

(UH Protocol number ...LMS/05131...)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

Initial

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

6 I have been told that I may at some time in the future be contacted again in connection with this or another study.

Anonymity code (initials D.O.B e.g 79)............. ....Date...05/05/23..............

Name of (principal) investigator [TOMÁS WALSH]

....

Appendix G

Recruitment Poster

University of Hertfordshire UH   Seeking Research Participants

- Have you suffered a bereavement from a road traffic collision?

- Have you used the services of the Road Victims Trust?

- Were you over the age of 18 years at the time?

Who Am I?
My Name is Tomás Walsh
I am a trainee Clinical
Psychologist
at University of
Hertfordshire
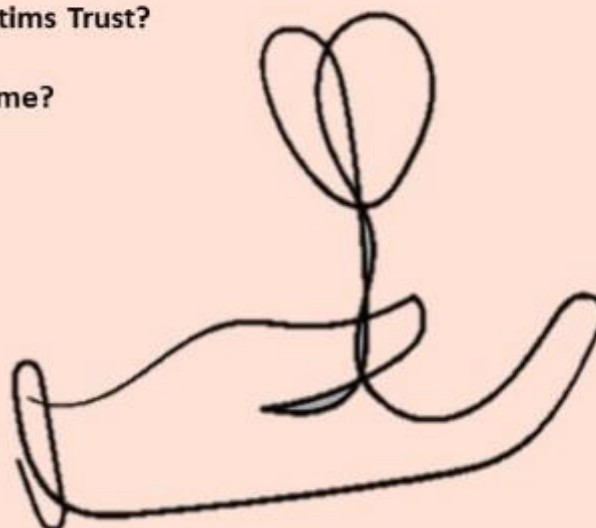
With your help I hope to better understand what helps people who suffered a bereavement in an RTC develop hope to rebuild and continue.

If you are interested in participating in this research or have any questions please contact
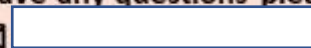
@Hope2Continue

All participation is voluntary and anonymous. Consent maybe withdrawn at any time

Road Victims Trust

This research has received ethical approval from the University of Hertfordshire Ethical Committee
LMS/PGR/UH/05131

Appendix H

Line by line coding of RVT Annual Reports in NVivo 12

Appendix I

Memos of Coding

Appendix J

Comparison of Codes between Interviews

Appendix K

Cross Tabs for Comparison of Codes

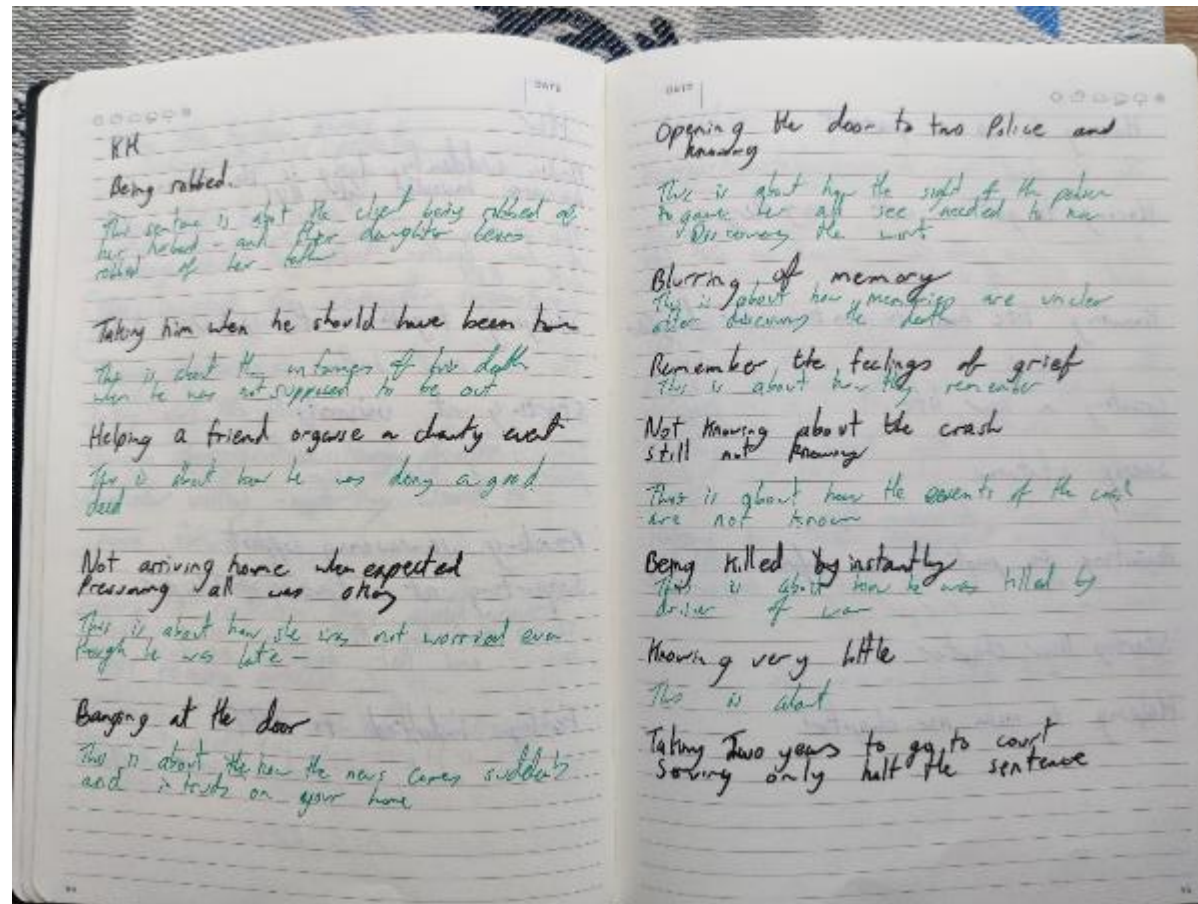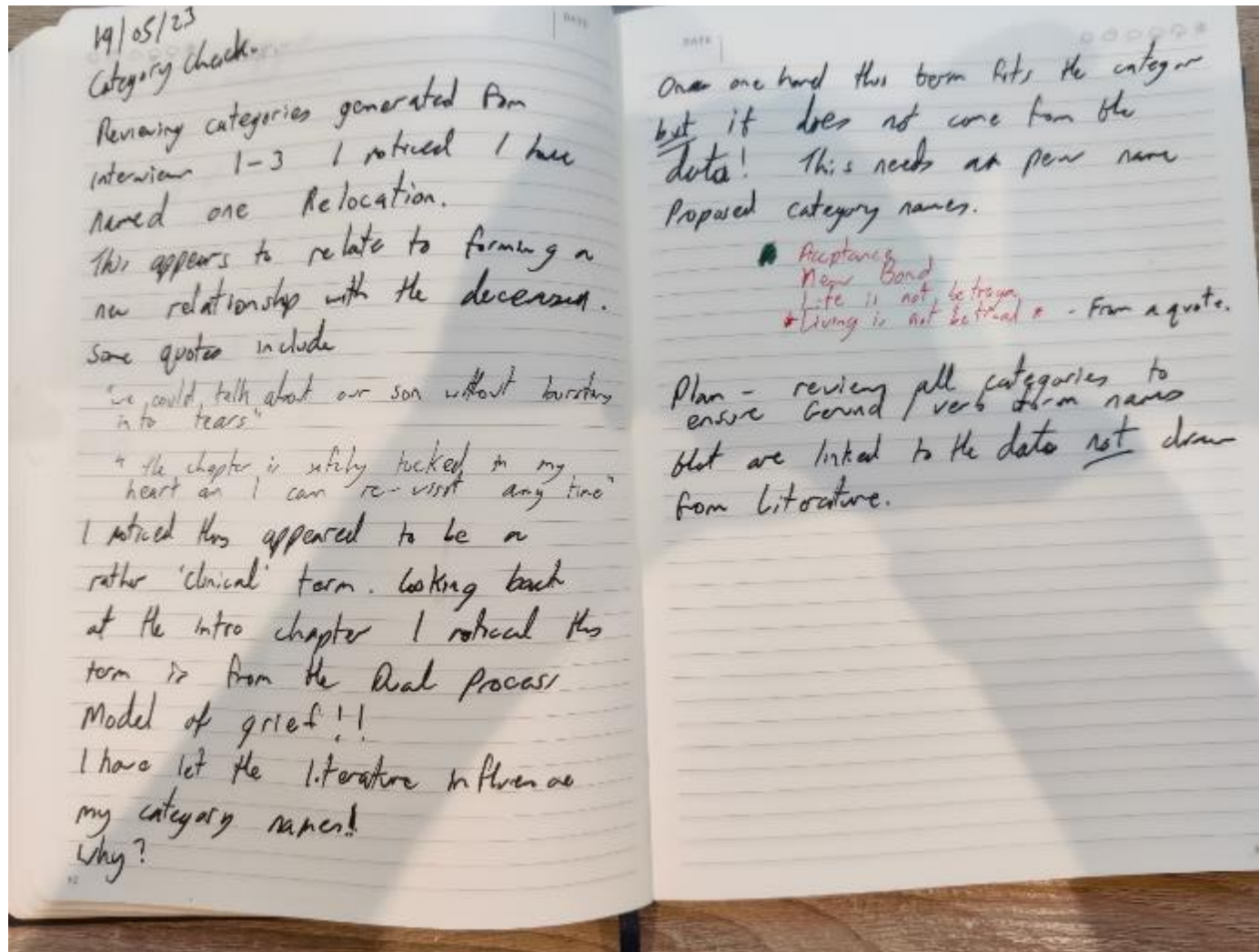|	FLO and Police	Counsellor Knows how to help	Courts and Inquests	RVT Office Support	Consistency of Care	Not Having Information Re RTC	Being on the journey with Me	Pathway to RVT	New Life or New Normal	Objective Person	Find it hard to adjust to life	Intrusion	Regaining Hope or Acceptance	Normalisation	Not Getting Support Elsewhere	Bang on the Door	Tools to Cope	Knowing I Needed Help	Gratitude for RVT	Injustice	Being Killed	Other People Not Getting it	Expressing Grief	Protecting Family From My Grief	Unassigned	RVT Provide Amazing Support	Worrying for Loved One	Keeping the Bond	Relocation	Total
FLO and Police	54	10	11	18	2	12	0	1	1	0	0	0	0	0	0	8	0	0	0	2	1	0	0	0	0	0	0	0	0	132
Counsellor Knows how to help	18	56	12	1	0	6	0	1	1	1	0	0	0	0	2	0	0	1	0	4	2	0	0	0	0	0	0	0	0	103
Courts and Inquests	11	12	54	1	5	6	0	3	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	102
RVT Office Support	18	1	1	37	2	2	8	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	71
Consistency of Care	2	0	5	2	37	0	4	0	2	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	57
Not Having Information Re RTC	12	6	6	2	0	31	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	61
Being on the journey with Me	0	0	0	8	4	0	32	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	43
Pathway to RVT	1	0	5	1	0	0	0	30	0	0	0	0	0	0	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	38
New Life or New Normal	1	1	0	0	2	0	0	0	31	1	2	0	7	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	2	48
Objective Person	0	1	0	0	1	0	0	0	0	28	0	0	0	0	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	38
Find it hard to adjust to life	0	1	0	0	0	0	0	0	2	0	23	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	28
Intrusion	0	0	0	0	0	0	0	0	0	1	26	1	1	0	1	0	1	0	0	0	2	0	0	0	0	0	0	0	0	33
Regaining Hope or Acceptance	0	0	3	0	0	0	0	0	7	0	1	1	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36
Normalisation	0	0	0	0	0	0	1	0	0	0	0	0	0	24	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	23
Not Getting Support Elsewhere	0	0	0	1	0	1	0	0	0	0	0	0	0	22	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	28
Bang on the Door	0	0	0	0	0	0	2	0	0	0	1	0	0	0	18	0	0	0	2	0	0	0	0	0	0	0	0	0	0	30
Tools to Cope	0	2	0	0	0	0	0	1	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	22
Knowing I Needed Help	0	0	0	0	0	0	1	0	1	0	0	0	4	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	21
Gratitude for RVT	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Injustice	0	1	8	0	0	3	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	0	1	0	0	23
Being Killed	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	13
Other People Not Getting it	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	15
Expressing Grief	0	2	0	0	0	0	0	0	1	2	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	14
Protecting Family From My Grief	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	10
Unassigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	6
RVT Provide Amazing Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	5
Worrying for Loved One	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	6
Keeping the Bond	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	4	1	0	0	7
Relocation	0	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	0	6
Total	132	103	102	71	57	63	45	38	49	36	59	33	36	23	28	30	22	21	16	25	13	15	14	10	6	5	6	7	8	1002

Appendix L

Reflective Journal Extract

19/05/23
Category Check-

Reviewing categories generated from interview 1-3 I noticed I have named one Relocation.
This appears to relate to forming a new relationship with the deceased. Some quotes include

"we could, talk about our son without bursting into tears"

+ "the chapter is safely tucked in my heart an I can re-visit any time"

I noticed this appeared to be a rather 'clinical' term. Looking back at the intro chapter I noticed this term is from the Dual Process Model of grief!!
I have let the literature influence my category names!
Why?

On the one hand this term fits the category but it does not come from the data! This needs an new name
Proposed category names.

- Acceptance
  New Bond
  Life is not, betrayal
  + Living is not betrayal + - From a quote.

Plan - review all categories to ensure Gerund verb form names that are linked to the data not drawn from literature.

Appendix M

Early Drafts of Model

Appendix N

Summary of RVT Referrals by Ethnicity

Ethnicity	18/19	19/20	20/21	21/22	22/23	Total	Acceptance Rate	Percentage Referred
White British	147	192	137	131	192	799	51.95%	67.37%
White British Declined	211	240	155	90	43	739		
White Irish	0	0	1	0	1	2	50.00%	0.18%
White Irish Declined	0	1	1	0	0	2		
Other White	14	4	9	9	24	60	36.81%	7.14%
Other White Declined	42	27	15	15	4	103		
Unknown	2	0	7	67	3	79	19.80%	17.48%
Unknown Declined	52	65	50	129	24	320		
Other Ethnic Group	1	0	2	0	0	3	60.00%	0.22%
Other Ethnic Group Declined	0	0	0	0	2	2		
Mixed	0	1	0	3	4	8	57.14%	0.61%
Mixed - Declined	6	0	0	0	0	6		
Black Other	0	0	4	1	3	8	66.67%	0.53%
Black Other Declined	0	0	4	0	0	4		
Black Caribbean	2	1	2	2	2	9	47.37%	0.83%
Black Caribbean Declined	3	7	0	0	0	10		
Black African	3	0	2	0	2	7	63.64%	0.48%
Black African Declined	3	0	0	0	1	4		
British Asian Other	0	0	2	0	4	6	66.67%	0.39%
British Asian Other Declined	0	0	1	0	2	3		
British Asian Pakistani	0	1	0	3	2	6	35.29%	0.74%
British Asian Pakistani Declined	4	1	1	4	1	11		
British Asian Indian	6	4	0	3	9	22	34.92%	2.76%
British Asian Indian Declined	1	25	5	7	3	41		
British Asian Bangladeshi	2	0	0	1	0	3	42.86%	0.31%
British Asian Bangladeshi Declined	0	1	1	2	0	4		
Asian Other	3	1	1	2	3	10	45.45%	0.96%
Asian Other Declined	4	3	2	2	1	12		
	506	574	402	471	330	2283	48.47%	100.00%

Appendix O

Referrals for Family

	18/19	19/20	20/21	21/22	22/23	Total
Number contacted	519	588	404	479	476	2466
Number who accept the service	186	210	166	228	246	1036
Out of Area (referred onward)	90	74	38	42	40	284
Acceptance Rate	43.36%	40.86%	45.36%	52.17%	56.42%	47.63%
Family Accepted	117	122	87	116	144	586
Family Declined	122	143	97	66	39	467
	48.95%	46.04%	47.28%	63.74%	78.69%	56.94%