Doctoral Thesis

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Experiences, Memories, and Exiting Suicidal States: A Meta-Ethnography and Case Series

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Thesis Abstract

Suicidal ideation is linked to both risk and psychological distress in people with mental health difficulties. There is a need for further research around how suicidal thinking can be reduced. This thesis considers the role of suicide 'exits' – both how they are experienced, and how they can be used within a clinical intervention. The intervention explores this within the wider construct of 'autobiographical memory'.

Section one presents a meta-ethnographic literature review which considers how people with mental health difficulties experience suicidal thinking in the absence of an attempt. Five databases were searched (PsycINFO, CINAHL, MEDLINE, Web of Science, PubMed) and 12 studies were included in the review. Five overarching themes were synthesised: 1) Unbearable Beliefs, 2) Disconnection, 3) The Flow of Suicidal Thoughts, 4) In-The-Moment Exits, 5) Long-Term Attitudes. Themes 1-4 were presented temporally in a cycle, whilst theme 5 was placed adjacent to this. All themes were assimilated using a metaphorical depiction of a river. This aimed to support understanding of the relationship between themes.

Section two presents a case series exploring the acceptability and feasibility of an autobiographical memory-based intervention for suicidality. A non-concurrent A-B multiple-baseline design was followed (3-5 baselines, 6 intervention sessions). Four people attended the initial assessment; one was assessed as ineligible at this stage. All eligible participants (n=3) completed the study, with a high attendance rate (93.10%). No adverse effects were reported. Clinical outcomes varied, with a marked improvement for one participant. Whilst the study was limited by its small sample size, it established the need for a fully powered trial to investigate this further.

A critical appraisal of the process of conducting both the meta-ethnography and case series is included in section three. This summarises sections one and two, and makes suggestions about potential research for the future.

Declaration

This thesis documents research undertaken for the Doctorate in Clinical Psychology at the Division for Health Research, Lancaster University. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher of a higher degree elsewhere.

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Date: 15th September 2024

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My particular thanks go to my tutor pair – James and Amy – who have been there for me every step of the way. Suicidal ideation is not an easy topic to research but having such a supportive team looking out for me has meant the world. James, thank you for sharing your knowledge and reflections with me, I have grown so much from our supervisions and I'll miss our weekly walk and coffee! Amy, you have been a star, thank you for always being in my corner.

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Section One: Systematic Literature Review

How People with Mental Health Difficulties Experience Suicidal Thinking in the Absence of an Attempt - a Meta-Ethnography

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Abstract

Purpose: Suicidal thinking is a risk factor for future suicide attempts, in addition to causing significant mental distress. The progression from suicidal ideation to action is well established in the key suicide models. Instances of suicidal thinking which do not lead to an attempt remain less well understood, despite being more frequent. This review aimed to synthesise how people with mental health difficulties experience suicidal thinking in the absence of an attempt. **Methods:** Participants had mental health difficulties and experiences of suicidal thinking without an attempt. Five databases were searched systematically: PsycINFO, CINAHL, MEDLINE, Web of Science and PubMed. The CASP tool was used to assess the papers' quality. **Results:** Twelve studies (total = 354 participants) were included. Five main themes emerged, synthesised temporally with a drawn representation. Suicidal experiences grew from unbearable beliefs. People disconnected and entered a suicidal state; subsequently they found ways to exit this. In the longer-term, people adopted active or passive coping methods. **Conclusions:** Suicidal thinking in the absence of an attempt involves both disconnection and reconnection. This review synthesises the dynamic moves towards and away from suicidality within one framework. It has clinical relevance in supporting mental health professionals' and suicidal individuals' understanding of experiences of suicidal thinking.

Keywords: suicidal ideation, meta-ethnography, mental health, resilience

Introduction

Context

Suicide is a major global issue, with over 720,000 people estimated to die by suicide each year (World Health Organisation, 2024). For every completed suicide, many people attempt suicide, and many more have suicidal thoughts which are not acted upon. In the UK around 1 in 15 people have attempted suicide in their lifetime, whilst 1 in 5 people have experienced suicidal thinking (NHS Digital, 2016). Suicidal ideation is a risk factor for future suicide attempts (Han et al., 2016) and it is associated with high levels of psychological distress (Bell et al., 2015; Tanji et al., 2018) Understanding the experiences of suicidal thoughts in the absence of an attempt is crucial to reducing risk and providing the best support possible to these individuals.

Suicidal thinking is a broad term referring to all suicide-related cognitions, including verbal thoughts, mental images (Lawrence et al., 2021), and rumination (Rogers & Joiner, 2018). The term suicidal ideation is most frequently used, but there is a lack of consensus around its definition – some studies suggest it includes all elements of suicidal thinking, whilst others contend that it refers to suicidal thoughts in the absence of plans/intent (Valtonen et al., 2009). In this review the all-encompassing term ‘suicidal thinking’ is used to capture the broad range of suicidal cognitions which may be present at times when there is no eventual attempt.

A recent review concluded that there are no typical experiences of suicidal thoughts (Harmer et al., 2022). This paper noted within every individual, suicidal thoughts are changeable and inconsistent, waxing and waning. However, the dynamic and changeable nature of suicidal thoughts and intensity is in its own right an experience which requires attention and understanding. Our review therefore considers both moves towards and away

from suicide. Harmer et al. (2022) also links the lack of 'typical' suicidal thoughts to the fact this phenomenon does not arise within a heterogeneous population. However, the qualitative literature notes similarities and overlapping experiences within certain groups, linked to gender, ethnicity, and health difficulties (e.g. Cheref et al., 2015; Karasouli et al., 2014; Vivier et al., 2023). We narrowed our focus accordingly, considering a population with mental health difficulties.

Suicidal Thinking in the Absence of an Attempt

Suicidal thinking is often researched as a risk factor for suicidal behaviour; however, fewer studies have considered this phenomenon outside of its relationship to suicidal action. Several key models present an ideation-to-action framework, which describe how people move from thinking about suicide to acting upon suicidal thoughts. These include the interpersonal theory of suicide (IPT), the integrated motivational-volitional model (IMV), and the three step theory (3ST) (Klonsky & May, 2015; O'Connor, 2011; Van Orden et al., 2010). These models predominantly present suicidal ideation within a linear progression towards suicidal behaviour. Any bidirectional components (e.g. in the IMV) have risk and behaviour as their focal point; 'exits' from ideation are omitted.

Most suicidal thoughts are not, however, acted upon. They are commonly experienced as ego-dystonic, in conflict with people's underlying goals and self-image (Brådvik & Berglund, 2011). Understanding the forces which lead people away from suicidal thinking, and how these relate to the key suicide models, is therefore an important endeavour.

May and Klonsky (2016) have attempted to gain insight into what qualities characterise 'ideators' compared to 'attempters', noting that most research amalgamates these groups. Our review similarly sets thinking apart from behaviour. However, the binary

separation between 'ideators' and 'attempters' seems less clinically relevant in the qualitative literature, given that many who attempt suicide subsequently experience longer-term ideation without action. We therefore took a different perspective, considering any experiences of suicidal thinking in the absence of an attempt, regardless of past behaviour.

Our review considered the risk and resilience-focused research. Suicide models and treatment models have been developed and presented separately, with negative implications clinically (Michel, 2021). Understanding these together enables an integrated understanding of people's experiences.

Models of resilience and recovery such as the Schematic Appraisals Model of Suicide (Johnson et al., 2010) and COURAGE (Sokol et al., 2022) have proposed several factors which provide suicide resilience, including empowerment, connectedness, and positive self-appraisals. Empowerment involves the development of internal and external skills to generate a sense of agency, and connectedness refers to a sense of belonging and of being valued (Sokol et al., 2022). Positive self-appraisals involve self-belief in one's internal strengths and coping skills (Johnson et al., 2010). These can be viewed in opposition to factors described in suicide risk models: for example, entrapment (feeling stuck/trapped), defeat (feeling powerless and humiliated), and interpersonal difficulties (feeling like you are a burden/ do not belong) (Gilbert & Allan, 1998; Joiner, 2007). Our review aimed to synthesise risk and recovery within one framework.

Suicidal Thinking in the Context of Mental Health Difficulties

Mental health difficulties and suicidality are strongly linked, as around 90% of registered suicides are in people with psychiatric conditions (Mann et al., 2021). Over a quarter of people who die by suicide contact mental health services in the year before their death (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2023).

People are also most likely to accurately disclose their suicidal thinking to mental health professionals (Hom, Stanley, et al., 2017). However, whilst it is well-established that this group hold the highest levels of suicide risk, there has been limited success in translating theoretical knowledge into clinical use (Michel, 2021). Within risk-algorithms, the experience of the individual is lost; the need for a person-centred understanding of suicide has been called for (Espeland et al., 2021).

The qualitative literature provides rich information about individuals' experiences of suicidal thinking. By developing understanding around this there is the potential to improve staff training, to support suicide risk formulations, and to develop models of suicidal thinking outside of the context of suicidal behaviour. This translates into preventing suicide and helping people understand their suicidal thoughts when they are not active suicidal.

Increasing healthcare staff's understanding of suicidality through training has been shown to increase their confidence, with shifts towards less stigmatising attitudes and more empathetic approaches (Boukouvalas et al., 2020). Given the move from risk assessments towards needs-led risk formulations, it is vital clinicians have access to resources for understanding and discussing suicidal thinking with clients (Hawton et al., 2022; NICE, 2022). Service users have commented that when clinicians focus solely on suicide risk, their experiences and emotions can be lost (Gooding et al., 2023). More knowledge is needed about people's experiences to enable person-centred support which steers interactions beyond risk management.

Aims of the Review

This review increases understanding around how people experience thoughts to end their lives in the absence of an attempt. To our knowledge, this is the first qualitative review to explore this. The term 'experience' is left intentionally broad.

Method

The protocol for this meta-ethnography was registered prospectively on PROSPERO (registration number: 2023 CRD42023477811), accessible at https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023477811. The review is reported following the ENTREQ statement to improve transparency (Tong et al., 2012; Appendix B). It follows the guidelines for conducting a meta-ethnography, as reported by Sattar et al. (2021).

Search Strategy

The following electronic databases were searched systematically in January 2024: PsycINFO, CINAHL, MEDLINE, Web of Science and PubMed. The search strategy was developed in consultation with a librarian. It consisted of three search strings: 'suicidal ideation', 'mental health difficulties', and 'qualitative research'. The search strategy was formed for PsycINFO and adapted for the remaining databases. The full search strategy is included in Table 1. The references and forward citations of included studies were screened for additional eligible literature.

Inclusion and Exclusion Criteria

To meet the review's inclusion criteria, papers had to be full text studies published in English. All studies were qualitative and included first-person accounts of their personal experiences of suicidal thinking. Included studies needed to have a focus on participants aged 18-65 years who either had mental health difficulties (diagnosed/self-reported) or were referred from a psychiatric/mental health setting. The review excluded studies which used quantitative or mixed methods; focused on the impact of a specific intervention, treatment, or healthcare; explored suicidal ideation only in the context of suicide attempts;

or primarily focused upon physical health conditions. Review articles, theses and dissertations were also excluded.

To our knowledge, this is the first systematic review focused upon people's experiences of suicidal thinking in the absence of an attempt. The term 'experiences' was intentionally broad, aiming to capture the qualities of suicidal cognitions alongside people's responses to having these suicidal thoughts. The age range (18-65 years) was selected with clinical relevance in mind, to match the population seen in UK adult mental health services. As the review aimed to capture all studies primarily related to mental health difficulties, the inclusion criteria consider mental health contexts and diagnoses. A date restriction of January 1997 – December 2023 was implemented, informed by previous qualitative reviews looking at experiences of 'living with' suicidal thoughts (Lakeman & FitzGerald, 2008; Søndergaard et al., 2023). In both papers, no qualitative literature on experiences of suicidal thinking was identified prior to this timeframe.

Study Selection

The studies were exported onto Rayyan (Ouzzani et al., 2016). Titles and abstracts were screened by the first author for relevance. Subsequently full-text papers were reviewed for eligibility. All included papers were discussed and agreed by the reviewing team. An independent second rater also screened 10 papers to check reliability. One paper was identified by word-of-mouth after the search was conducted; this met the eligibility criteria and was thereby included (Reid et al., 2022).

Data Extraction

The first author extracted the relevant data and recorded this onto Microsoft Excel (Microsoft Corporation, 2018). Data extracted included first order constructs (participant quotations), second order constructs (author interpretations), and study characteristics

(Sattar et al., 2021). We planned to contact study investigators in the case of missing data and to note if no response was received.

Study Quality

The Critical Appraisal Skills Programme (CASP, 2018) was used to assess the quality of the studies included. An independent second rater assessed 15% of these to check reliability. Scores between the two independent reviewers were within one point for all papers with 90% inter-rater agreement; differences in opinion were discussed and a consensus was mutually agreed. No papers were excluded due to this assessment; however, their quality was considered during data interpretation and synthesis.

Synthesis

A meta-ethnography was selected for reviewing the data, as this uses a form of synthesis which is both inductive and interpretative; it is therefore the most commonly selected qualitative synthesis method for exploring and understanding people's internal experiences (Sattar et al., 2021). A seven stage process was followed (Noblit & Hare, 1988), with guidance from recent literature pertaining to this (France et al., 2019; Sattar et al., 2021). These stages involved 1) getting started, 2) deciding relevance, 3) familiarising self with studies, 4) considering study relatedness, 5) translating studies into each other, 6) synthesis of translations, and 7) reporting. The first author conducted this process, with regular discussion from the reviewing team.

During phase 3, a data extraction table was used in which quotes were lifted verbatim from the studies, and themes or metaphors arising from these were summarised (Table 4). Within phase 4, themes from each study were then compared for differences and similarities, and reduced into relevant categories (Figure 2). In phase 5 these were

translated into each other chronologically by summarising each study's contributions to the different themes (Appendix C).

When synthesising the translations, three methods may be used – reciprocal and/or refutational translation, followed by a line of argument translation (Noblit & Hare, 1988). This review uses reciprocal translation. Differences in people's experiences were noticed within subthemes, and drawn together within an overarching theme. The final synthesis understands the themes temporally, using an accessible pictorial depiction (Figure 3). The review is reported with reference to a recent meta-ethnography, alongside guidelines for using this approach (Haw et al., 2023; Sattar et al., 2019).

Reflexivity

Both the first and second authors were working clinically within adult mental health teams at the time of this review, and were conducting a suicide-based clinical intervention. This direct clinical experience, alongside the exposure to healthcare professionals' narratives around suicidality, may have led to potential biases. Supervision and a reflective log detailing decision-making were used to discuss and attempt to mitigate the risk of bias.

Results

Search Results

A PRISMA flow diagram summarising the search process is included (Figure 1). Twelve papers (total = 354 participants) met the eligibility criteria.

Study Characteristics

The study characteristics are included in Table 2. Papers included a balance of male and female participants (165 men; 189 women), with fewer non-binary/transgender participants (n=4). Of these, two studies were all female and three were all male; the remainder were mixed. The studies were conducted across 8 countries, and predominantly

focused upon Western populations (n = 10). A range of mental health difficulties were represented, including depression and anxiety (n = 3), bipolar (n = 1), psychosis-related diagnoses (n=2), and self-reported conditions (n=2).

Quality Appraisal

Studies showed moderate-strong CASP scores across all 10 areas, as reported in Table 3 (Critical Appraisal Skills Programme, 2018). No papers were removed; however, where CASP scores were lower, the extent to which each theme and point was reliant upon that particular study was considered. The CASP tool also identified areas of common weakness across the studies. Several studies did not consider the research-participant relationship; it is recognised that this may have impacted upon the analysis.

Translation and Synthesis

The themes and concepts from the studies were extracted (Table 4) and their relatedness was determined (Figure 2). A new set of themes were formed and the contributions of each study into these is summarised in Appendix C, with supporting information provided in a translations table (Table 5). Whilst each theme describes a distinct element of this population's suicidal experiences, the themes can be understood as a continuous, interlinking process. The interactions between themes are synthesised and understood within the wider concepts of disconnection and connection. A summary of how each study contributed to the themes is also outlined in Table 6.

Theme One: Unbearable Beliefs

The World is Against Me

Suicidal thoughts arose within a context where people felt misunderstood, injured, or ostracised. People felt they lacked control within a world which rejected them: "A lack of perceived social support […] extended to a lack of perceived social control" (Peterson &

Collings, 2015). People felt like “outcasts” (Gooding et al., 2023); sometimes due to personal rejection (e.g. relationships ending, family conflicts), widespread societal views (e.g. mental health stigma), or life circumstances (e.g. unemployment, job insecurity). Personal rejection and hurt was embedded not only in the present, but also linked to historical abuse and injury: “many of the men belabored such events linking injuries past to their current challenges and suicidality” (Oliffe et al., 2017).

People consequently felt misunderstood, unimportant, or attacked. The world was perceived as actively against them: for example, women felt “attacked by motherhood” (Reid et al., 2022). This led to high levels of internal mental pain, or to externalised anger towards an unjust, unsafe world: “anger was not only directed inwardly, others were also blamed” (Ridge et al., 2021). Whilst the locus of blame varied between people, their distress was unified in being untenable.

Anticipating rejection could be as unbearable as experiencing it. A central concern was others’ perceptions, such as “a fear of appearing stupid” (Skodlar et al., 2008) without the ability to change these views. Gender impacted upon this, with men worrying about being perceived as “weak” (Oliffe et al., 2017)

I am Worthless

Suicidal thoughts were said to come from a place of feeling “totally worthless” (Karlsson et al., 2023). These negative self-appraisals led to intense feelings such as shame (Castro-Ramirez et al., 2023), guilt (Skodlar et al., 2008), or self-disgust (Karlsson et al., 2023); intense and unbearable emotions.

Inferiority and the perception of being ‘less than’ dominated people’s negative views of themselves (e.g. (Oliffe et al., 2017; Skodlar et al., 2008). People made negative comparisons with others: “the patients constantly compared themselves to these others

and felt disappointed, sad, guilty, and ashamed" (Skodlar et al., 2008). Often these comparisons were framed by societal ideals - for example, one man believed "his lack of masculine capital rendered him inconsequential" (Oliffe et al., 2017) whilst a study focused on the perinatal period noted several comparisons to maternal ideals, with the appraisal of being a "bad mother" (Reid et al., 2022).

Interpersonal struggles were central to negative self-appraisals, with the idea of being a 'burden' present in several narratives (e.g. Gooding et al., 2023; Peterson & Collings, 2015). There was an assumption of bringing suffering to others: "It's the shame and guilt of recognising what impact and what a huge burden my behaviour […] has been on people I genuinely care about" (Owen et al., 2015).

I Can't Do This

Suicidal thoughts arose from an environment where people felt trapped, hopeless, and struggled with problem solving. Powerful metaphors were used to describe feeling 'trapped', from being "crushed in the black hole with no escape" (Skodlar et al., 2008), to being a combination lock with its numbers mixed (Oliffe et al., 2017). These images suggest an all-encompassing and overwhelming experience. Without alternative solutions, suicide is considered "the only means of escape" (Peterson & Collings, 2015).

Hopelessness and an inability to imagine the future permeated throughout narratives. The context varied significantly, but the unbearable feelings were consistent – one participant noted "it's not the triggers even, it's the inner experience of feeling trapped inside the despair" (Oliffe et al., 2017). Reduced problem solving skills were interlinked with hopelessness, as "mental resources are felt to be dangerously depleted" (Benson et al., 2013). This connected to participants' psychological experiences of stress and anxiety:

"typically men's problem solving abilities faltered and mounting stress and anxiety reduced their functionality and productivity" (Oliffe et al., 2012).

Theme Two: Disconnection

Disconnection From Others

In response to internal distress, people experiencing suicidal thoughts often withdrew from family, friends, and colleagues. This withdrawal had multiple functions, including "protecting others and/or themselves from their low affect and suicidality" (Oliffe et al., 2017). For example, several men did not want others to see them as weak or emotional, so responded by hiding their pain. Men not only described physically isolating from others, but also hiding their emotions: "hiding away stemmed from the shame associated with seemingly unmanly displays of emotionality" (Ridge et a., 2015). Masculinised ways of coping thus seemed to add to this need to disconnect:

Whilst this disconnection was largely described with a negative valence, some studies showed a mixed attitude. Ridge et al. (2015) noted this retreat can bring short-term comforts, and Gooding et al. (2023) that this behaviour is "not necessarily viewed negatively". Whilst overall physical isolation was perceived as "unwanted, troubling, and inadequate" (Gooding et al., 2023), it felt important to capture that some comfort and advantages were experienced through this behaviour.

Physical isolation was a bidirectional experience – people's experiences of being left by others, or rejected by the social group, lead to them becoming increasingly isolated as they stopped reaching out to others. Mental health experiences could contribute; for example, people with psychosis may experience voices telling them not to go out (Gooding et al., 2023).

Disconnection Into Self

Several studies noted people's internal withdrawal which could occur both with or without physical isolation. "Bell jar-esque" images were used to describe people's suicidal feelings: "I want to reach out to the world, but it isn't there to reach out to […] I am emotionally isolated, on an island with sea all around and no chance of rescue" (Benson et al., 2013). As people withdrew into themselves, they became disconnected from the world: "When in Crisis, [participant] could not be reached or helped by external sources" (Oliffe et al., 2017) as the person stops being "integrated with her environment" (Benson et al., 2013). In this isolated bubble, people's thoughts became increasingly negative and harmful: "their introspection contributed to negative and self-destructive rumination" (Ridge et al., 2021).

Disconnection From Self

Some studies noted a disconnected sense of self, as people struggled to reconcile the 'functioning' self in the external world, and the 'suffering' self within. Consequently, the "core assumption of being an integrated self, ordinarily taken for granted, is problematised" (Benson et al., 2013). People's experiences of internal disconnection could be damaging – it "could feel inauthentic" as well as adding "to feelings of shame" (Ridge et al., 2021).

The disconnection was often around a 'lack of consistency between the public or social self and the hidden suicidal self" (Benson et al., 2013); thus whilst people did not physically isolate themselves, they could be left feeling "isolated in company" as they hid their pain from the world (Oliffe et al., 2017). For others, their self-disconnection was embedded within their mental health experiences, as people battled with internal voices (Harris, 2023).

Theme Three: The Flow of Suicidal Thinking

The Strength of the Suicidal Current

Suicide was described, in the primary and secondary data, as an “urge” or “pull”. The idea of submitting to the thoughts was seen as the easy option – the “flow” was strong, and people anticipated feelings of “relief” by going along with this (Peterson & Collings, 2015). The focal population did not act upon their thoughts; therefore, this feeling of “relief” was not achieved through behaviour. However, the imagined comfort of suicide could in its own right be accompanied by relief (Skodlar et al., 2008).

Suicidal thoughts were described as varying in strength and intensity. Their strength impacted upon how easy they were to resist or ‘exit’. Benson et al. (2013) suggests the difference between ‘suicidal thoughts’ and ‘suicidal feelings’ differentiates between this intensity. Whilst this study focuses upon suicidal feelings, this observation was seen elsewhere: for example, “chronic” suicidal thoughts were separated from an intense “acute feeling which drove an immediate need to die” (Reid et al., 2022).

It was noted that when people experienced their suicidal thoughts as particularly strong, their “vulnerability appeared to be very high” (Reid et al., 2022). Thus, not only was the intensity of the thoughts important, but the participants’ ability to withstand these.

Immersed Beneath the Surface

Suicidal thinking was often described as an immersive experience: “they seemed less like a thought and more akin to being overwhelmed or consumed” (Gooding et al., 2023). This sense of consumption is encapsulated in the phrase “the darkness descends” (Reid et al., 2022) and one participant’s comment that “the whole world seemed as if it was closing in on me” (Skodlar et al., 2008).

Suicidality was for many an exhausting, whole body experience. This was a theme throughout Benson et al. (2013), which focused on suicidal feelings rather than thoughts, as they noted how the “mental exhaustion that goes along with the feeling of relentless

demand can thus be felt as physical exhaustion" (Benson et al., 2013). However, it also emerged within studies focused on ideation: "Suicidality could render men fatigued, without the capacity to quall or bear the accompanying pain" (Oliffe et al., 2017). Both the suicidal thinking and emotions, such as shame, were experienced with this whole body physicality (Karlsson et al., 2023). One participant described how it "feels like it's coming from your body rather than directly from your mind" (Reid et al., 2022). Thus, suicidality was for many an immersive, lonely, and exhausting experience.

Above the Surface

Calm and seemingly rational thinking could act as a vessel taking people towards suicide. Some participants deliberated "on the practicalities of suicide", or calmly debated whether suicide was "logical or illogical" (Ridge et al., 2021). For some, this planning was ultimately experienced as protective (Skodlar et al., 2008).

For others, moments of "intermittent rationalisation" enabled them to move out of their overwhelming thoughts to see their suicidal thoughts from a new perspective (Harris et al., 2019). They were "the wise, rational charge to safeguard survival", enabling people to recognise and gain control over their suicidal thoughts (Oliffe et al., 2012).

Fighting the Current

Whilst people often experienced "urges" to kill themselves, this population did not act on these thoughts. This was frequently described in terms of resisting and "fighting". Participants described "embodying the good fight" (Oliffe et al., 2012) and, when this became difficult, it was akin to "a losing battle" (Oliffe et al., 2017). All three papers focused on male participants frequently used military metaphors. Ridge et al. (2021) also described participants as "in the trenches" as they battled their thoughts of suicide. This

conceptualisation of engaging with suicidal thoughts in terms of warfare was seen as a means to move from a position of feeling vulnerable, to becoming strong and masculinised.

In studies considering a mix of genders, resistance could be framed as violent, physical acts e.g. a 'wrestle' (Peterson & Collings, 2015). However, elsewhere participants described "holding on to the window ledge" or parts of the self not "letting" them act (Benson et al., 2013). In these examples, a struggle was apparent, however it involved remaining motionless rather than actively opposing the suicidal thoughts. Nevertheless, the implication was similar in that giving in or 'losing' would lead to suicidal behaviour.

People not only fought their thoughts; the body itself was experienced as a battleground: "a sometimes visceral sense of a battle being fought between distinct parts of the self, both of which are competing for control" (Benson et al., 2013). This interlinked with people's experiences of having disconnected selves. The importance of 'control' emerged; interestingly, this control was - to a greater or lesser extent – regained when people exited their thoughts.

Theme Four: In-The-Moment Exits

Regaining Agency

A wide range of strategies were used to exit suicidal thoughts. Sometimes this involved actively engaging with their thoughts; at other times, it involved distraction techniques (e.g. Harris et al., 2019). Other people found creative outlets to express their emotions in less destructive ways such as by writing poetry (Peterson & Collings, 2015). However, some strategies were considered less societally acceptable, such as using self-harming or drugs to cope (e.g. Oliffe et al., 2017).

The need to be flexible when selecting strategies was named (Peterson & Collings, 2015). Regaining agency and self-reliance could act as a contrast to feeling out of control.

However, the negatives of elevated self-reliance could undercut the positives attached to agency; for example, when people struggled to find a helpful strategy, feelings of being 'out of control' could resurface.

Reaching Out for Support

Whilst suicidal thoughts were managed by some people alone, many looked for external support. The purpose of this could vary. For some it was for social distraction: "buffering against feelings of hopelessness by distracting the participant away from suicidal thoughts and feelings" (Owen et al., 2015). For others it was to "feel less alone" (Harris et al., 2019) or "just to have someone listen" (Oliffe et al., 2012). People most commonly spoke to family, friends, and healthcare professionals.

Reaching out could bring significant positives through social connection. It was seen as a counter to becoming disconnected and withdrawing into the self (Oliffe et al., 2012). Gooding et al. (2023) noted that people valued "being acknowledged and appreciated" after reaching out to others. However, at times people felt misunderstood or dismissed following disclosures, looping back into theme 1. This was true of family, friends, and healthcare professionals: indeed, suicidal crisis was seen as "a time when health professionals were less likely to really listen because they were occupied with assessing risk" (Gooding et al., 2023).

Reconnecting

Exits from suicidal thoughts were often accompanied by a mental shift, as people remembered their reasons for living: "countering by connection" (Oliffe et al., 2012). Relationships with loved ones were most frequently mentioned; additionally, people described reconnecting with a "a sense of purpose which offset suicidal desires" (Gooding et al., 2023). Reconnection was accompanied by "a sense of movement, going from being resigned about death and having no regrets about dying, to a change […]" (Gooding et al.,

2023) . Others described this as “turning points” (Ridge et al., 2021) or a “change of mind” (Oliffe et al., 2017). Reconnection could be gradual or sudden; it could be internally sought or brought about by an external interruption. However, it was underpinned by an apparent shift from one state into another. One interpretation is to see this as a step back towards ‘living’, captured by one participant who described their children as an “anchor to the world” preventing them getting swept away (Ridge et al., 2021).

Fear-Based Shifts

Not all shifts were based on moves towards ‘living’ and ‘reconnection’; others were based on fears associated with dying. Several of these were around family reactions, such as “considering the devastating impact of their suicide on family and friends” (Owen et al., 2015). Religious and moral reasons were also cited: “fears about transgressing beliefs featured as prohibitive for taking one’s life” (Oliffe et al., 2012). Intense emotions, most frequently guilt, fear, and shame, were linked to the idea of suicide: “Participants indicated they had not yet killed themselves due to feelings of guilt, fear” (Castro-Ramirez et al., 2023).

Sometimes the fear of death itself was named as the reason for not going through with suicide. These reasons were associated with strong negative appraisals, linking back into theme 1. People described themselves as “too cowardly” (Ridge et al., 2021) and it was seen as “evidence of a weak character and failed masculinity” (Oliffe et al., 2012). Both these papers focused on men’s experiences, suggesting that masculine ideals of being brave and tough were central to these narratives.

Theme Five: Long-Term Attitudes

Active Coping and Resilience

Whilst some people described 'in the moment' reactions, strategies, and reasons for living that stopped them acting upon their suicidal thoughts, others described a longer-term shift in their attitudes. These shifts took effort and time: "The resilience did not happen overnight, however, and took lots of work on the participants' part" (Peterson & Collings, 2015). One way this was achieved was by learning, reflecting upon, and understanding their mental health difficulties and suicidal thoughts: "Actively seeking an explanation for the origin of psychosis and the subsequent suicidal experiences through educating themselves" (Harris et al., 2020). Another frequently reported means was by making lifestyle shifts to support their wellbeing: "People described looking after themselves physically as key to helping themselves with suicidal thoughts and feelings. It was seen as a way of preventing these thoughts and feelings returning, not just a distraction" (Peterson & Collings, 2015). Internal resilience also interacted with external resources - a change in social circumstance or environment could be key in enabling someone to gain a new perspective on their suicidality (Reid et al., 2022).

For some, resilience meant prevention or reduction of thoughts. However, for others, resilience and coping could occur whilst they continued to experience thoughts; despite this they felt confident they had the learning and skills in place to cope. For these individuals, resilience was more about the ability to continually and actively manage the thoughts: "Everyday you have to manage it and everyday you do" (Peterson & Collings, 2015). Whilst resilience and coping meant different things to different people, they were underpinned by a sense of control over their experiences.

Passive Coping

A different long-term experience of suicidal thoughts was to adopt a "passive approach to coping", as one participant encapsulated saying "There's nothing I can fucking

do about it" (Harris et al., 2019). These individuals did not feel they had any active power or control over their thoughts. Their acceptance had not come from developing strategies but from a feeling of being stuck within the cycle. Noticeably, the two papers where this theme was most prevalent focused on people with psychosis; this long-term attitude towards suicidal thinking may be more likely to arise in people with this diagnosis.

In contrast to the distress many feel when speaking about suicide, this passivity occurred in an environment of separateness and disconnection from strong emotions towards suicide. People spoke about suicide in a "casual, dispassionate way" (Skodlar et al., 2008). There was an ambivalence within this group of people about whether they wished to live or die (Skodlar et al., 2008; Oliffe et al., 2017).

Synthesis

When synthesising our themes, inspiration was drawn from one of the included studies which used a photovoice methodology (Oliffe et al., 2017). Within this, participants used photographs to capture their experiences. One participant photographed a combination lock, symbolising how when suicidal thinking is present but not acted upon, the lock is not fully closed and there is still a way out – a powerful metaphor. Using an image within our synthesis was an appropriate reflection of the included literature, in addition to being an accessible way to illustrate the inter-related concepts.

We sought a depiction which would encapsulate the wider elements of the cycle, supporting understanding of people's experiences of both entering and exiting from suicidal thinking. The word 'flow' was repeatedly used in Oliffe et al. (2017)'s paper. The movement this evoked inspired the depiction of a river to be chosen (Figure 3).

Our synthesis linked themes 1- 4 temporally. People firstly experience something unbearable - they move away from the safety of the riverbank, and onto the bridge. They

disconnect (i.e. enter the river) and experience the current of suicidal thinking. Their thoughts are pulling them towards suicidal behaviour; however, they are able to exit the water and return to 'safety'. This exit may permanently take them away from their thoughts – however, for others, the exit is temporary and they re-enter the cycle.

Theme 5 is adjacent to this process, describing longer-term attitudes which impact on this process. In theme 5a, people see their experiences from a new perspective. Theme 5b is depicted as a stagnant pool. Devoid of the movement of disconnection and reconnection, individuals experiencing a more passive approach to coping remain close to the suicidal river, never fully moving away from entertaining suicide as a possibility. Arrows between theme 5 and the rest of the cycle are tentatively added, due to limited evidence in the literature. For some, active resilience involved a full move away from suicidal thoughts; for others, suffering continued. Therefore, arrows point away and towards theme 1.

The temporal nature of this synthesis was influenced by the content of the papers, which tended to largely focus either on the entry into suicidal experiences (themes 1-2), experiencing the thoughts (themes 2-3), or 'exits' from suicidal thoughts (themes 4-5). There is a recognition that these experiences are not purely linear, with several themes interacting. Arrows from theme 4 are largely speculative, as no papers focused upon the return into suicidal thinking.

Discussion

Summary and Relevance of the Findings

Overall, this synthesis adds to the current literature base by presenting the dynamic processes which occur during suicidal thinking when no attempt is made. It outlines how people's internal processes are characterised by shifts between disconnection and reconnection, feeling out of control and regaining agency, and internal battles between a

wish to live and die. This backwards-and-forwards movement has been omitted from key suicide models; the 3ST and IPT are linear (Joiner, 2007; Klonsky & May, 2015) and the IMV does not include movements away from suicidal ideation (O'Connor & Kirtley, 2018). This is surprising, as shifts both towards and away from suicidal thinking stood out within the review, and both have potential clinical importance. One model which captures suicide's dynamic nature is the fluid-vulnerability theory, where the "ebb and flow" of suicidal desire is named (Bryan et al., 2020). This model is useful when considering risk; however, whilst constructs such as defeat, entrapment, and thwarted belonging are congruent with this, they are amalgamated under the 'cognitive domain' of the suicidal mode (Rugo-Cook et al., 2021). Our synthesis bridges the gap between these models, presenting a dynamic model in which such suicide constructs can be separated.

Our synthesis has noticeable parallels with the 3ST (Klonsky & May, 2015). Their steps 1-2 ('pain and hopelessness' and 'pain overwhelming connectedness') link to themes 1-2. Our review noted psychological suffering, but not physical pain; this is perhaps unsurprising given the focus on people with mental health difficulties. However, it suggests this internal pain predominantly arises from negative inter- or intra-personal challenges (Themes 1a-b: 'I am Worthless' and 'The World is Against Me'), linking with the IPT model (Joiner, 2007). In this review, people's interpersonal needs are understood alongside a perception that their situation is inescapable ('I can't get out of this'); akin to the 'no rescue' element in the Cry of Pain model (J. M. G. Williams et al., 2001). This was a precursor to another well-established suicide construct: entrapment (O'Connor & Kirtley, 2018; Siddaway et al., 2015; Teismann & Forkmann, 2017). Thus, our review suggests it is the combination of both suicide constructs - interpersonal needs and entrapment – which leads to beliefs feeling unbearable, culminating in suicidal desire.

In both the 3ST and the IPT model, the movement from 'suicidal desire' to an attempt requires capability (Klonsky & May, 2015; Van Orden et al., 2010). Our synthesis suggests that fear of death and its consequences (i.e. a lack of capability) can be an exit from suicidal thoughts (Theme 4d: 'Fear-Based Shifts'). However, the qualitative data provided richer and more varied reasons for people not acting upon their thoughts than lacking capability. Many presented it as a struggle not to act, with suicidal behaviour seen as the easy option. This suggests people's conscious experiences are more influenced by the opposing forces of their wish to live and their wish to die. Recent research suggests these antagonistic wishes should be modelled separately, and that the strength of people's wish to live may hold more importance in future research (Ernst et al., 2024). Our findings corroborate this qualitatively, suggesting that understanding and strengthening people's wish to live could have clinical significance.

This review proposes there are both in-the-moment exits from active suicidal thoughts, in addition to longer-term shifts in attitude. The reactionary exits correspond with factors explored in safety or crisis plans (Kayman et al., 2016). However, our review indicated that exits have the potential to retrigger unbearable feelings. Fear-based shifts could lead to people seeing themselves as 'cowards' (theme 1b); thwarted attempts to regain agency left people disheartened (theme 1c); and people could feel further ostracised by the world around them if misunderstood by their chosen support channel (theme 1a). Recent research considered clinicians' confidence and skills in safety planning; however, a component which was not assessed was clinicians' responses to a client saying strategies have not worked (Moscardini et al., 2020). It would be beneficial for clinicians conducting safety planning to understand more around failed or temporary exits, to increase understanding around these processes and disrupt the cycle.

Safety planning also needs to be completed in conjunction with conversations about people's longer-term attitudes towards their suicidality to help them build understanding and resilience. The importance of facilitating this shift in perspective has been corroborated by quantitative research, as positive reappraisals of events have been linked to higher suicide resilience (Johnson et al., 2010). This paper considered appraisals of life events; it would be interesting to consider how changes in the way people appraise their suicidal thinking (and their exits from this) impact upon resilience too.

Finally, this review suggests that for some people, their long-term attitude towards suicidality is one of passive acceptance. This raises the question of how to provide support to individuals who may not wish to actively move towards understanding or re-appraising their situation. It could be hypothesised that this group is likely to hold high levels of risk, given their sense of hopelessness and passive relationship with coping. The research did not contain information about people's experiences of moving into having an active or passive relationship with their suicidal thinking. It would be helpful to know more about this transition, so clinicians can consider the best strategies for supporting individuals.

Strengths and Limitations

This review enables people's experiences of both entering into and moving away from a period of suicidal thinking to be explored and synthesised within one model. Suicide models often explore people's experiences in terms of risk, with suicidal behaviour as the final destination. There is separately extensive literature around coping and resilience; however, this is not usually presented in these models. For people who have suicidal thoughts but do not act upon these, their experiences involve both pulls towards and away from suicidality. This synthesis helpfully enables both to be understood together.

In doing this, parallels between the drives into suicidal thinking and out of it can also be observed. For example, the unbearable nature of people's beliefs could be seen as being counteracted by experiences of agency and understanding, making their load easier to bear. Moreover, people's experiences of disconnection seem to be opposed by reconnection through reasons of living or through using the support of others. The synthesis enables the sense of movement between different internal beliefs to be more clearly understood, providing insight into personal experiences of this process.

The synthesis may also have value in helping clinicians to better understand how people with mental health difficulties experience suicidal thoughts. This may provide a useful compass for directing questions about people's internal experiences of suicide. Risk assessments often ask about planning or intent; however, people's descriptions display a greater richness and breadth of thought, such as internal battles and immersive experiences. This review suggests there is more scope for asking about wider feelings and sensations when formulating risk, and for using the individual's own language and metaphors to explore existing and new exits from suicidal states.

The model suggests that people experience both in-the-moment, reactionary exits from suicidal states, in addition to longer-term attitude shifts. It may be helpful for clinicians to move their focus from shorter-term safety planning to longer-term support, including considering psychological and social aspects to build resilience and coping strategies.

Another strength of the review was the fairly balanced male-female gender split (165 men; 189 women; 4 non-binary/other). Within the analysis, we were able to extract some gender-related differences and to consider the way this impacted upon how people constructed their experiences; particularly in relation to male-specific experiences. There was, however, little focus on specific elements of women's experiences of suicidality; there

were also few non-binary/transgender people included. Quantitatively, differences have been established (Richardson et al., 2023) and risk levels are shown to be elevated in transgender people (McNeil et al., 2017); it would therefore be valuable to increase our understanding of these differences within qualitative research.

The studies were predominantly from Western countries – there was one study from a Latin American population, one from a Central European country, and no studies from African or Asian countries. Several studies also lacked ethnicity data. Given the differences in the intersectional prevalence of suicidality, again it would have been interesting to have had more information about this to better understand how this impacted upon people's experiences (Forrest et al., 2023).

The review was limited by there being few studies which focused exclusively on a population with both mental health difficulties and suicidal ideation in the absence of an attempt. Consequently, we included studies where this was the 'focus', meaning that whilst the majority fulfilled this description, inevitably some studies included data from participants outside of this scope. Where this was the case, it was not always possible to conclude which may have impacted on our findings. Additionally, the review excluded mixed-methods studies, following guidance that meta-ethnographies should include only qualitative literature (Sattar et al., 2021). However, the review may have been enriched by including the qualitative components of such studies.

Several studies were not conducted in English; however, the translation process was not described. Qualitative research relies on language to understand the experience of others, and the need for rigor in translation has been named and explored (McKenna, 2022). For example, metaphors, jargon, and slang may not translate easily; moreover, if it is not apparent a study has been translated, elements of the culture it is embedded in may

also be lost in the analysis. More transparency in the translation process would have strengthened the review.

Finally, one study was identified through word of mouth after the search had been completed. This may suggest that some relevant studies were not identified by the search terms used. However, given that less than 0.3% of all screened studies were included, it would likely have been infeasible to use broader search terms.

Recommendations and Conclusions

Overall, this review indicates that people's experiences of suicidal ideation in the absence of an attempt involves a series of movements and shifts between states. In contrast with suicidal thoughts which lead to action, experiences ended with an 'exit' and a move away from thoughts of ending their life. People's experiences involved some form of battle or resistance to their thoughts; their will to live ultimately was stronger than their will to die.

To better understand how people re-enter suicidal thoughts, further qualitative exploration of people's experience of failed or temporary exits is needed. This could have important clinical implications both in disrupting this cycle, and in helping people move into a position of active resilience – not only understanding their thoughts, but also their exits from these.

A second recommendation is for future research to consider longer-term attitudes to suicidal thinking. Our review had little information around how people begin passively accepting their situation rather than actively moving away from it or learning about it. It would be helpful clinically to understand more about both the demographic information of people who describe these different responses and their journey to viewing their suicidal thinking from this perspective. It would be interesting to understand the role of social

situations within this; there is an acknowledgement in the resilience literature that both internal and external resources play a part in how people achieve this (Sher, 2019).

Finally, within mental health services, this synthesis could support clinicians' understanding of suicidal thinking. It provides a tool for beginning conversations not only about risk, but more broadly around distress and how people manage their thoughts. It can support clinicians to think about how 'exits' can be helpful and harmful, and to think with their clients collaboratively about breaking this cycle.

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Tables and Figures

Table 1

The Search Strategies Used for the Five Databases

	Suicidal ideation	**Mental health difficulties**	**Qualitative Research**
PsycINFO/ CINAHL/ MEDLINE	(DE "Suicidal Ideation" OR DE "Suicidality") OR TI (((suicid*) N5 (ideation OR thought* OR thinking OR imag* OR cognition* OR feeling* OR urge*))) OR AB (((suicid*) N5 (ideation OR thought* OR thinking OR imag* OR cognition* OR feeling* OR urge*)))	(DE “Mental Health” OR DE "Mental Disorders" OR DE "Affective Disorders" OR DE "Anxiety Disorders" OR DE “Schizophrenia” OR DE "Behavior Disorders" OR DE "Bipolar Disorder" OR DE "Chronic Mental Illness" OR DE "Dissociative Disorders" OR DE "Eating Disorders" OR DE "Obsessive Compulsive Disorder" OR DE "Personality Disorders" OR DE "Psychosis" OR DE "Serious Mental Illness" OR DE "Stress and Trauma Related Disorders" OR DE "Thought Disorders”) OR TI (anxiety OR depression OR psychosis OR ((mood OR obsessive compulsive OR post*traumatic stress disorder OR bipolar OR borderline personality OR eating OR panic) disorder) OR	(DE "Qualitative Method*" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis") OR TI (focus group* OR qualitative OR ethnograph* OR interview* OR group discussion* OR grounded theory OR interpretative phenomenological analysis OR narrative OR thematic analysis OR discourse analysis)

		schizophrenia OR psychiatric hospital OR ((mental health OR psych*) N3 (difficult* OR diagnosis OR illness* OR issue*))) OR AB (anxiety OR depression OR psychosis OR ((mood OR obsessive compulsive OR post*traumatic stress OR bipolar OR borderline personality OR eating OR panic) disorder) OR schizophrenia OR psychiatric hospital OR ((mental health OR psych*) N3 (difficult* OR diagnosis OR illness OR issue*)))	OR AB (focus group* OR qualitative OR ethnograph* OR interview* OR group discussion* OR grounded theory OR interpretative phenomenological analysis OR narrative OR thematic analysis OR discourse analysis)
Web of Science	Topic: (suicid*) NEAR/5 (ideation OR thought* OR thinking OR imag* OR cognition* OR feeling* OR urge*)	Topic: anxiety OR depression OR psychosis OR ((mood OR obsessive compulsive OR post*traumatic stress OR bipolar OR borderline personality OR eating OR panic) disorder) OR schizophrenia OR psychiatric hospital OR ((mental health) NEAR/3 (difficult* OR diagnosis OR illness* OR	Topic: focus group* OR qualitative OR ethnograph* OR interview* OR group discussion* OR grounded theory OR interpretative phenomenological analysis OR narrative OR thematic analysis

		issue*)) OR ((psych*) NEAR/3 (difficult* OR diagnosis OR illness* OR issue*))	OR discourse analysis (topic)
PubMed	MeSH Terms: \"suicidal ideation" OR Title/Abstract: ("suicidal ideation" OR "suicidality" OR "suicidal thinking" OR "suicidal thought*" OR "suicidal cognition*" OR "suicidal image*" OR "suicidal urge*" OR "suicidal feeling*")	MeSH Terms: "mental disorder" OR Title/Abstract: "mental health" OR "mental disorder" OR "anxiety" OR "depression" OR "psychosis" OR "schizophrenia" OR "mood disorder" OR "obsessive compulsive disorder" OR "post-traumatic stress disorder" OR "bipolar" OR "eating disorder" OR "borderline personality disorder" OR "panic disorder" OR "psychiatric hospital"	MeSH Terms: "qualitative research" OR Title/Abstract: "qualitative research" OR "grounded theory" OR "narrative" OR "interpretative phenomenological analysis" OR "thematic analysis" OR "interview" OR "interviews" OR "focus group" OR "focus groups" OR "discourse analysis"

Table 2

Study Characteristics for the Studies Included in this Meta-Ethnography

Authors (Year)	Country	N	Sex	Mean Age (range)	Ethnicity	Mental health	Methodology	Analysis
Skodlar et al. (2008)	Slovenia	19	7f, 12m	32.1 (21–50)	Not specified	Schizophrenia	Interview: 2 questions with follow up	Qualitative phenomenological analysis
Oliffe et al. (2012)	Canada	38	All male	36.2 (24–50)	30 Anglo-Canadian; 3 First Nations; 3 European; 3 Asian	Depression	Semi-structured interview	Grounded theory
Benson et al. (2013)	UK	124	85f, 36m, 3 ns	37.89 (16–67)	Not specified	81.45% self-report MH diagnosis	Questionnaires and face-to-face interviews (with sample of 22)	Grounded theory
Peterson & Collings (2015)	New Zealand	27	17f, 9m, 1 ns	44** (early 20s–mid 70s)	Not specified	Self-identified mental illness for at least 3 years	Structured interview of 8 questions (with flexibility)	Narrative thematic analysis
Owen et al. (2015)	UK	20	13f, 7m	45.6 (26–60)	Not specified	Bipolar disorder	Semi-structured interview	Thematic analysis
Oliffe et al. (2017)	Canada	20	All male	42 (20–62)	70% Canadian; 5%	70% received psycholog	Photo-voice assignmen	Constant comparison methods

					Aboriginal; 15% Asian; 5% Lebanese; 5% Mixed	ical support, 65% with formal mental illness diagnosis	t and photo elicitation interview	
Harris et al. (2019)	UK	20	10f, 10m	48 (23–75)	16 White British; 1 Black British; 3 Mixed Ethnicity	Recruited from mental health services	Semi-structured interview	Thematic analysis
Ridge et al. (2020)	UK	11	All male	37 (no range)	10 White British; 1 Black British	Previous diagnosis of depression and/or anxiety; 3 with multiple MH difficulties	Narrative interviews	Inductive thematic analysis
Reid et al. (2022)	UK	12	All female	36 (27-47)	10 White British; 1 Arabian; 1 White Eastern European	Perinatal mental health difficulties; range of diagnoses	Semi-structured interview	Grounded theory
Gooding et al. (2023)	UK	22	11f, 11m	37.6 (18–62)	19 White / Caucasian	Non-affective psychosis	Semi-structured interview	Inducive reflexive thematic analysis
Castro-Ramirez (2023)	Colombia and Mexico	38	27f, 11m	21.84 (no range)	Not reported – predomantly Latin American	Meet diagnostic criteria for depression or anxiety	Semi-structured interview	Framework analysis approach

Karlsson et al. (2023)	Sweden	7	All female	3 are 20-40, 3 are 41-65, 1 is over 65	Not reported – varied European	Gambling disorder	Semi-structured interview	Qualitative content analysis

‡ This study did not include a mental health diagnosis, and was therefore not included in the original analysis. However, as its population had experienced sexual trauma and the population was akin to those seen within mental health services, the paper was considered alongside the final synthesis

§ Median used as mean age not available

Table 3

Quality Appraisal CASP Scores for the Included Papers

Authors (Year)	Aims	Qualitative Methodology	Research Design	Recruitment	Data Collection	Relationship	Ethical Issues	Data Analysis	Findings	Value	**Total**
Skodlar et al. (2008)	YES	YES	3	3	2	1	3	2	3	2	**19**
Oliffe et al. (2012)	YES	YES	3	3	3	2	3	3	3	3	**23**
Benson et al. (2013)	YES	YES	1	1	2	1	2	2	2	2	**13**
Owen et al. (2015)	YES	YES	3	3	3	1	3	2	1	3	**19**
Peterson & Collings (2015)	YES	YES	1	3	3	1	2	2	3	2	**17**
Oliffe et al. (2017)	YES	YES	3	2	2	1	3	3	3	3	**20**
Harris et al. (2019)	YES	YES	3	3	3	1	3	3	3	3	**22**

Ridge et al. (2020)	YES	YES	2	3	3	1	2	3	3	2	**19**
Reid et al. (2022)	YES	YES	3	3	3	3	3	3	3	3	**24**
Castro-Ramirez (2023)	YES	YES	3	3	3	1	3	2	2	3	**20**
Gooding et al. (2023)	YES	YES	2	3	3	2	3	3	3	3	**22**
Karlsson et al. (2023)	YES	YES	3	3	3	3	3	3	3	3	**24**

Table 4

An Example Data Extraction Table Using the Theme 'Solitude' from Subjective Experience and Suicidal Ideation in Schizophrenia (Skodlar et al., 2008)

Primary Themes	Participant quotes	Primary author interpretations	Additional concepts/ metaphors
Solitude	'I started to think about and to plan suicide especially because I couldn't deal with people anymore and I was all the time alone, alone, alone. This was not a life'. (22 years, male)	[He] felt that something was wrong with him. He could not communicate with others anymore, actively withdrawing from them because of a fear of appearing stupid in their eyes. He felt very lonely.	Anticipated negative views of others
	'From my childhood onward, I felt different from others. I could never associate or make contacts with other people. I was very closed as a person and I felt guilty about it. I felt guilty the I was so different from others. I could	Such patients experienced a feeling that something was wrong with them, that they were profoundly different from other people, and that they were not able to engage in relationships with others.	Internally flawed Difference/inferiority Suicidal ideation as black hole Entrapment

never associate or make contacts with other people. I was very closed as a person and I felt guilty about it. I felt guilty that I was so different to others. The whole world felt as if it were closing in on me, and I was crushed in the black hole with no escape. When it was very bad, I thought about death. If one enters such a state, one can do something stupid'. (41 years, female)		
'I had a very negative opinion of other people. I saw them more like animals, not rational beings: beings with free will. I observed details proving that I was right – details that people are not	He connected [his suicidal thoughts] to difficulties with other people: he could not ask anybody for anything, not even his parents.	Mental health difficulties interacting with isolation

at all aware of in interactions, but still they convey messages. When I was interacting with others, I observed all this as well, and I got scared.' (24 years, male)		
	These [listed] inabilities were so burdensome and stressful, and the consequential solitude so unbearable, that they began to consider or even planned suicide.	Experiences as unbearable
	Some patients also reported finding a potential solution in suicide was a strong source of relief.	Suicide as relief

Table 5

Example Translations Table Using the Subtheme 'Passive Coping'

Descriptor (groups of similar concepts clustered together/ broad thematic headings	**First Order Data (participant quotes/primary data from the studies)**	**Second Order Themes (themes developed by primary authors)**
Suicidal ideation described as a normal part of daily life which is not challenged or questioned	'He spoke about it as if committing suicide or going for a walk in the afternoon was of about equal value' (Skodlar et al., 2008)	Suicide as a whim of the day (Skodlar et al., 2008)
	'I was always asking myself why I should commit suicide, but I never found a reason for it. So I was saying to myself: 'You can always do it tomorrow'' (Skodlar et al., 2008)	General casualness when talking about suicide (Skodlar et al., 2008)
	"Chronic suicide" […] "I'll just stay in this behaviour"' (Oliffe et al., 2017)	Ambivalence for living; injury (Oliffe et al., 2017)
	"There's nothing I can fucking do about it […] I just accepted it." (Harris et al., 2019)	Passive approach to coping (Harris et al., 2019)

Table 6

Summary Table of the Studies Contributing to Each Theme

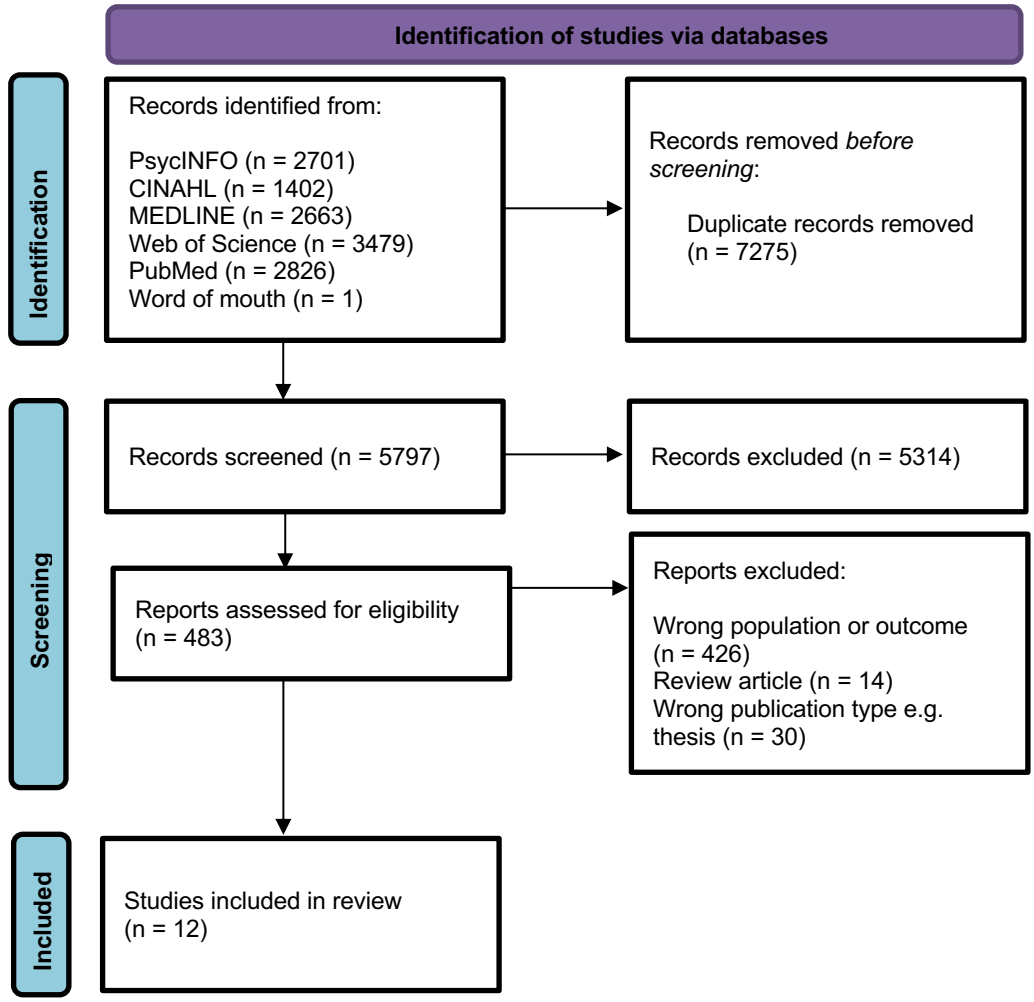
Study	1. Unbearable Beliefs			2. Disconnection			3. The Flow of Suicidal Thinking				4. In-the-moment Exits				5. Long-Term Attitudes	
	a	b	c	a	b	c	a	b	c	d	a	b	c	d	a	b
Skodlar et al. (2008)	√	√	√	√				√	√		√	√	√	√		√
Oliffe et al. (2012)	√	√	√	√		√	√	√	√	√	√	√	√	√		
Benson et al. (2013)	√	√	√	√	√	√	√	√	√	√	√	√				
Peterson & Collings (2015)											√	√	√	√	√	
Owen et al. (2015)	√	√	√				√				√	√	√	√	√	
Oliffe et al. (2017)	√	√	√	√	√	√		√		√	√	√	√	√		√
Harris et al. (2019)	√	√		√					√		√	√	√	√	√	√
Ridge et al. (2020)	√	√		√	√	√		√	√	√	√	√	√	√	√	√
Reid et al. (2022)	√	√	√	√	√	√	√	√		√				√		

Gooding et al. (2023)	√	√	√	√		√			√	√	√	√	√	√
Castro-Ramirez (2023)	√	√	√			√			√	√	√	√	√	
Karlsson et al. (2023)	√	√	√	√		√		√		√	√			

Key: 1a = The World is Against Me, 1b = I am Worthless, 1c = I Can't Do This, 2a = Disconnection from Others, 2b = Disconnection Into Self, 2c = Disconnection From Self, 3a = The Strength of the Suicidal Current , 3b = Immersed Beneath the Surface, 3c = Above the Surface, 3d = Fighting the Current, 4a = Regaining Agency, 4b = Reaching Out for Support, 4c = Reconnecting, 4d = Fear-Based Shifts, 5a = Active Coping and Resilience, 5b = Passive Coping

Figure 1

PRISMA Flow Diagram



Note. Adapted from "The PRISMA 2020 statement: an updated guideline for reporting systematic reviews" by M. J. Page, J. E. McKenzie, P. Bossuyt, I. Boutron, T. C. Hoffmann, C. D. Mulrow, et al., 2021, *BMJ*, 372(71). https://doi.org/10.1136/bmj.n71

Figure 2

Reducing Themes into Relevant Categories

1. **External persecution**

- Stigma
- Thwarted belonging
- Rejection
- Persecution
- Historical Trauma

2. **Internal negative perceptions**

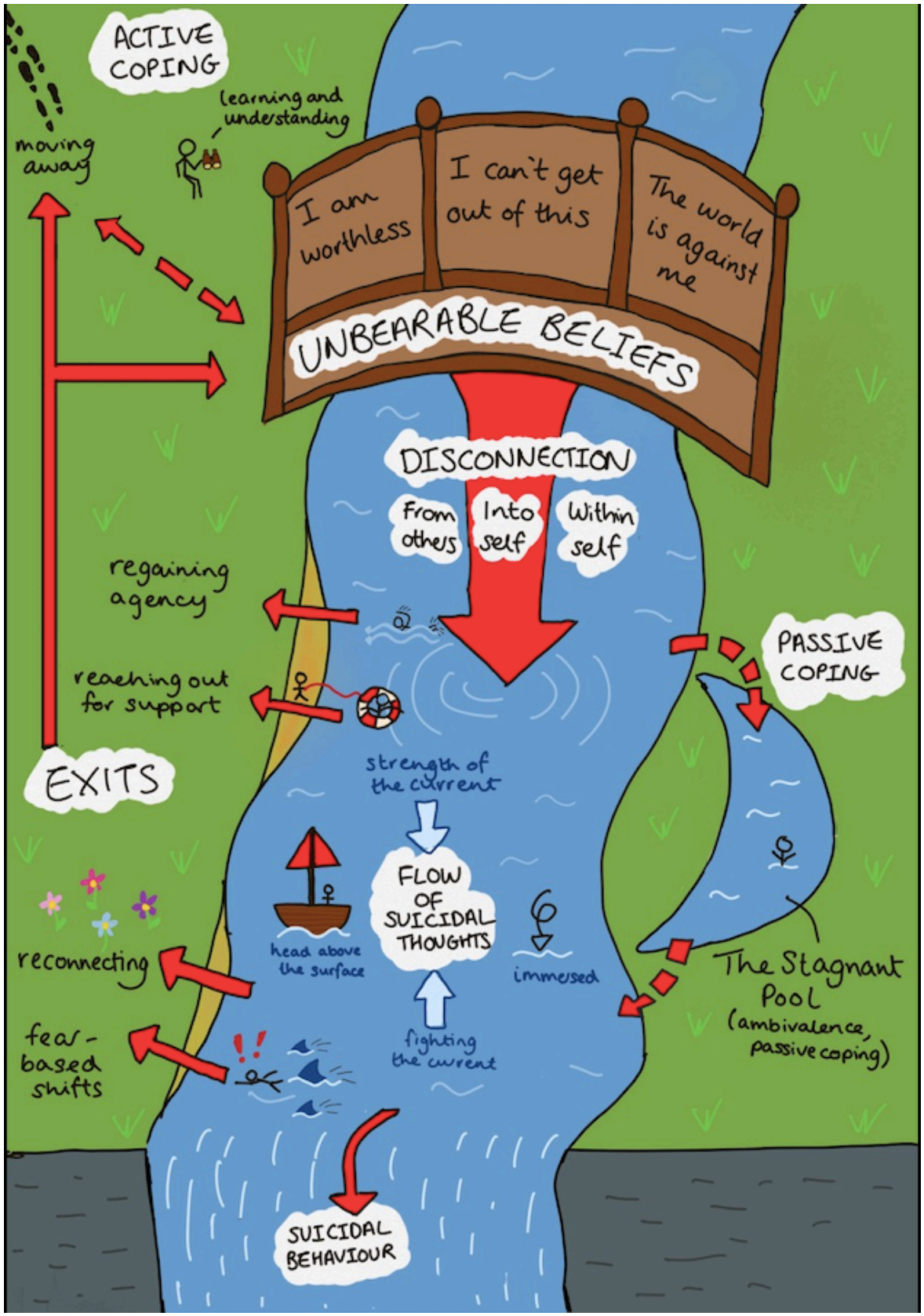
- Inferiority
- Perceived burdensomeness
- Shame

3. **Feelings of entrapment**

- Defeat
- Hopelessness
- Deficits in problem solving
- Inability to escape

Figure 3

The River of Suicidal Thinking – A Synthesis of the Reviews' Key Themes and Concepts



Appendix A

Psychology and Psychotherapy Author Guidelines

Aims and Scope

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
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- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- Language: Authors must avoid the use of sexist or any other discriminatory language.
- Abbreviations: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- Effect size: In normal circumstances, effect size should be incorporated.
- Numbers: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Appendix B

ENTREQ statement

No	Item	Guide and description
1	Aim	State the research question the synthesis addresses.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology *(e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).*
3	Approach to searching	Indicate whether the search was pre-planned (*comprehensive search strategies to seek all available studies)* or iterative (*to seek all available concepts until they theoretical saturation is achieved)*.
4	Inclusion criteria	Specify the inclusion/exclusion criteria *(e.g. in terms of population, language, year limits, type of publication, study type).*
5	Data sources	Describe the information sources used (e.g. *electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists)* and when the searches conducted; provide the rationale for using the data sources.
6	Electronic Search strategy	Describe the literature search *(e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).*
7	Study screening methods	Describe the process of study screening and sifting *(e.g. title, abstract and full text review, number of independent reviewers who screened studies).*
8	Study characteristics	Present the characteristics of the included studies *(e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).*
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion *(e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).*
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings *(e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).*

No	Item	Guide and description
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings *(e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope* [25]*; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).*
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? *(e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).*
15	Software	State the computer software used, if any.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data *(e.g. line by line coding to search for concepts).*
18	Study comparison	Describe how were comparisons made within and across studies *(e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).*
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. *new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).*

Note. Retrieved from "Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ" by A. Tong, K. Flemming, E. McInnes, S. Oliver, and J. Craig, 2012, *BMC Medical Research Methodology, 12(181),* https://doi.org/10.1186/1471-2288-12-181

Appendix C

Reciprocal Translations Paragraph: Synthesising the Primary Author Interpretations

The translations phase below has followed the methodology and reporting used in Figure 4 of Sattar et al. (2021).

Key –

Study	Number
Skodlar et al. (2008)	1
Oliffe et al. (2012)	2
Benson et al. (2013)	3
Peterson & Collings (2015)	4
Owen et al. (2015)	5
Oliffe et al. (2017)	6
Harris et al. (2019)	7
Ridge et al. (2020)	8
Reid et al. (2022)	9
Gooding et al. (2023)	10
Castro-Ramirez (2023)	11
Karlsson et al. (2023)	12

Theme 1 – Unbearable Beliefs

The World is Against Me

Paper 1 shows that other people are perceived as being a source of fear. There was a sense of rejection as people felt abandoned. Paper 2 adds that relationship and work dysfunction has a role in triggering suicidal thoughts, indicating a context in which people may feel unsupported or rejected. Paper 3 similarly adds to this theme to indicate how during suicidal experiences others are described in strong negative language - uncaring, hostile, manipulative, or hateful. Paper 5 similarly found that a perceived lack of social support was a trigger for suicidal thoughts. The role of stigma and misunderstanding from others was also noted to play a role. In Paper 6 a photo titled ‘abandoned’ demonstrated the experience of rejection and isolation which foregrounded suicidality.

The paper found that past and current injuries and hurt played an important role in suicidality; men spent extensive amounts of time ruminating upon this and how the world had treated them. Paper 6 also contributes to this theme though noting the role of gender-based criticisms, especially around others seeing them as 'weak'. In Paper 7, the role of feeling rejected or lacking support from others was similarly highlighted as something which could lead them back towards suicidal thinking. Paper 8 similarly finds that the hurt experienced through the actions of others is central to suicidal thoughts arising; this is linked to the role of the strong emotions anger and blame, as feelings of blame towards others is highlighted. Conversely, seeing suffering as universal rather than personal was found to reduce suicidality. Paper 9 added the idea that it may not only be people who are perceived as antagonistic; the social construct of 'motherhood' in its own right could be experienced as attacking. A sense of 'attack' and threat pervaded from multiple angles. Stigma around this was central to experiences of feeling misunderstood and, consequently, of suicidality arising. Paper 10 similarly described people feeling as outcasts, noting a range of reasons which corroborate previous papers including personal rejection (and perceived rejections), societal views, and life circumstances. An experience of not being understood or listened to by others was again found. Paper 11 reiterates the role of stigma and of family conflict (and consequent feelings of shame/rejection). It expands upon this to highlight the role of cultural factors in contributing to these feelings. Finally, paper 12 describes the stigma and self-stigmatisation which leads women with a gambling disorder to believe others are against them.

I am Worthless

Paper 1 suggests people feel something is wrong with them and they feel a profound difference/ inferiority to others. This was connected to a sense of guilt and shame. Paper 2 similarly noted feelings of shame, blame, and guilt. In paper 3, evidence is added to the idea that people experience certain parts of their self or life as worthless or fraudulent; however, its focus is more upon how this leads to a sense of disconnection. Paper 5 identifies the role of social interactions and perceptions in triggering or reinforcing ideas of the self as worthless. It introduces the concept of being a 'burden', and indicates that suicidal individuals believe they bring suffering to others. It adds that the actions of others – unintentional or intentional – could reinforce such negative self-appraisals. Similarly to papers 1 and 2, it reinforces that feelings of shame and guilt are attached to this. Paper 6 similarly found that perceived inferiority and the perception of being 'less than' was present before/during the experience of suicidal thinking. This was found to be conceptualised in terms of masculine ideals. Paper 7 similarly noted the negative impact of perceiving oneself as being a 'burden'. Paper 8 adds the idea of being left behind by life, with the conclusions from this as being that the self is inferior or deficient in some way, with multiple negative self-appraisals. Similar to other papers focused on

men, this was conceptualised in terms of a failure to 'be a man'. Paper 9, which focused on suicidality in the perinatal period, also found that social constructs and roles impacted upon self-appraisals – in this population the idea of being a 'bad mother' and failing to live up to societal standards of motherhood prevailed. Paper 10 reiterates the idea of the self as a 'burden' under the theme 'not mattering', finding the importance of a perception of the self as being inconsequential or unvalued. Paper 11 similarly corroborates the role of the intense feeling 'shame' attached to worthlessness, and a view of one's life as being inconsequential. Finally, paper 12 describes the feeling of being 'totally worthless', encapsulating experiences noted in all papers. It adds that this can lead to a feeling of self-disgust, and links the feeling to people's appraisal of their mental health condition (gambling disorder). The theme of being a burden again arises.

I Can't Do This

People struggled to see a future in paper 1. They felt trapped with no escape; powerful metaphors were used to encapsulate how powerful and overwhelming this experience was. Paper 2 similarly noted this to indicates that suicide is perceived as a solution to end people's feelings of unrelenting and unbearable pain and despair. It also noted the role of reduced problem solving in contributing to this feeling, with an impact upon functioning. Paper 3 concurs with this, noting how people are in a space where they have few mental resources. Paper 5 indicated the importance of feeling trapped, and believing oneself to lack social control. Similarly to paper 1 and 2, paper 5 contributes to the idea of suicide being seen as an 'escape' at this time. Paper 6 similarly found that men experienced this sense of being trapped, suggesting this unbearable feeling – rather than any specific triggers - was central to the context to suicidality. Similar to paper 1, it uses powerful images to capture this feeling, with the image of a combination lock central to conveying this sense of being trapped. The phrase 'I can't do this' is a theme from paper 9 – similarly to other papers, an appraisal of the self as being trapped and unable to find a solution other than suicide pervades. A loss of control was also found to be experienced, as previously seen. Paper 10 similarly notes a sense of constraint and a belief that other 'solutions' to a difficulty would not work. Paper 11 similarly described suicide as 'escape' and as a form of relief after feeling trapped and desperate to put an end to unbearable and desperate feelings; the idea of having no future again arises.

Theme 2 – Disconnection

From Others

Paper 1 indicated people feel they are alone, and react to their struggles by actively withdrawing from others. Paper 2 similarly notes the role of social withdrawal. Paper 3 describes the experience of withdrawal from others in terms of internal perceptions rather than physical actions; the world was however still perceived as far away and people noted a sense of being unable to leave a physical

mark on their external surroundings. Paper 6 adds to this theme by indicating the function of this withdrawal – to protect others and themselves from their low mood and suicidal feelings. It also presents the image titled 'faded away' to capture the stark isolation people feel during times of suicidality. Paper 7 similarly indicated that this sense of social isolation or disconnection was present; it contrasted this with the sense of connection which arises when out of (or moving out of) a suicidal state. Paper 8 provides an alternative perspective to physical isolation as always being negatively valanced, to highlight how it can bring short term comforts. Paper 9 noted how the changes brought by motherhood could lead to a sense of disconnection from their partners; although this was not a physical separation, this change of role and identity appeared to lead to a sense of disconnection. Mothers were also found to avoid others due to fear of judgement, with a consequent increase in isolation. Paper 10 indicated that 'being disconnected' was a central theme, and can involve not only suicidal individuals leaving other people, but also disconnection through others withdrawing. It reinforces the idea arising in paper 8 that physical withdrawal is not always experienced as negative and may present some level of comfort; however, it emphasises that overall this was perceived as an unwanted and troubling behaviour by suicidal individuals. People's mental health experiences could contribute to their sense of disconnection (e.g. voices telling people not to leave). Paper 12 describes the role of shame in driving people to withdraw from others following gambling.

Into Self

Paper 3 uses multiple visual images to describe a sense of withdrawal into the self e.g. 'bell jar-esque images' and of being 'an island with sea all around and no chance of rescue'. Paper 3 also describes how during the process of suicidality people stop being integrated with the world around them. Paper 3 had low-medium scores on the CASP; however, it is corroborated by the higher scoring Paper 6 and Paper 8. Paper 6 under the theme of 'interiority' similarly found that people could not be reached by the external world during times of crisis, with an impact on the role which external support could provide. Men consequently spent more time ruminating on their negative thoughts without the ability for the outside world to disrupt these. Paper 8 similarly found that the experience of introspection was a vessel facilitating self-destructive rumination; an experience similarly arising within the mothers in paper 9, who withdrew from their stressful external world and instead began to focus on their internal conflict.

From Self

Paper 2 takes a gendered perspective when considering suicidality, exploring the difference between the strong masculine ideal and the vulnerability and hurt connected to suicidality. Paper 3 indicates that this sense of separation extends beyond gender, and can be seen within social expectations

more generally due to the differences between the social public self and inner suicidal self. It describes a feeling of detachment between parts of the self during this time. In paper 6, similarities can be seen to Paper 2, as a masculine population felt isolated in company, hiding their pain from their social surroundings. The idea of a 'partial self' is contributed, with the idea that this disconnection leads to a degraded masculine self as men struggled to integrate their suicidal self into their masculine social self. Paper 7 indicated that disconnected selves could be reflected within people's mental health experiences, as experiences of battles with internal voices was described. Paper 8, similarly to paper 2, connected this internal disconnection to feelings of inauthenticity and shame – this also focuses on a male population, adding to the idea of the male public image as contributing to the sense of disconnection. In paper 9, mothers described the difference between their expected self as a mother, and the reality of this; the comparison between these brought a sense of disconnection. Paper 10 again recorded a societal belief that suicidal experiences should be kept hidden, which seemed to facilitate a split between a hidden and social self. Paper 11 also noted a duality between having both reasons for living and reasons for wanting to die. Paper 12 adds that the disconnection may involve hiding other parts of the self, such as the part struggling with mental health difficulties more widely (gambling disorder).

Theme 3 – The Flow of Suicidal Thinking

The Strength of the Current/ Fighting the Current

Paper 2 focused on a male population, and used military metaphors to describe suicidal ideation as a 'fight'. Paper 3 similarly describes a struggle; thus, the experience of suicidal ideation as a 'battle' is shown to extend across genders. However, the language used is not always military and can be experienced as a 'hanging on' (e.g. to the window ledge) rather than a fight. Suicidal feelings are also described separately to suicidal thoughts, and are conceptualised as being more intense. Paper 5 similarly found that suicidal ideation could vary in strength, and indicated that this could impact on the ease in which a suicidal state was exited from. Paper 6 noted military metaphors such as it being 'a losing battle', as had arisen from paper 1; as did Paper 8 which described people as 'in the trenches'. These were both focused upon a male population. In Paper 9, this struggle is also described in terms of conflict between the will to live and the will to die; this is visually described by one participant as two powers pulling her in different directions. Paper 9 again presents suicidality as a strong force which people had to withstand. It found that the intensity of ones thoughts varied – there were both times of chronic thinking and separately of acute suicidal feeling. Vulnerability to suicidality was higher during this time of acute feeling.

Immersed Beneath the Surface/ Above the Surface

Paper 1 noted that suicide could feel like the whole world was closing in. However, it conversely found that for some people the cognitive, controlled element of planning suicide could ultimately be experienced as protective, providing a sense of control. In Paper 2, suicidal thinking was described by participants to people in their support network in a measured and controlled manner, rather than in emotional terms. Whilst this paper did not explore whether people's narrative framing matched their internal experience, it indicated an ability for this internal experience to be framed in this manner, and was explored as a 'masculine' framing of the experience. Paper 2 also notes how rational thinking was later utilised to support people to manage and exit their suicidal thoughts. Paper 3 has more similarities with paper 1's idea of suicide as immersive; it describes suicide as a whole body experience which leads to physical as well as mental exhaustion. Paper 6 also supported this, indicating that men could be left feeling fatigued from their suicidal experiences; this paper also continues to describe the impact of this, noting that this fatigue can impact on men's mental resources to make it all the more difficult to cope with the pain of suicidal feelings. Paper 7 indicates that suicidal thinking may be both immersive/overwhelming and have moments of 'intermittent rationalisation'; it suggests the presence of rational moments is what enables people to gain control over their thoughts and to move away from them. Paper 8, again in a male population, noted a more detached experience of suicidal thinking where people calmly debated whether suicide was logical; however, there was found to be some confusion within the participants around whether suicide was a logical step or not. Paper 9 returns to the idea of suicidality as being felt in the body, rather than in the mind alone; supporting ideas from paper 3 and paper 6. The immersive nature is vividly captured through the phrase 'the darkness descends'. However, again the rational element is alluded to, as the suicidal pull is experienced as a voice which is 'trying to be rational'; this has similarities to paper 7 and 8 in suggesting suicidal thinking contains a mixture of both a detached rational voice and a sense of overwhelm and immersion. Paper 10 found more of the latter experience, indicating that people felt overwhelmed or consumed by their thoughts; again powerful metaphors are used to capture this. Paper 12 again describes a whole body physicality to which both suicidal thoughts – and emotions attached to this such as shame – are experienced.

Theme 4 – In-the-moment Exits

Regaining Agency

Paper 1 noted that people could reduce their suicidal thoughts through external activities such as going for a walk. In Paper 2 this agency involved internal self-management, in which the participants used methods to consciously manage their internal world e.g. monitoring and self-talk. Paper 3 is conceptualised in terms of agency [although this seems perhaps sits separately to agency within exits]. In Paper 4, a number of ways of self-management are noted, with similarities to papers 1 and

2 in describing a mix of using activities to either distract from or to engage with their suicidal thoughts e.g. reading, writing poetry, music, television. Paper 4 expands on methods, with exit strategies as its focus. It adds the idea that self-management can also involve 'unhealthy' strategies for managing emotions such as self-harm. Paper 5 indicated that people could actively employ cognitive techniques to recall positive social experiences, without actually reaching out to others, with a protective impact. However, it noted that these methods of coping were only possible when suicidal urges were less intense. Paper 6 similarly indicated that self-harming or drugs could be used as a way to regain agency from one's suicidal thoughts. Paper 7 in particular found the role of distraction ('I do anything to take my mind off suicide') was crucial to people regaining agency and moving away from their suicidal thoughts. Like paper 5, it also found that whilst effective sometimes, these activities did not always work – the paper said it was unclear why they did not always work, but that their appeared to be a link to the strength of distress/ mental health experiences. Paper 8 corroborated with earlier papers to indicate that men could find it helpful to take an autonomous approach; this included exploring ways of recovery and the theory behind this. However, again Paper 8 found such an approach was associated with some negatives, as an overly-analytical mind was said to be part of the problem by some men. Paper 10 similarly found that regaining control could be instrumental to reducing suicidal thoughts; it suggests that this agency can be regained through talking rather than only managing alone, but that people may only be motivated to do so if they believe talking would lead to an internal change. Paper 11 also found that suicidal thoughts may be improved by people taking actions on their own, through attending activities, using substances, or choosing to spend time with pets.

Reaching Out for Support

Paper 1 notes that reaching out to a therapist could reduce suicidal intentions. Paper 2 similarly found that having someone to listen was seen as beneficial. This extended beyond the therapy space, to include reaching out to friends. Paper 4 similarly indicates the role of support from others in reducing suicidality; this included community involvement, support from friends, and peer support. It added that support needed to be accessed in people's own terms. However, it also indicated that reaching out for support could have a negative impact e.g. failed attempts to accessing mental health support leading to a view of needing to manage alone, or a dislike for the mental health system's approach to difficulties. Paper 5 similarly indicates the role of social interactions; it indicates that these interactions are useful through distraction, unlike some of the earlier papers where support involved disclosure and listening. Paper 6 similarly notes instances of people using external protection to help them when they were at crisis point; it noted how for men this may require a break from masculine ideals of staying silent to ask for help. Paper 7 similarly

described a purpose of reaching out for support as to feel less alone. It suggested the role of others could be particularly important when managing alone failed. Paper 8 also found that the support of therapists and other health professionals could be instrumental to stepping away from suicidality. Paper 10 included similar themes; in this paper, the greatest value of reaching out to others was the feeling of being acknowledged or appreciated. However, if this was feeling was not accessed, this process could lead to people feeling misunderstood or dismissed, with an associated increase in suicidal thinking. Paper 10 noted how this may look in a mental health context, finding a pattern of people feeling dismissed because health professionals were focused upon risk assessment. Paper 11 similarly found an important role for social support, both by having a support network available and being able to pursue social contact. It highlights the role of Latin American culture in driving how this may look; reaching for support could include spiritual guidance or using family support. However, the importance placed on family support could in turn make it harder to seek support for some. Paper 12 described key turning points when people made a decision to reach out to others and to 'come clean' about their gambling behaviours. However, similarly to paper 9, this was said to rely on a response of understanding and empathy for suicidality to decrease.

Reconnecting

In Paper 1, connection to others is reported as protective. Similarly Paper 2 reported that suicidal states could be countered through connection; this extend beyond social connection to include the role of religious and moral beliefs in countering connection. Paper 4 similarly notes the role of having a purpose and meaning in life in suicidal resilience. A sense of reconnection to the self – 'getting to know themselves better' – is added in this paper. Paper 5 suggested that recalling incidences of social connection could be helpful in exiting suicidal states. It also noted that the actions of others could disrupt suicidal thoughts through by distracting away from these, and instead prompting reconnection with the outer world e.g. getting out of the house. Paper 6 added how a 'change of mind' in which people turned away from suicide and chose life could facilitate a larger sense of reconnection, fostering a new sense of purpose. Paper 7 similarly found that acquiring and reconnecting to a sense of purpose in life was key to exiting suicidal states, such as a responsibility to others or a desire for personal development. It suggested however that for this to become an 'in-the-moment' exit required active effortful processes in the longer-term. Paper 8 similarly to paper 6 described 'turning points' where people reconnected to life and moved away from thoughts of suicide. A strong image accompanied this point of one participant's children being an anchor to the world. Connection involved more than 'reaching out for support'; it required an experience of being seen or of being intimately connected with another. Paper 8 builds upon the idea introduced in paper 4 of reconnecting with the self as being vital. Paper 10 similarly indicates the importance of a

sense of purpose in leading people away from suicidality. This is highlighted as a dynamic process, linking the idea to reconnection as a sense of movement or a turning point. Paper 11 similarly found the importance of reasons for living, including acquiring a sense of purpose, personal goals, and having connections and support from other people in their life. It highlighted the role of Latin American cultural norms in driving the perceived importance of connection. Paper 12 similarly found that feeling connected to others could lead to a decrease in suicidality.

Fear-Based Shifts

In Paper 1 reasons for not acting on suicidal thoughts included not acting due to not wishing to inflict pain on loved ones. Paper 2 similarly notes this. It adds that fears could arise from transgressing beliefs around suicide as morally wrong. Paper 2 additionally notes the role of fear of death in preventing people acting upon suicidal thoughts; it links this to negative appraisals of the self as 'weak', connecting this to gender. Paper 4 describes how self-management strategies can be linked to anger, frustration, and fear. Actions like self harm were used as the lesser of two evils, with a fear of acting upon one's suicidal urges implied. Paper 5, similar to paper 1, noted the 'devastating impact' on friends and family as a significant reason not to act. Paper 7 similar spoke of the impact of their loss on their family as a reason not to act. Paper 8 similarly to paper 2 noted the appraisal of being 'too cowardly' as arising after people had turned away from suicide. In Paper 9, the fear appeared more connected to reactions to a failed suicide attempt, and the shame women anticipated would come with this. This was found to be worse for mothers due to societal perceptions that motherhood should be a time of happiness, so the fear of judgement from a failed attempt is heightened. Paper 10 touches upon the role of fear in whether someone reaches out for help or not, impacting upon their exit from suicidal states; it links this fear to intensifying suicidal thoughts, forming a cycle. Paper 11 corroborates the previous papers in highlighting the roles of emotions including guilt and fear in stopping them from acting on suicidal thoughts. Again fears were linked to religious beliefs (similar to paper 2) and to the impact on family.

Theme 5: Long-Term Attitudes to Suicidality

Active Coping

Paper 4 indicated that people's self-management techniques could have a long-term impact and shift upon their attitude to suicidality. Experiences of looking after themselves physically could prevent their suicidal thoughts from arising; learning about their mental health and suicidal thoughts could also have a long-term impact upon either preventing or relieving future suicidal occurrences. This was linked to a sense of control. However, this was described as a process which could take a long time. Paper 5 similarly noted changes to suicidal thought processes which could be developed out-of-the moment and support people to actively cope with their suicidal thoughts when they

arose. Paper 7 similarly found that active learning and understanding about both suicidality and mental health more widely was a crucial step in long-term coping. Again this was shown as something which was not developed quickly; it was also described as something which waxed and waned, developing dynamically, rather than a static end point. Paper 7 also noted the longer-term role of supportive relationships in the development of suicidal resilience. Paper 8 similarly notes this, highlighting relationships with others and men's appraisals of these relationships as seeing themselves as worthy of love and care. This was built upon to suggest active coping requires a change in relationship with the self. Paper 8 also suggests a role for learning in facilitating recovery for some men. Paper 9 adds that active coping may be facilitated by an external change in circumstance, provide access to additional resources to provide a longer-term shift in one's ability to cope. Paper 10 expands upon the role of relationships and feeling connected in facilitating longer-term, active coping; it highlights how the actions of others (responding with understanding and acceptance) has an important role in enabling resilience. Paper 11 added that the experience of suicidal thinking could in its own right prompt people to realise they needed help and be a vehicle towards making longer-term changes.

Passive Coping

Paper 1 highlighted that suicide could be spoken about dispassionately. It was something which could be accessed on a 'whim'. Paper 6 adds to this by noting how men, in their wish to avoid seeking help, may enter into a form of chronic suicidality in which they chose to stay within their behaviour rather than actively trying to change this. This as conceptualised as an ambivalence for living. In Paper 7, this theme is brought to the forefront as a passive approach to coping is described. This is accompanied by a belief that it is not possible to change the thoughts, so the only way to cope is to accept that life will always involve such suicidality. Paper 8 found a perception that some people would never get over suicide, despite the participants in the group having reached a place of 'recovery'. Paper 10 indicates that a lack of understanding from others and mental health stigma may place people in a position where they do not believe change is possible. Paper 11, similar to earlier papers, noted that suicidal thoughts could leave people feeling unmotivated to attempt to change their experiences.

Section Two: Empirical Paper

Autobiographical Memory-Based Intervention for Suicidality: A Case Series

Word count (excluding references, tables and appendices): 7931

Abstract: 250 words

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†See Appendix A in Section 1 for submission guidelines

Abstract

Objectives: This study aimed to consider the feasibility and accessibility of an autobiographical memory-based intervention for suicidality within secondary mental health services. Incidence of suicidality is high within secondary care; however, there is no 'gold standard' psychological intervention for this population. Autobiographical memory (AM) is an important mechanism for psychological change – emotionally-laden memories are powerful and have links to individuals' goals and identity. Memories of 'exits' from suicidal thoughts are an untapped resource requiring exploration. **Design:** An experimental case series following a non-concurrent A-B multiple baseline design was followed. **Methods**: Participants with experiences of suicidal ideation and/or attempt(s) within the past 3 months were recruited from community-based mental health teams. Those screened as eligible were randomly assigned to 3-5 baseline sessions, followed by 6 intervention sessions. The Broad-Minded Affective Coping (BMAC) procedure was used, with adaptations including a session on suicide 'exits'. Outcome measures considering suicidal ideation and its risk factors were completed throughout. Data were analysed using visual inspection and calculation of Cohen's *d.* **Results:** After randomisation, one person was assessed as ineligible. Of the people who participated (n=3), completion rates (100%) and attendance rates (93.10%) were high. Despite recruitment challenges, participants engaged well and rated the intervention 'acceptable'. Overall, improvements were observed on clinical measures, with marked improvements for one participant. **Conclusions:** The intervention appeared acceptable and feasible for this population, although the small sample size limits conclusions. Investigation of AM in a fully powered study is indicated.

Keywords: suicidal ideation, autobiographical memory, case series, secondary care

Introduction

Suicide is a widespread and increasing problem in the UK, with over 6000 deaths registered for England and Wales in 2023 (Office for National Statistics, 2024). Most people who die by suicide have co-occurring mental health difficulties (Mann et al., 2021), with around one third open to mental health services (NCISH, 2017). Providing effective support within these services is key to helping people with suicidal thoughts, regardless of diagnosis. This study explores whether AM could be effectively targeted in a psychological intervention adapted for this population.

Definitions

The terms suicidal ideation and suicidality are used throughout this paper. 'Suicidal ideation' does not have a universally consistent definition; it is used here as an umbrella term describing preoccupation with thoughts, ideas, and wishes to take one's own life (Harmer et al., 2022). 'Suicidality' refers broadly to suicide risk, as indicated by ideation, behaviours, and associated risk factors (APA, 2018).

Suicide and Psychological Interventions

Suicidal ideation is both a risk factor of attempted suicide (Large et al., 2021), and a cause of high levels of mental distress (Garlow et al., 2008). Secondary care mental health services offer evidence-based support with the aim of reducing risk and distress. These include brief interventions (e.g. safety planning) and longer psychotherapies (e.g. cognitive behavioural therapy (CBT)) (National Institute of Mental Health, n.d.). However, despite extensive trials, the efficacy of suicide and self-injury interventions has not improved across the last five decades (Fox et al., 2020). This meta-analysis notes that whilst all produced small effects, none were identified as the gold standard. This highlights the need for more targeted approaches.

To be both effective and achievable, interventions must consider the needs of suicidal individuals alongside the services in which they would be offered. Most key suicide models are transdiagnostic (e.g. Joiner, 2007; Klonsky et al., 2021; O'Connor & Kirtley, 2018), suggesting an intervention across diagnoses is appropriate. Moreover, many secondary mental health services, such as Community Mental Health Teams (CMHTs), support people with a range of diagnoses; consequently, inclusive and accessible interventions are advantageous.

Brief interventions are recognised as a means of support in busy and stretched services (Melhem & Brent, 2020). However, a recent review indicated that whilst they reduce suicidal behaviour, suicidal thoughts are not affected (Homan et al., 2023). Consideration is therefore required around developing brief interventions which address these needs.

Suicidal Ideation, Cognitive Mechanisms, and Autobiographical Memory

Multiple models have considered the mechanisms underpinning suicidality (Johnson et al., 2010; Joiner, 2007; O'Connor & Kirtley, 2018). The Integrated Motivational-Volitional (IMV) model is helpful as it incorporates multiple putative mechanisms linked to suicidality, highlighting their moderating role on suicide's key predictors – defeat and entrapment (O'Connor & Kirtley, 2018). 'Defeat' involves feelings of powerless and humiliation; 'entrapment' describes feeling stuck with no way out (P Gilbert & Allan, 1998a). Entrapment in particular has been highlighted as a key driver of suicidal ideation (O'Connor & Portzky, 2018).

The transition from 'defeat' to 'entrapment' to 'ideation' has multiple moderators (O'Connor & Kirtley, 2018). 'Threat to self moderators' underpin defeat-entrapment, including factors such as social problem-solving, coping, memory biases, and ruminative

processes. ‘Motivational moderators’ act upon entrapment-ideation, including future thoughts, goals and attitudes. These factors are key targets for suicide interventions, as improvements could reduce entrapment and, consequently, in suicidality.

AM involves recollecting past events from one’s own life. It has a strong relationship with several moderators within the IMV, including goals and identity (Krans et al., 2017; J Mark G Williams et al., 2007), problem solving (L Maurex et al., 2010; Pollock & Williams, 1998), and memory biases (S. Williams et al., 2022). Thus, it is a potential vehicle for reducing suicidality.

Research has highlighted the significance of AM in suicidality. Suicidal individuals often have over general AM (Jiang et al., 2020; Rohrer et al., 2006). This is strongly linked to deficits in social problem-solving (Arie et al., 2008; L Maurex et al., 2010). Social problem-solving difficulties involve struggles coping in everyday interpersonal situations. Its relationship to suicide risk has been linked to both entrapment (Wang et al., 2023) and to interpersonal factors (Chu et al., 2018). Indeed, the interpersonal theory (IPT) of suicide highlights perceived burdensomeness (PB) and thwarted belonging (TB) as key risk factors of suicidality. Thus, negative relational memories may hold particular importance in a suicidal population. Without the internal resources and perceived interpersonal support required to navigate the world around them, suicide may appear the only solution in challenging situations.

In people with non-affective psychosis and past suicidal behaviour, specific negative AM were observed to hold most importance (P. J. Taylor, Gooding, et al., 2010). Theories suggest negative memories have high durability, due to increased attention on emotional moments during encoding (S. Williams et al., 2022). Additionally, increased selective memory for negative details means these aspects of memories are retrieved and rehearsed

frequently; thus, negative components become accessible and vivid (S. Williams et al., 2022). The impact of powerful traumatic memories alongside an overgeneral negative outlook must therefore be considered.

Autobiographical Memory-Based Interventions

The power of negative memories is concerning in a population who have a history of suicidality, as these guide our future actions (Gershman, 2017). Conversely, the Broaden and Build Theory suggests the potential for using powerful positive memories to counteract this (Fredrickson, 2004; Johnson et al., 2013). A focus upon such memories may increase their accessibility through frequent retrieval and rehearsal (Brewin, 2006; S. Williams et al., 2022).

The clinical utility of such memories has been acknowledged and targeted within the BMAC procedure. In the BMAC, imagery-based techniques support the recall and rehearsal of positive AM (Johnson et al., 2013; Tarrier, 2010). Mental imagery evokes strong emotional responses (Holmes & Mathews, 2005). The BMAC aims to build upon this by asking people to ‘re-live’ their positively-valanced memories, strengthening associated affective responses and attached personal meanings (Panagioti et al., 2012). In this way the technique aims to elicit changes in the individuals’ current perspectives and beliefs about themselves and the world. The BMAC has been linked to feelings of warmth and safety (Holden et al., 2016). Indeed, it may counteract suicide risk factors noted within the IMV and ITP models, as it has been linked to connectedness (Holden et al., 2017), hope (Johnson et al., 2013), and reductions in defeat (Panagioti et al., 2012).

The feasibility, acceptability, and clinical efficacy of the BMAC has been researched in a number of pilot studies and trials (e.g. Tarrier et al., 2014; Taylor et al., 2023). It has been indicated to be acceptable and feasible for use with university students (Holden et al., 2016;

Knagg et al., 2022), people experiencing psychosis (Tarrier et al., 2014; Johnson et al., 2012), and people in suicide crisis (Pratt et al., 2022). It was initially researched as a one-session intervention, to be delivered as an adjunct to other interventions; however, it has also been successfully embedded within a longer intervention for cognitive behavioural prevention of suicide in psychosis (CBTp; Tarrier et al., 2014).

Further research is nevertheless warranted. The BMAC procedure has not yet been researched within secondary care community mental health teams. Moreover, current BMAC research has frequently focused upon suicidality within psychosis presentations; however, most suicide risk models are transdiagnostic (e.g. O'Connor, 2018). Whilst promise has been shown for the intervention being extended to other diagnoses such as post-traumatic stress disorder, further research is needed to understand whether the BMAC procedure may be used transdiagnostically (Panagioti et al., 2012). This study therefore aims to expand the scope of the BMAC's clinical use by exploring whether an autobiographical memory intervention could be delivered to a population with severe and enduring mental health difficulties.

Secondly, there is a need for further research considering whether an autobiographical memory-based intervention can be implemented as a stand-alone intervention. Pratt et al. (2022) considered this using the 1-session BMAC with a crisis population; however, whilst overall the intervention was found to be acceptable and feasible, this study observed lower referral, consent, and attendance rates than expected. A longer intervention may be expected to increase feasibility. Brief suicide interventions (4 or fewer sessions) have in general been found to have a high rate of drop outs, whereas lengthier interventions have been linked to higher retention (Acolin, 2022; Homan et al., 2023). Promising outcomes have been found for the implementation an extended 6-session

BMAC within a student population (Knagg et al., 2022; Taylor et al., 2023); it is hopeful this can be replicated in a clinical population.

Adapting the Intervention for People with Suicidal Thoughts

There is also the potential for further adaptations to be made around an autobiographical memory-based intervention to place the needs of suicidal individuals at their centre. As suicide is linked to high entrapment levels, our adaptations aimed to consider the role of power and control. Indeed, a perceived lack of control and freedom has been reported to precipitate suicidal thinking (Gooding et al., 2023; Owen et al., 2015); by contrast, regaining agency is linked to coping and resilience (Harris et al., 2019; Peterson & Collings, 2015). Embedding some element of control (e.g. to the frequency or content of sessions) could be beneficial.

A unique memory held by suicidal individuals is of times when suicidal thoughts have not been acted upon, or suicidality has reduced. These memories are an untapped resource which could be explored in interventions (Tarrier et al., 2013). For memory-based interventions to have long term effects, it has been proposed that the underlying memory representation of suicide must be targeted (Miguel-Alvaro et al., 2021). 'Exits' involve a perceptual experience of becoming less suicidal, or transitioning to a non-suicidal state. For someone feeling 'trapped', strengthening the retrieval of exit memories could be transformative (Brewin, 2006). It may enable people to learn that situations which are perceived as intolerable are transient and bearable.

Exits from suicidal thinking often involve active coping strategies (Harris et al., 2019; Peterson & Collings, 2015). Revisiting these memories has the potential to alter a person's appraisal of their coping skills; an important alteration given that positive self-appraisals are central to suicide resilience (Johnson et al., 2010). People with suicidal thoughts are also

more likely to believe they are burdensome or do not belong (Joiner, 2007). Conversely, reasons for living and support from others may reduce suicidal thoughts (Gooding et al., 2023; Owen et al., 2015). Rehearsing these memories may strengthen moments of reconnection that reduced previous suicidal states, which in turn could impact on people's interpersonal views and – according to Joiner's (2007) theory – reduce the motivation for suicide.

Aims

This study considers the acceptability and feasibility of a novel autobiographical memory-based intervention for people within secondary mental health services experiencing thoughts of suicide. It focuses upon community-based teams.

Research questions

Our primary research questions were: Is this intervention 1) acceptable and 2) feasible to people with thoughts of suicide within secondary care mental health services? Our secondary research question was: Do people's levels of suicidality and their risk factors – entrapment, TB, and PB – change during the intervention? We hypothesised that the intervention would be both feasible and acceptable, in accordance with previous research into memory-based interventions. We also hypothesised that a reduction in suicidality and its associated risk factors would be observed.

Method

Design

A case series following a non-concurrent A-B multiple baseline design was adapted and implemented (C. D. J. Taylor et al., 2020). Case series are a recommended starting point for complex interventions, as small samples enable the interventional impact to be visually compared to a baseline (Skivington et al., 2021). We randomised baseline numbers to

reduce potential confounds (e.g. timing effects), increasing internal validity (C. D. J. Taylor et al., 2020).

Our proposal was sponsored by Lancaster University and given a favourable opinion by East Midlands - Nottingham NHS Research Ethics Committee (23/EM/0211). Members of the research team (AP and JK) completed the principles of Good Clinical Practice training (GCP; Health Research Authority, 2022), and the research was conducted in accordance with this. It was registered as a clinical trial on ClinicalTrials.gov (registration ID: NCT06225531), following guidelines surrounding transparency (Cybulski et al., 2016). The TIDieR guidelines are used to report the intervention (Appendix A; Campbell et al., 2018).

Participants

To be eligible, individuals must: have had experiences of suicidal ideation and/or suicidal behaviours within the previous 3 months; currently be under a community-based mental health team within which supervisory support could be arranged; have had a recent risk assessment (completed within the past 3 months) from their mental health team; be 18-65 years old; and be English-speaking. Individuals were not eligible if they: had a moderate/severe learning disability; had significant language comprehension or expression difficulties; experienced acute psychosis which would affect engagement; were receiving psychological treatment/participating in another research intervention; were open to a home-based treatment team; were currently in an inpatient setting; or had a history of violence such that their direct care team would advise against one-to-one sessions.

Measures

A full schedule of when measures were administered is shown in Figure 1. Measures of feasibility and acceptability are based upon scoping searches of case series (e.g. C. D. J. Taylor et al., 2020).

Feasibility

Feasibility was assessed by considering recruitment, attendance, and completion rates.

Recruitment and Retention. To be feasible, ≥80% approached would be eligible, of which ≥80% would provide consent, as based on an on-going secondary care trial (Hutton et al., 2023). We aimed to recruit 5 participants; studies are usually defined as 'case series' at this number (Abu-Zidan et al., 2012). Retention rates were calculated as the percentage of randomised participants who completed the final set of outcome measures (i.e. the number of individuals included in the final analysis divided by the number of individuals randomised into the trial).

Attendance and Completion. We set reasonable attendance as ≥3 out of 6 sessions, reflecting the criteria from Taylor et al. (2020). This gave participants the opportunity to receive psychoeducation and practise the intervention twice. Did not attend (DNA) and could not attend (CNA) rates were calculated. Completion required pre- and post- data alongside reasonable attendance rates.

Acceptability

Acceptability data considered therapeutic alliance, adverse effects, and overall acceptability. Adverse events and serious adverse events were monitored and recorded in accordance with the risk protocol (Appendix B).

Clinical Global Impressions Scale (CGI; Busner & Targum, 2007; Appendix C). This therapist-completed measure assesses adverse clinical changes. A score of ≥6 indicates severe mental health difficulties. Negative changes were discussed in supervision, with the participant, and with their care coordinator. The safety of continued participation was reviewed.

Working Alliance Inventory – Short Revised (WAI–SR*;* Hatcher & Gillaspy, 2006; Appendix D). Both the practitioner and participants completed this therapeutic alliance measure. Large discrepancies between scores and ratings below 30 were classified as 'poor'; high ratings suggested acceptability (Hatcher & Gillaspy, 2006). The measure has good internal validity (coefficient alpha ranges from 0.85 to 0.92).

Adverse Events in Psychotherapy Scale (AEP; Hutton, 2016; Appendix E). Completed in the final session, participants rated a series of potential adverse events on a 5-point Likert scale. High scores indicated low acceptability. This was considered on a case-by-case basis.

Acceptability Form (Based on Sekhon et al., 2017; Appendix F)**.** This form was developed though adapting the Acceptability Scale, based upon research into the qualities deeming an intervention 'acceptable' (Sekhon et al., 2017). It considers affective attitude, burden, ethicality, perceived effectiveness, intervention coherence, self-efficacy, opportunity costs, and general acceptability. Responses were interpreted qualitatively due to limited evidence around a quantitative acceptability level thus far.

Qualitative Feedback. Participants were invited to describe their experiences of the intervention in their final session. Positive experiences would be taken to indicate high acceptability.

Clinical Changes – Sessional Measures

In accordance with key suicide models, measures of clinical changes were selected to consider levels of suicidality and its risk factors (Joiner, 2007; O'Connor & Kirtley, 2018). To minimise the burden of completing multiple forms, only mood and entrapment were measured sessionally.

Entrapment Scale – Short Form (E-SF; De Beurs et al., 2020; Gilbert & Allan, 1998; Appendix G). Entrapment is an important predictor of suicidal ideation and behaviour (De

Beurs et al., 2019). The 4-item form has a 0.94 correlate with the original 16-item full scale within a clinical sample (De Beurs et al., 2020); the E-SF was selected to reduce administrative burden.

Sessional Mood Scale (Appendix H)**.** Mood was rated sessionally, with 0 as worst and 10 as best, to assess for changes and facilitate clinical discussion.

Clinical Changes – Pre- and Post- Measures

Interpersonal Needs Questionnaire – 15 (INQ; Van Orden et al., 2012; Appendix I). This measure considers two suicide risk factors from the IPT model – PB and TB. It met the criteria for acceptable fit and consistent factorial validity in a study evaluating different versions of this measure (Hill & Pettit, 2014).

Columbia – Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011; Appendix J). The C-SSRS uses a semi-structured interview to assess the severity and intensity of suicidal ideation and behaviours. It was evaluated as equal to other widely used suicide rating scales in detecting suicide risk (McCall et al., 2021). It has been recommended for research and clinical use (Posner et al., 2011), and has been used in another memory-based suicide trial, allowing for comparison (Högberg & Hällström, 2018). In baseline 1, ideation was considered over the lifetime and past month. It was repeated at intervention sessions 1 and 6, with consideration of the previous week.

Procedure

Participants were recruited from secondary care mental health teams based in the community, following the recruitment protocol (Appendix K). Clinicians were asked to identify eligible individuals. The trainee clinical psychologist (AP) attended team meetings to promote the study and answer questions. An information sheet was provided (Appendix L).

Clinicians approached potential participants; those showing an interest were given an information sheet (Appendix M) and expression of interest form (EoI; Appendix N). If completed, a more in-depth conversation was held with their care coordinator to confirm eligibility. Potential participants were contacted by the research team. For those happy to proceed, an initial appointment was arranged and the consent form was sent for completion (Appendix O).

The CI randomised participants to baseline numbers using a web-based randomisation programme (Sealed Envelope). Eligibility was re-assessed in the initial assessment; for those eligible, the assessment ran into baseline session 1. Participants completed 3-5 baseline sessions and 6 intervention sessions. Baseline sessions lasted approximately 30 minutes and were completed within 4 weeks of the initial assessment. Baseline 1 was face-to-face at the recruitment site; remaining sessions could be face-to-face, online, or via telephone. As compensation for the burden of completing additional outcome measures, a payment of £10 was provided for the initial assessment and final session (£20 total).

Two experts by experiences with a history of suicidality were consulted about the supporting documents and intervention structure. Consequently, we embedded more flexibility around session timings, and increased the use of visual resources. Recruitment documents were also amended after being reviewed by a CMHT care coordinator.

Intervention

The research team developed an autobiographical-memory based intervention for suicidality. In this, the BMAC procedure was adapted with a population experiencing suicidal thinking in mind. The intervention aimed to increase people's ability to access and retrieve

'positive' memories, and more specifically memories of times where they felt a sense of agency or connectedness.

Each participant was offered 6 intervention sessions, summarised in Table 1. All intervention sessions were one-to-one, took place face-to-face at the recruitment site, and lasted for up to 60 minutes. There was an 8-week window for completion of these sessions.

An in-depth overview of the session structure is included in Appendix P. Session 1 involved familiarisation to the intervention and its key concepts. This was supported by image-based psychoeducational resources, from which participants could choose between two metaphorical depictions of the role of autobiographical memory (Appendix Q). Participant goals were established, and safety plans were reviewed and updated.

Whilst the BMAC has typically focussed upon 'positive' memories, this intervention introduces three types of memories - neutral memories (Session 2), positive memories (Session 3), and 'exits' from suicidal thinking (Session 4). In recognition that 'exit' memories are likely to be a new and more complex concept for participants, Session 4 also included additional psychoeducation around this (Appendix Q). In Sessions 5-6, participants were given the flexibility to choose one out of the three types of memory introduced in Sessions 2-4, dependent on preference.

In each session (2-6), participants were asked to identify a recent memory to focus upon in the session. The BMAC procedure was followed. Participants firstly took part in a brief relaxation procedure. They then engaged in a guided imagery exercise in which the memory was re-experienced, with a focus upon the senses experienced and the emotions felt. At the end of the procedure, the participant was invited to reflect upon their appraisal of their memory and its connected emotions. Between sessions, participants were

encouraged to practice techniques introduced in the session with the support of structured sheets (Appendix R).

Flexibility was built into the intervention to tailor it to each individual's needs, with specific consideration of their suicide-specific experiences. In particular, we drew upon the IMV model with reference to entrapment and its moderators (O'Connor & Kirtley, 2018). In addition to asking participants' to focus on their preferred memory in Sessions 5-6, participants were given choice around: 1) the timings of their sessions (weekly or twice weekly), 2) the format of delivering psychoeducation (verbal, image based, or both), and 3) the delivery of the BMAC (using mindfulness-based strategies, or in conversation, dependent on the participants' needs).

Therapists

All baseline and intervention sessions were delivered by a trainee clinical psychologist (AP). Weekly supervision was provided by a HCPC registered clinical psychologist (JK), who sat in both the research team and one of the community mental health teams (CMHTs). Fidelity to the protocol was reviewed and discussed using the C-TSR framework. Informed consent was requested to video and/or audio record intervention sessions for manual fidelity and supervisory purposes.

Risk and Safety

Risk was assessed, monitored, and managed using the risk protocol (Appendix B). All suicide-related information was recorded on the NHS clinical record-keeping system. Risk-related changes were passed onto the participants' care coordinators, and considered against their usual clinical picture. Adverse events (AEs) and serious adverse events (SAEs) were monitored throughout, and their expectedness and relatedness to the trial was recorded.

Data Analysis

Analysis was conducted in Microsoft Excel. Acceptability was evaluated by considering therapeutic alliance, adverse effects, overall acceptability, and qualitative feedback. Feasibility was analysed by considering recruitment rates, attendance rates, and completion rates.

To answer our secondary research question, changes on clinical outcome measures were considered. Changes of >25% were seen as clinically significant, and changes of >50% seen as 'much improved' (Durham et al., 2003). Visual inspection of the data was conducted to consider patterns in the data (Ledford et al., 2018). Cohen's *d* was calculated, and effect sizes were interpreted as small (d = 0.2), medium (0.5), and large (d = 0.8) as recommended (Cohen, 1988). Demographic information was also collected.

Results

Demographic and clinical details

Four people were invited to the initial assessment, of whom three were eligible to participate (two male, one female). Their ages ranged from 36 and 52 years (*mean* = 46.33; *SD* = 8.95). All three were white British, heterosexual, and cisgender. Two were living with a partner; one was single. Two were unemployed; the third was in full-time work.

All three participants had depression diagnoses. Two had personality disorder diagnoses, and one an obsessive-compulsive disorder diagnosis. All three had one or more previous inpatient admissions related to their suicidal thinking and/or behaviour and had attempted suicide in the past. They had all experienced mental health difficulties from a young age (15 – 25 years). Demographic details are summarised in Table 2.

The pre- and post- data from the measures used within the case series are presented in Table 3. The mean scores, standard deviation, and effect sizes are reported. Given the

small sample size (n=3), conclusions made from these results must be seen within this context.

Feasibility

Recruitment

Recruitment was originally planned within one specific CMHT. However, referral rates were low, and an amendment was submitted and approved to extend this to any consenting community-based secondary care mental health service within our NHS trust site. Of the five mental health teams who consented to host, we successfully recruited from two.

A CONSORT diagram presents the flow of referrals throughout the study (Schulz et al., 2010; Figure 2). The percentage of participants who were eligible (60%) and who consented (57.14%) fell short of the ≥80% threshold set for recruitment to be classified as feasible, as summarised in Table 4. Administrative requirements in the recruitment process impacted upon this. Three care coordinators asked if participants could verbally express interest; however, we did not have ethical approval to do so. Despite suggesting alternative ways to complete this form, ultimately none of these individuals participated.

Four individuals consented to participate; this was fewer than the recruitment target (five participants). After randomisation to multiple baselines by the CI, one person was excluded as they reappraised the time period of their most recent suicidal ideation as being over the three-month period stipulated in the inclusion criteria. This lowered the overall retention rate to 75%. However, all three participants who met the inclusion criteria were retained.

Attendance and Completion

Completion and attendance rates were high, as summarised in Table 4. The reasonable attendance threshold of ≥3 sessions was exceeded for all participants and the completion rate was 100%. This highlights that engagement in the intervention was consistent and at a high level, indicating that the intervention can feasibly be delivered to this population.

Acceptability

Therapeutic Alliance

Alliance ratings were high on the WAI-SR (Hatcher & Gillaspy, 2006); participants' scored ranged between 45-48 (mean = 47) and therapist scores were similar, differing by a range of 2-6 (mean = 4). Alliance scores below 30 would have been considered poor; these scores are far above this threshold, as represented in Figure 3.

The WAI-SR was intended to be completed in session 3 of the intervention. However, there were delays in administering this measure for two participants. Participant 1 reported fatigue; for participant 2, clinical priorities demanded that the distress protocol was followed. Completion of this measure was moved to the start of their next session; this may have impacted upon reliability.

Clinical Impression

Participants' clinical presentation remained largely consistent throughout, ranging from mildly – markedly ill (Figure 4). Participants' baseline severity level was never exceeded, and there was a reduction in severity for participant 2.

On the improvement rating scale, scores ranged between minimally improved to minimally worse (Figure 5). At times when a participant's clinical presentation appeared to worsen slightly, changes were discussed with the individual and their care coordinator. On all occasions, changes were seen as in keeping with the participants' usual fluctuations in

their mental health and suicidality and participants did not believe changes were linked to the intervention. Thus, the intervention appeared acceptable to them.

Adherence to the Protocol

There was overall a strong adherence to the protocol. Participants reported that they understood the session concepts and were able to follow the BMAC procedure with minimal changes. Deviations from the protocol are summarised in Table 5. Most deviations were to meet the individual needs of the participants, including shortening sessions for a participant with high levels of fatigue, having a second session on neutral memories for participants who struggled to identify positive memories, and following the distress protocol with use of grounding skills to support someone having a dissociative flashback.

Adverse Effects and Overall Acceptability

All participants agreed or strongly agreed that the intervention was 'acceptable' to them (Table 6). In general, statements were scored neutrally or positively. All participants felt comfortable taking part in the intervention, understood the intervention techniques, and felt able to engage in the sessions.

One participant disagreed that the intervention had 'improved [his] overall wellbeing' and 'reduced [his] levels of suicidal thinking'. Nevertheless, this participant described plans to continue practicing the techniques and wondered if changes may be seen with more time. This suggests he felt it was acceptable for him to continue using these techniques in daily life.

Three AEs and two SAEs were recorded during the intervention. None were deemed to be related to participation; both SAEs related to a hospitalisation due to a pre-existing physical health condition, and was unrelated to the participants' mental health. On the AEP, scores were notably low, indicating high acceptability. Most statements were scored 'not at

all' or 'very little'. Only seven statements had higher ratings, summarised in Table 7. Most of these were linked to participant 2's dissociative experience and his fears of being asked to leave the intervention due to this. The participant raised this when these fears arose; they were discussed and reassurance was provided that this was not the case.

One participant agreed 'a little' that 'taking part increased my thoughts of killing myself'. He expanded upon this to say that talking about suicide more frequently during the intervention meant it was on his mind more often. However, whilst our risk-based discussions about suicidality led him to notice his suicidal thoughts more, the intervention itself did not appear to impact upon this. In contrast, this same participant strongly agreed that 'the intervention has reduced my levels of suicidal thinking'. Moreover, no associated increases in suicidal behaviour were observed; the statement 'taking part was making me want to harm myself' was rated 'not at all' by all participants.

Qualitative feedback was not provided by any of the participants on the feedback form. This appeared to be due to the burden of completing this feedback immediately following the session. Informal verbal feedback was shared. Participant 1 described having someone there to listen to her as the most beneficial aspect of the intervention, rather than the techniques themselves. Participant 2 spoke positively about the impact of the intervention, and reported starting to see changes and to integrate techniques into his daily life. He however reported that he may have struggled to engage during less stable periods of his life. Participant 3 noticed small changes after completing the memory-based procedure; however, he said he had not observed a larger-scale impact. He hoped to keep practicing the technique, but had concerns about feeling disheartened without support from the researcher. A theme from all three was needing more time to consolidate the

intervention techniques, and appreciating the opportunity to focus on reducing their suicidality.

Exploratory Measures

The E-SF, INQ, C-SSRS, and mood rating scale are reported with the purpose of illustrating clinical changes which arose during the intervention (Table 3).

In general, participant 1 experienced an improvement in scores during the baseline period; however, these returned to their baseline level in intervention session 6. It should be noted that difficulties associated with this participant's underlying health condition arose during the intervention period, including two short-term hospital stays. The participant attributed changes in measures to this.

Participant 2 experienced minimal changes during the baseline period; his scores however visibly improved during the intervention. Participant 3's scores were largely unchanged; they remained near the negative end of each measures' spectrum.

Entrapment

An overall improvement was seen in entrapment levels, with a decrease of medium effect size (Cohen's $d = 0.58$). Visual inspection reveals, however, that this decrease was seen in only one participant's scores; conclusions must be made with caution. Participant 2's scores showed a downward trajectory throughout the intervention period, with fluctuations to very high entrapment levels on multiple weeks (Figure 6). Participant 1's scores dipped during the baseline period alone. For participant 3 they were consistently at maximum level.

All participants scored the maximum of 16 at some point during the intervention, with one participant scoring this throughout. This indicates there may have been a ceiling effect in which smaller shifts in entrapment levels were missed.

Mood

Visual inspection reveals an overall increase in mood for participant 2, with a dip in session 4. This increase began during the baseline; however, the greatest increases can be observed during the intervention. Participant 1's mood increased during baseline; her scores dropped to 0 in the final session. For participant 3, mood was consistently low (Figure 7).

Interpersonal Needs

Whilst there were some fluctuations in INQ scores, there were no clinically significant changes on this measure for any participant, and Cohen's *d* indicated a minimal effect size (< 0.2). Visual inspection reveals scores fluctuated for participants 1 and 2 in the first intervention session, before returning to baseline levels (Figure 8). Participant 3's scores were consistently high, with a slight downward trajectory, indicating a slight improvement in his interpersonal needs.

When scores were split between PB and TB, more shifts could be seen. On average there was a reduction in PB scores, with a medium-large effect size (Cohen's *d* = 0.73). In participant 2, changes in PB fell to below the cut off associated with 'desire for suicide' (Figure 9). This 23.81% reduction fell just short of the threshold set for clinically significant change (25%). Notably, this reduction was seen solely in the intervention period. A small and gradual improvement was also observed for participant 3. However, positive changes were not observed in participant 1. Whilst her scores dipped after her baseline sessions, they returned to a maximum score of 42 in the final session.

TB scores were stable for participants 1 and 3 (Figure 10); they were consistently below threshold for participant 1 and at the upper limit for participant 3. An increase was seen for participant 2 during the baseline period. Scores remained at this level in the final session. Thus, whilst improvements in PB were observed during the intervention, TB did not seem to be impacted upon.

Suicidality

Both suicidal ideation and behaviour reduced from baseline to post-intervention. Ideation intensity scores reduced with a medium effect size (Cohen's *d* = 0.61) and ideation severity reduced for two participants (Figure 11). For participant 2, no suicidal thoughts were reported in the final session.

Participant 1's ideation dropped to 0 in the baseline period. However, it returned to baseline levels post-intervention (severity = 3). In discussion, this participant related this to external stressors rather than the intervention itself.

A reduction in suicidal behaviours was also observed (Table 8). Two participants reported suicidal behaviour in the month preceding the intervention (preparatory acts; an interrupted attempt). One participant reported engaging in preparatory acts at intervention session 1. However, no specific plan was reported, and intent to act had reduced in session; he was therefore assessed as safe to continue in the trial. No suicidal behaviour was reported in the final session. Overall, a pattern was observed of scores dropping on measures of suicidality.

Discussion

Summary

Overall this novel intervention was found to be both acceptable and feasible for suicidal individuals within secondary care community mental health teams, with clinical promise. Three main points of novelty emerged from this research. Firstly, the study found that an extended version of the BMAC can be successfully implemented within a CMHT setting. Secondly, suicide 'exit' memories were safely introduced and used with a suicidal population. Finally, the intervention suggests a role for focusing upon neutral memories within this population.

Introducing 'Exit' Memories

This intervention marks the first time that suicide 'exit' memories have been targeted within an intervention. It indicates that a focus upon these memories was acceptable to participants, highlighting its promise for future clinical use. Participants initially anticipated that 'exit' memories would be completely negative; surprise was expressed when positive feelings such as relief and connectedness were attached to this distressing time. Thus, using the BMAC with 'exit' memories appeared to facilitate a shift from an over-general memory of this time as 'all bad' to a more balanced perspective (Williams et al., 2006). The participants reappraised both their memories and their role within them. Reappraisal has been linked to coping (Johnson et al., 2010), suggesting this emphasis on exits could support people in believing they can manage their suicidality.

Clinical observations during the trial also suggested that rehearsal of 'exit' memories may have strengthened feelings of connectedness and agency. Participant 2's 'exit' memory focussed upon connection, and this was also reflected by the structure of his practice, as he asked his partner to support him when practicing the memory procedure. Connectedness has been linked to suicide resilience (Bakhiyi et al., 2016; Zareian & Klonsky, 2020) and AM has strong links with social problem solving (Arie et al., 2008; Maurex et al., 2010). Participant 2's proactive suggestions could be understood within this context, highlighting the potential benefits of rehearsing an 'exit' memory. Conclusions cannot be made within this small sample, and alternative interpretations are possible. However, if replicated on a larger scale, this shows great promise for suicide exit memories to elicit changes in suicide risk.

Neutral Memories

Our study extends beyond the BMAC to suggests that targeting neutral memories is advantageous within this population. Two of the three participants were unable to retrieve a positive memory, instead opting to select a second neutral memory in Session 3. One participant also chose to focus on neutral memories within their final sessions. Thus, this study moves away from targeting positive memories alone to suggest that a focus upon neutral memories may have clinical utility within this population.

The use of neutral memories within suicide interventions has been neglected within the research; indeed, in trials, neutral memories have generally been selected for use in comparator control groups (Häfliger et al., 2024; Celano et al., 2017). Whilst the BMAC draws upon the 'Broaden and Build' theory to suggest the power of positive memories (Fredrickson, 2004), challenges with accessing and rehearsing positive or compassionate images have also been highlighted (Rockliffe et al., 2008). In this paper, those with higher levels of self-criticism and attachment difficulties had a stress-based response to compassionate imagery. Additionally, it is widely recognised in the compassion-focused literature that those with low self-esteem and high self-criticism find it more challenging to access and generate compassionate imagery (Gilbert et al., 2006). Thus, it is perhaps unsurprising that many suicidal individuals, who have high levels of PB alongside an over-general negative memory, will struggle to identify a memory they would appraise as 'positive' (Williams et al., 2006).

The potential benefits of neutral over positive memories have also been seen in a suicidal population. A paper hypothesising that a positive psychology intervention would reduce suicide risk found that, contrary to this, their comparator cognition-focused arm had more promising outcomes in reducing hopelessness and suicidal ideation (Celano et al., 2017). This cognition-focused intervention involved recalling a recent neutral event. Whilst

this was a small trial, it raises the potential that neutral memories may have clinical utility. Our study corroborates this to suggest that neutral memories are a useful addition to an autobiographical memory-based intervention. Whilst identifying a positive memory was too difficult for some participants, targeting a neutral memory appeared more feasible, and helped to challenge over-general appraisals of recent weeks as 'all bad'.

Using the Extended BMAC within a CMHT

An extended version of the BMAC has been successfully developed and delivered to university students (Knagg et al., 2021; Taylor et al., 2023). However, our study marks the first time an extended BMAC intervention has been researched for use within a secondary care population with significant and long-term mental health difficulties. Suicide affects people with a range of diagnoses, and has most often been conceptualised transdiagnostically within risk models (e.g. O'Connor et al., 2018). This study supports the use of this procedure not only in individuals with psychosis, but more widely within people with a range of mental health difficulties.

During the study, specific considerations for adapting the intervention to CMHTs arose. A need to draw upon the protocol's flexibility was observed, with adaptations made for neurodiversity, fatigue, and the occurrence of stressful life events. The requirement for suicide interventions to be person-centred had been identified previously (e.g. Procter, 2022). However, this study indicated that suicide-specific needs can be anticipated and incorporated into the protocol. For example, clients were asked to take a lead in decision-making around the final sessions' content, with the aim of providing control to a population with high levels of entrapment (Gilbert & Allan, 1998; Johnson et al., 2010). Participant 2 demonstrated increased agency and reduced entrapment at the end of therapy. Thus, it is

possible that the structure of this intervention positively influenced his ability to feel empowered outside of sessions.

Our study also highlighted the importance of considering and anticipating the impact of stressful life events when working with this population. Suicidal thoughts do not arise in a vacuum. Indeed, participants experienced a number of stressful life events throughout the intervention. These included hospitalisations for physical health procedures, interpersonal challenges, fears about job security or financial stability, bereavements (or significant anniversaries), and threats to safety at home. Previous research has found the importance of both stressful life events and people's appraisals of this in increasing suicidal ideation (O'Connor et al., 2018; Howarth et al., 2020). This association suggests an intervention addressing negative memory biases is needed (Howarth et al., 2020).

These multiple demands and stressors may, however, impact on people's capacity to integrate psychological concepts into their daily lives. For example, Participant 1 was in physical pain during the study and also described safety-related fears. The therapeutic needs hierarchy suggest safety, relationships, and comfort need to be well-established prior to working to develop people's therapeutic resources (Golding, 2013). Whilst this individual still found the intervention acceptable, this suggests there would be advantages to exploring the bottom of the pyramid prior to implementing this intervention within a CMHT setting.

Limitations

As with all case series interventions, the small sample size was a limitation; more formal and extensive analysis of the data was not possible, and conclusions made about the clinical impact are minimal. The sample is fairly homogeneous – all were white British, heterosexual, and came from a specific geographical region. A larger sample with more

diversity would be needed to assess the intervention's acceptability and feasibility on a wider scale.

Recruitment was difficult, and we did not meet our referral and participation targets. The needs of suicidal individuals were embedded into our session content and structure, but not our recruitment processes. Administrative barriers were reported, as people requested to express interest verbally rather than completing a written form. In a population with high levels of defeat, entrapment, and interpersonal needs (Gilbert & Allan, 1998; Joiner, 2007), such barriers may seem all the larger. In future research, there is a need for additional consideration around how to address this.

Previous memory-based interventions have used imagery-specific measures such as the Spontaneous Use of Imagery Scale (Reisberg et al., 2003), in addition to practice logbooks (Knagg et al., 2022; Pratt et al., 2022). To reduce the burden of completing an extensive number of measures, we did not monitor changes immediately following the memory-based procedure; instead, we chose to focus on suicidal ideation levels and risk factors associated with this. However, clinical scores were higher than anticipated for our sample. There may have been a ceiling effect to the E-SF and INQ in which smaller, in-the-moment changes were missed. Entrapment and interpersonal difficulties were strongly entrenched for participant 3 in particular; it is potentially unrealistic to have expected a change in these scores given the participants' level of clinical severity alongside the study's brevity.

A task-specific measure may have been more useful for noting smaller, in-the-moment changes. Moreover, given this population's experiences of negative memory biases and over-general memory, using more specific measures may have complemented the intervention to help participants notice any smaller changes. In hindsight, the advantages of

asking people to monitor their practice and immediate changes following this may have outweighed the burden of completing this. Monitoring changes over a longer period of time may have also enabled us to see beyond the weekly fluctuations caused by stressful life events. However, limited time and resources meant monitoring was limited to the baseline and intervention periods; thus, it was not possible to establish the longer-term impacts of the intervention. A future trial would be strengthened by collecting follow-up data.

Unfortunately, no written qualitative feedback was received. We attempted to collect this data at the end of the final session along with other rating scales; however, participants appeared too tired to complete this at this stage. The informal feedback shared was useful; however, collecting this more formally through a separate feedback session or a semi-structured interview about the intervention could have improved the analysis by providing more substance to our perceived benefits.

Future Research

A key area for future research is further understanding of people's exits from suicidal states. This intervention demonstrated the promise for these memories being used effectively in clinical practice. However, as a clinician there were challenges navigating memories with mixed emotions (e.g. regret alongside relief). More research would assist in ensuring this is done safely and effectively.

Further research is needed to explore challenges in recruiting individuals into suicide trials. This could involve qualitative interviews and quantitative research to consider how of factors such as entrapment, TB, and PB impact on recruitment. Such research may encounter its own recruitment challenges; it would need to be sensitive to engagement barriers through consultations with experts by experience.

Finally, our research extended upon previous research to suggest it is acceptable and feasible to adapt the BMAC protocol for a suicidal population (Knagg et al., 2022; Pratt et al., 2022). To expand upon this, a wider trial in which more formal analysis can be conducted is needed. Research may also consider further adaptations – for example, including a formulation component may strengthen the links between exit memories and underlying interpersonal or entrapment needs.

Summary

This study adds to a growing base of research to suggest autobiographical memory-based interventions are acceptable and feasible for people with suicidal thoughts. It extends beyond previous research by considering what adaptations can be made for suicidal individuals within a CMHT, and demonstrating the potential power of suicide 'exit' memories and of 'neutral' memories when supporting this population. It provides promise that an intervention focused upon autobiographical memories could reduce entrapment, interpersonal needs, and suicidal ideation.

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Tables and Figures

Table 1

Overview of the Intervention Session Content

Session No.	Session Content
Session 1¶	In the first session, there will be a focus on developing participant's understanding of the links between memory and suicidality. PowerPoint slides will be used to support this, with metaphorical examples used to aid comprehension. Participants will also be familiarised with the process of identifying autobiographical memories using relaxation techniques. We will explain how, as techniques are introduced, we can use these to add to the participant's safety plan.
Session 2¶	The second session will focus upon neutral memories. In the session, the concept of neutral memories will be introduced and relaxation techniques will be used to support participants to identify neutral memories in their life. In the session, recall of this memory will be practiced.
Session 3¶	The third session will focus upon positive memories. In the session, the concept of positive memories will be introduced. Relaxation techniques (as used in the previous session) will be used to support participants to identify positive memories in their life. In the session, recall of this memory will be practiced.

Session 4¶	The third session will focus upon memories of times when participants moved away from thoughts of suicide, and reconnected with life. Powerpoint slides will be used to support understanding of this concept. Relaxation techniques (as used in previous sessions) will be used to support participants to identify these memories. Participants will practice recalling this memory.
Session 5¶	Participants will be asked for feedback about which type of memory from the previous session has felt most useful. This session will focus on the participant's preferred choice of memory, and participants will use and develop the techniques previously introduced.
Session 6¶	Participants will continue focusing on the preferred memory or memories identified as most useful for them. The session will also consider future plans and anticipate barriers to using these techniques.

¶ All sessions will begin with outcome measures being completed, a general check in, and a review of risk/distress.

Table 2

Demographic and Clinical Information for Individuals Invited to Assessment (n=4)

Participant number	n/a	1	2	3
Assessed	Yes	Yes	Yes	Yes
Eligible	No	Yes	Yes	Yes
Gender	-	Female	Male	Male
Age (years)	-	36	51	52
Diagnoses	-	OCD, depression, EUPD	Depression, EUPD	Depression
Relationship status	-	Living with partner	Living with partner	Single
Employment	-	Unemployed	Employed	Unemployed
Age at onset	-	21	15	25
Baselines planned	5	4	3	4

Table 3

Outcome Data for All Measures and Cohen's d Effect Sizes

Measures	First Baseline (n=3) mean (*SD*)	End of Treatment (n=3) mean (*SD*)	Cohen's *d*
Pre- and Post- Measures			
INQ	84 (16.64)	83.67 (10.14)	0.024
INQ – PB	39 (5.20)	33.33 (9.61)	0.73
INQ – TB	45 (15.52)	50.66 (14.29)	0.38
C-SSRS – Ideation Intensity	18.33 (4.51)	13 (11.53)	0.61
Sessional Measures			
CGI – Severity	4.33 (0.58)	4.00 (1.00)	0.40
CGI - Improvement	4.33 (0.58)	4.00 (1.00)	0.40
E-SF	15.33 (1.15)	13.50 (4.33)	0.58
Mood	2.50 (1.80)	2.67 (3.78)	0.06

Table 4

Feasibility Calculations for the Study

Area monitored to assess feasibility	Rating (%)	Further Information
Referral Eligibility Rates	60%	Out of 10 suggested participants, 3 screened as not eligible. A further participant did not meet the eligibility criteria in the initial assessment.
Consent Rates	57.14%	Out of 7 individuals screened as eligible, 4 participants consented to participate
Attendance Rates	93.10%	27 out of 29 sessions offered were attended; 2 intervention sessions were cancelled due to physical health needs.
CNA Rates	6.90%	-
DNA Rates	0%	-
Retention Rates	100%	-

Table 5

Deviations from the Session Protocol

Deviation	Reason
1. Session length	The session length was routinely shortened to 45 minutes for participant 1 who experienced high levels of fatigue related to physical health difficulties; she reported feelings of tiredness following session tasks, and we mutually agreed to end the sessions at this earlier time. Sessions 4-5 were cancelled due to illness.
2. Change to session content to include grounding and psychoeducation	Participant 2 had an experience where a traumatic memory was triggered during the session task. This meant the session needed to be stopped and the distress protocol was followed. Grounding techniques were used and psychoeducation offered. The model /metaphor was used to explain this memory and it's low threshold for retrievability compared to other memories. We spoke about how focussing on specific aspects of other memories may stop this

	from being recalled as easily. At the end of the session, the participant's distress had reduced and he expressed a strong wish to continue in the research study which was agreed. This session lasted around 90 minutes.
3. Change to session 3 to focus on neutral rather than positive memories	Two participants struggled to identify a recent memory they viewed as 'positive'. Session 2 was therefore repeated, with a focus on the positive aspects of the memories selected. This change appeared more acceptable to the participants.
4. Delay in completion of the WAI-SR	Outcome measure delayed until subsequent session for two participants in connection to protocol deviations 1 and 2.
5. Omission of memory task in intervention session 6	Participants opted to focus on endings, discussing their practice, and planning for the future rather than repeating the memory task in the final session

Table 6

Outcomes of the Acceptability Questionnaire

Acceptability	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
1) I felt comfortable taking part in the intervention				2	1
2) Taking part in the intervention required a lot of effort.			1	1	1
3) The intervention was adapted to my individual needs and beliefs.			1	2	
4) The intervention has improved my overall wellbeing.		1	1	1	
5) The intervention has reduced my levels of suicidal thinking.		1	1		1
6) I understand how to use the techniques introduced during the intervention.				3	
7) I was able to engage with the intervention.				3	
8) Receiving the intervention interfered with my other priorities.	2	1			

9) The intervention was acceptable to me.	2	1

Table 7

Highest Rated Statements ('a little' or higher) on the AEP

Statement	A little	Quite a lot	Very much
Taking part hasn't helped me with my problems.	1		
Taking part made me think too much about bad things that have happened in the past.	2		
Taking part increased my thoughts of killing myself.	1		
Taking part was making me fall out with my family or friends.	1		
I felt embarrassed talking about my problems with people I had not met before.	1		
Taking part was making me feel hopeless about the future.	1		
Taking part made me worry that people would think badly of me because of my diagnosis		1	

Table 8

Participant scores on the C-SSRS – Suicidal Behaviour Scale throughout the Baselines and Intervention Sessions

	Lifetime				Baseline (past 3 months)				Session 1 (past week)				Session 6 (past week)			
	A	B	C	D	A	B	C	D	A	B	C	D	A	B	C	D
Participant 1	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N
Participant 2	Y	Y	Y	Y	N	Y	N	N	N	N	N	Y	N	N	N	N
Participant 3	Y	Y	Y	Y	N	N	N	Y	N	N	N	N	N	N	N	N

A = Actual Attempt, B = Interrupted Attempt, C = Aborted Attempt, D = Preparatory Acts

Y = behaviour reported; N= behaviour not reported

Figure 1

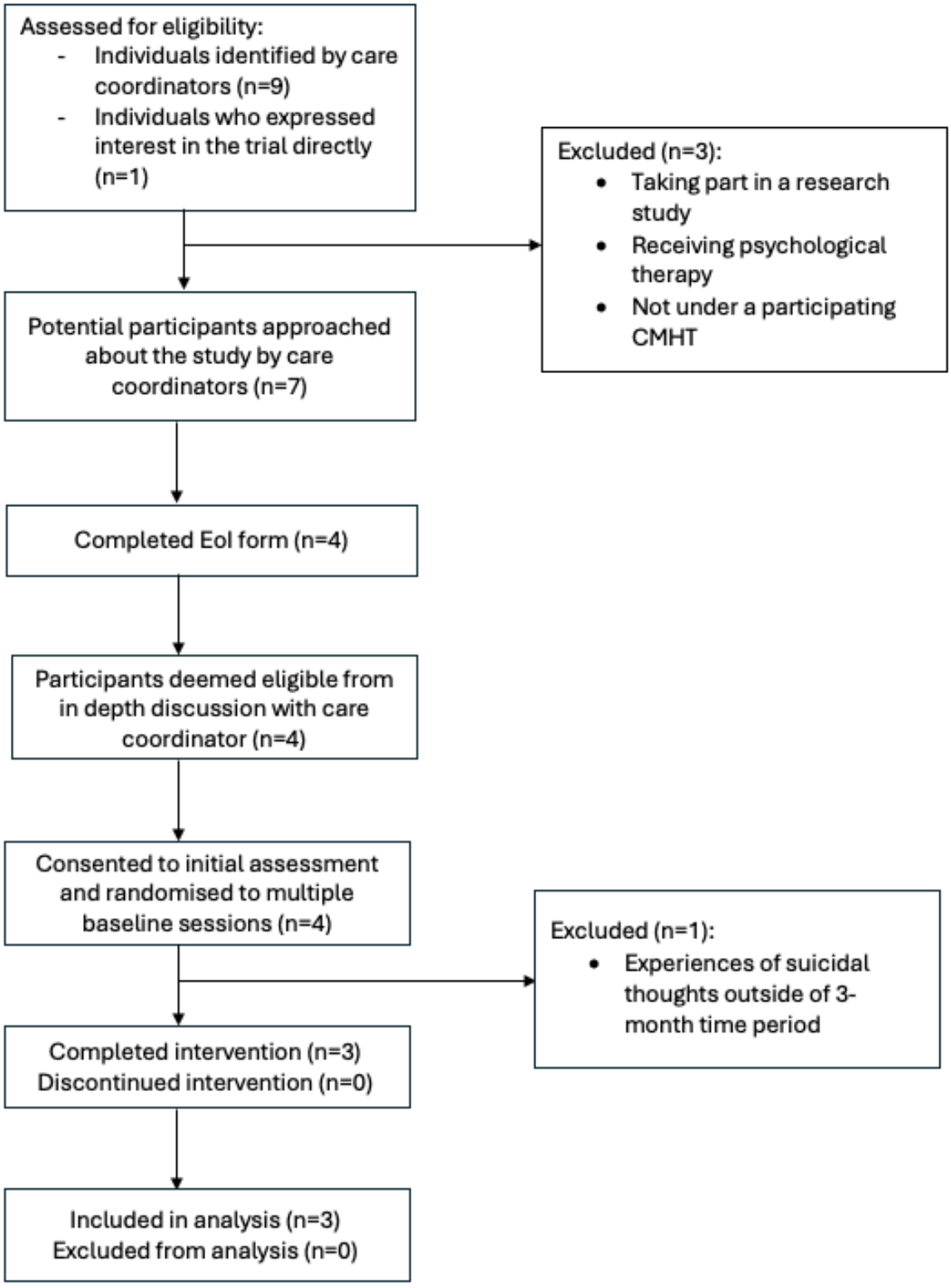
Schedule of Outcome Measures Throughout the Baseline and Intervention Sessions

	IA	B	B	(B)	(B)	I	I	I	I	I	I
Demographics Form	X										
INQ-15	X					X					X
E-SF	X	X	X	(X)	(X)	X					X
C-SSRS	X					X					X
CGI	X	X	X	(X)	(X)	X	X	X	X	X	X
Sessional Mood Scale	X	X	X	(X)	(X)	X	X	X	X	X	X
WAI-SR								X			
AEP											X
Qualitative Feedback											X
Acceptability form											X

Key: IA = Initial Assessment, B = Baseline, (B) = Baseline (if randomised to 3+ baseline sessions), I = Intervention

Figure 2

CONSORT Diagram of Recruitment and Participation



Note. Adapted from "CONSORT 2010 Statement: updated guidelines for reporting parallel

group randomised trials.” By K. F. Schulz, D. G. Altman, and D. Moher, 2010,. *BMC Medicine*, *8*(1), p. 18. https://doi.org/10.1186/1741-7015-8-18

Figure 3

Participant and Therapist WAI-SR Scores for Session 3

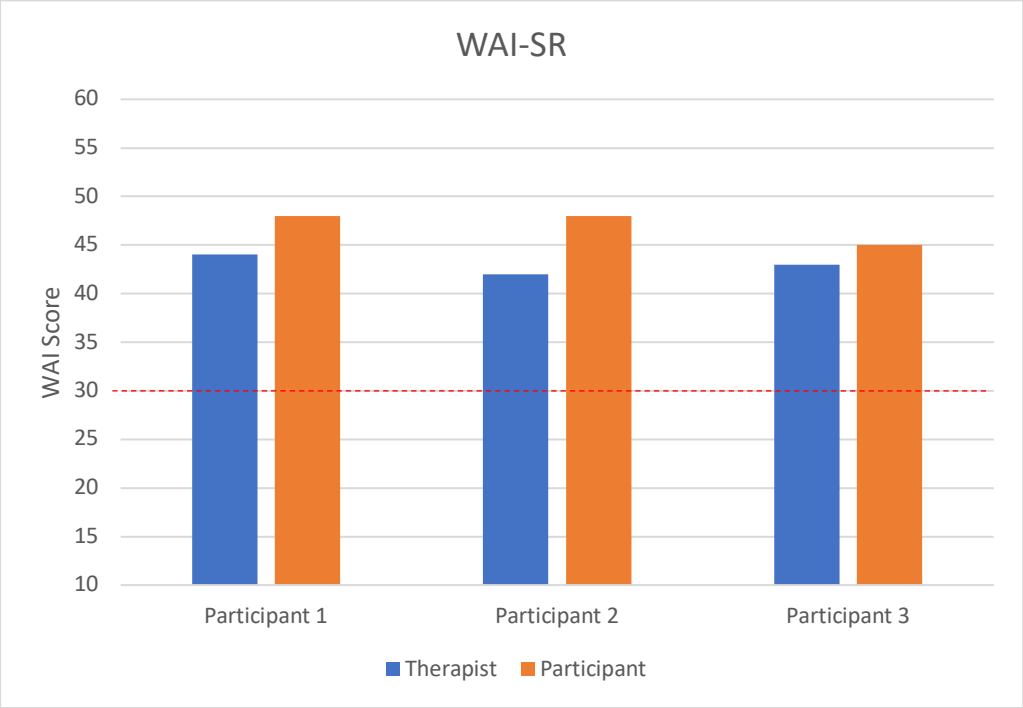


Figure 4

CGI Severity Scores Across Baselines and Intervention Sessions

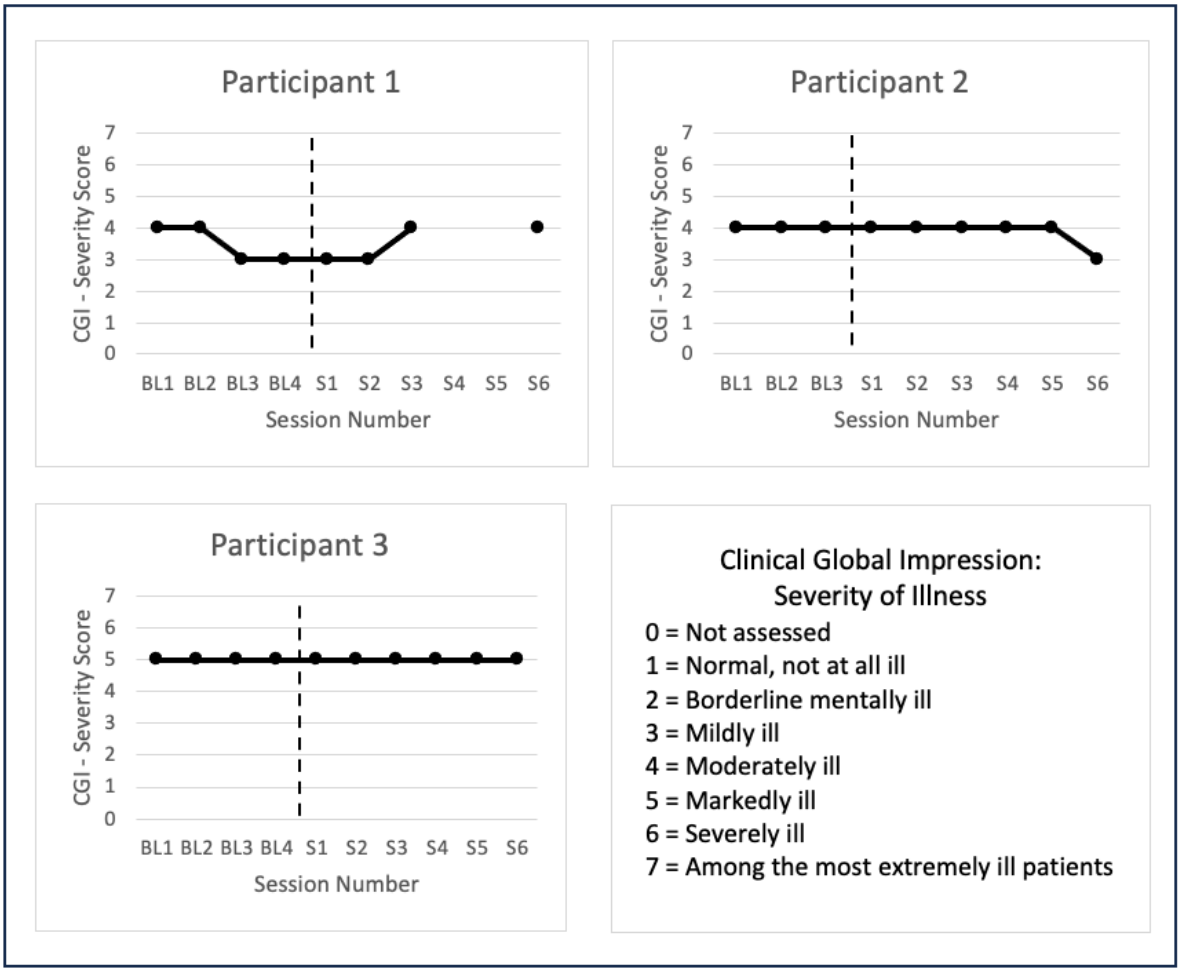


Figure 5

CGI Global Improvement Scores Across Baselines and Intervention Sessions

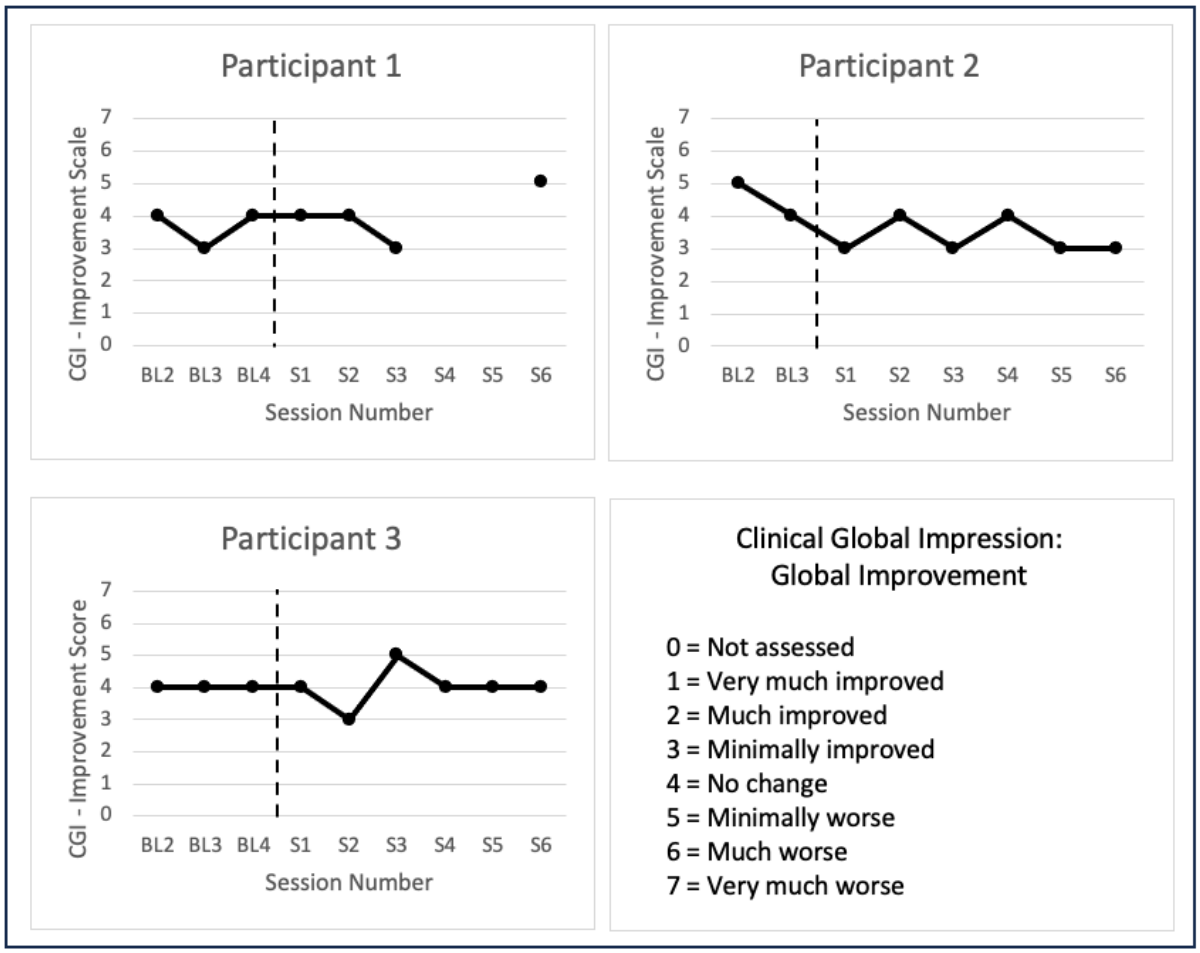


Figure 6

E-SF Scores Across Baselines and Intervention Sessions

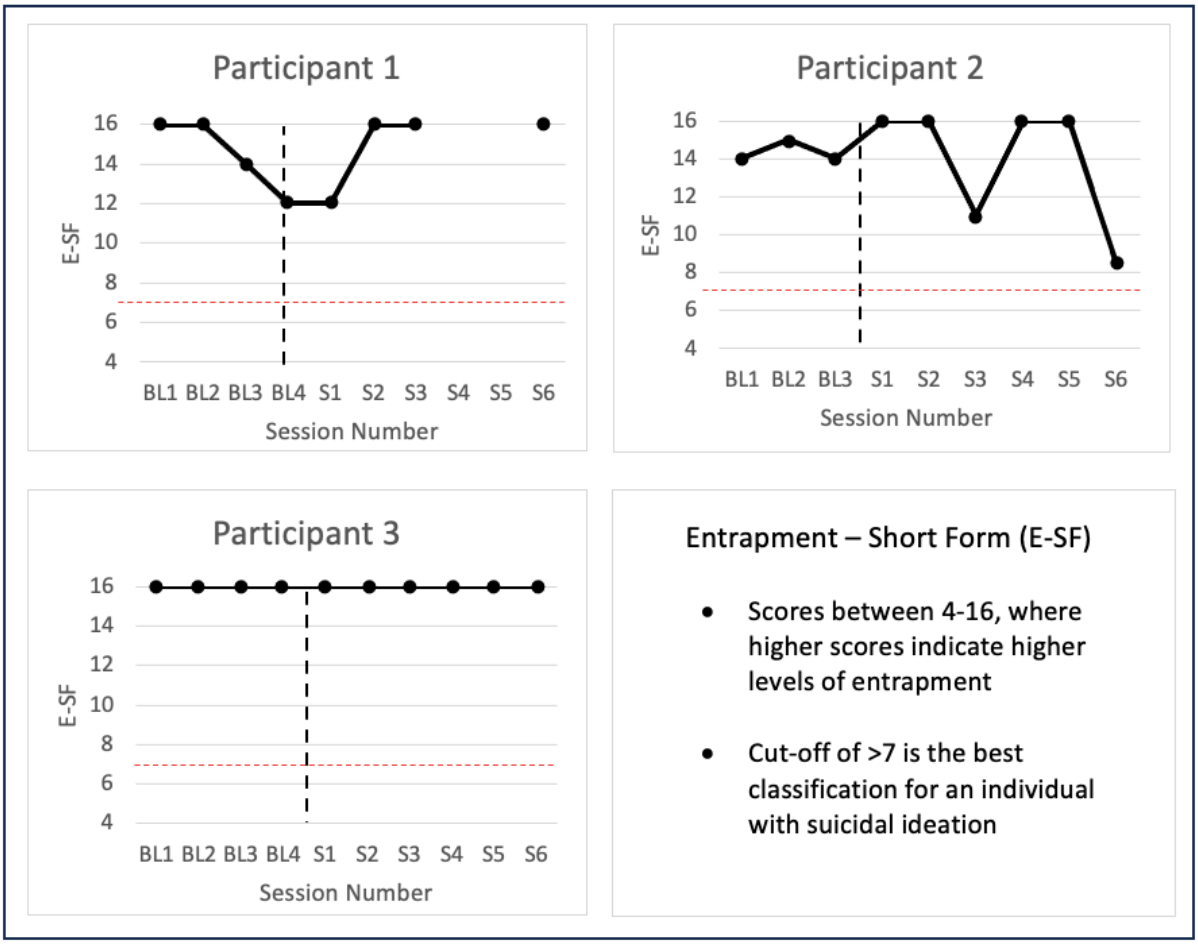


Figure 7

Mood Rating Scores Across Baselines and Intervention Sessions

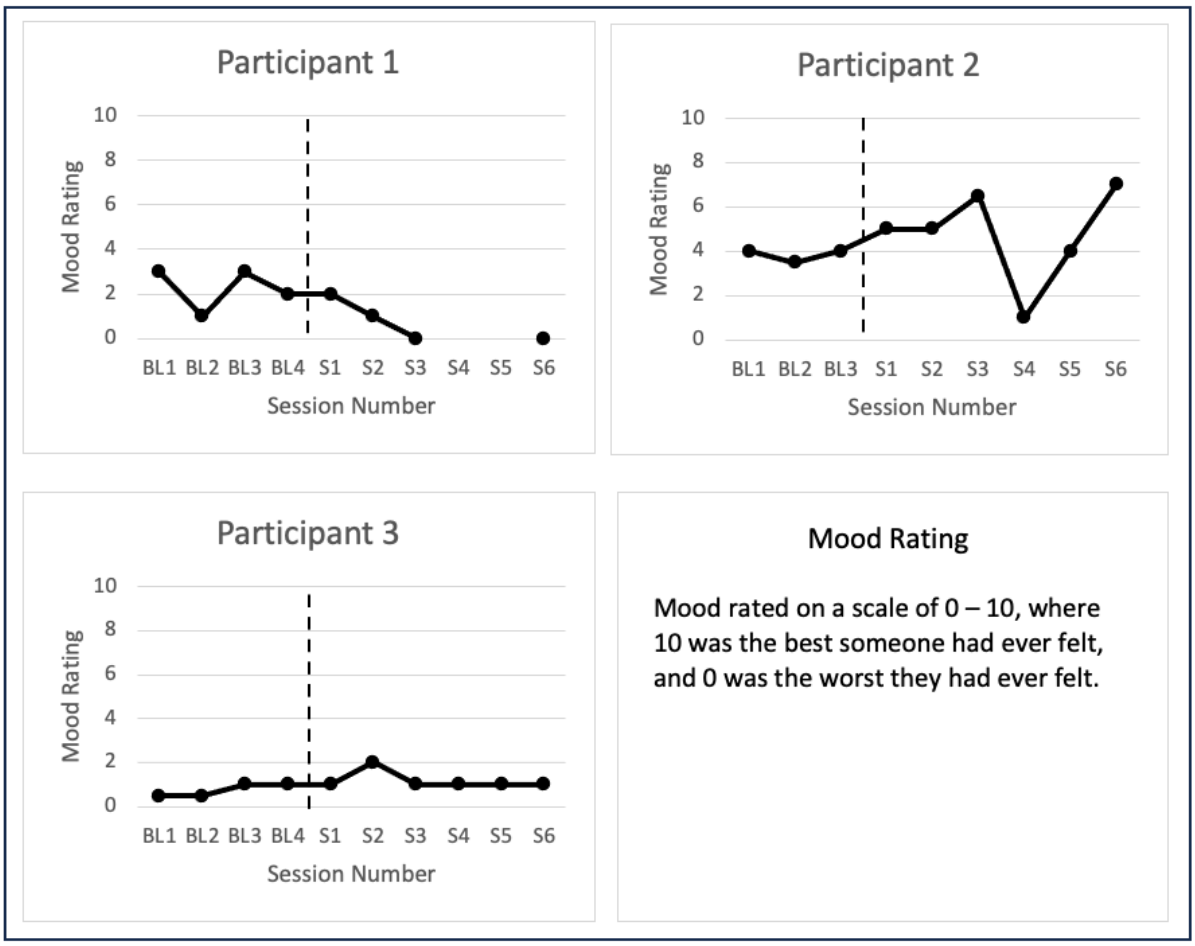


Figure 8

INQ-15 scores across baseline and intervention sessions

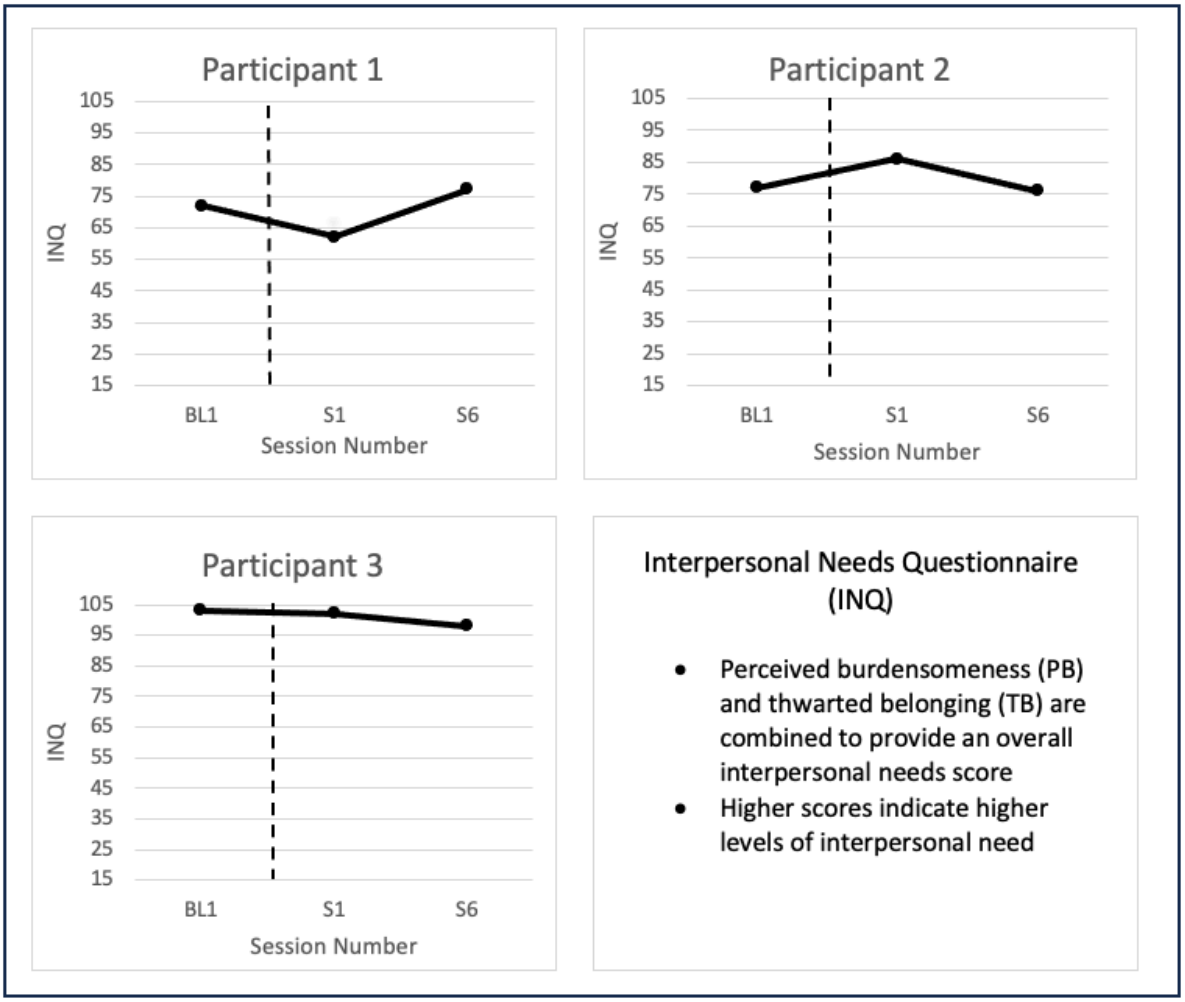


Figure 9

Perceived Burdensomeness Scores Across Baseline and Intervention Sessions

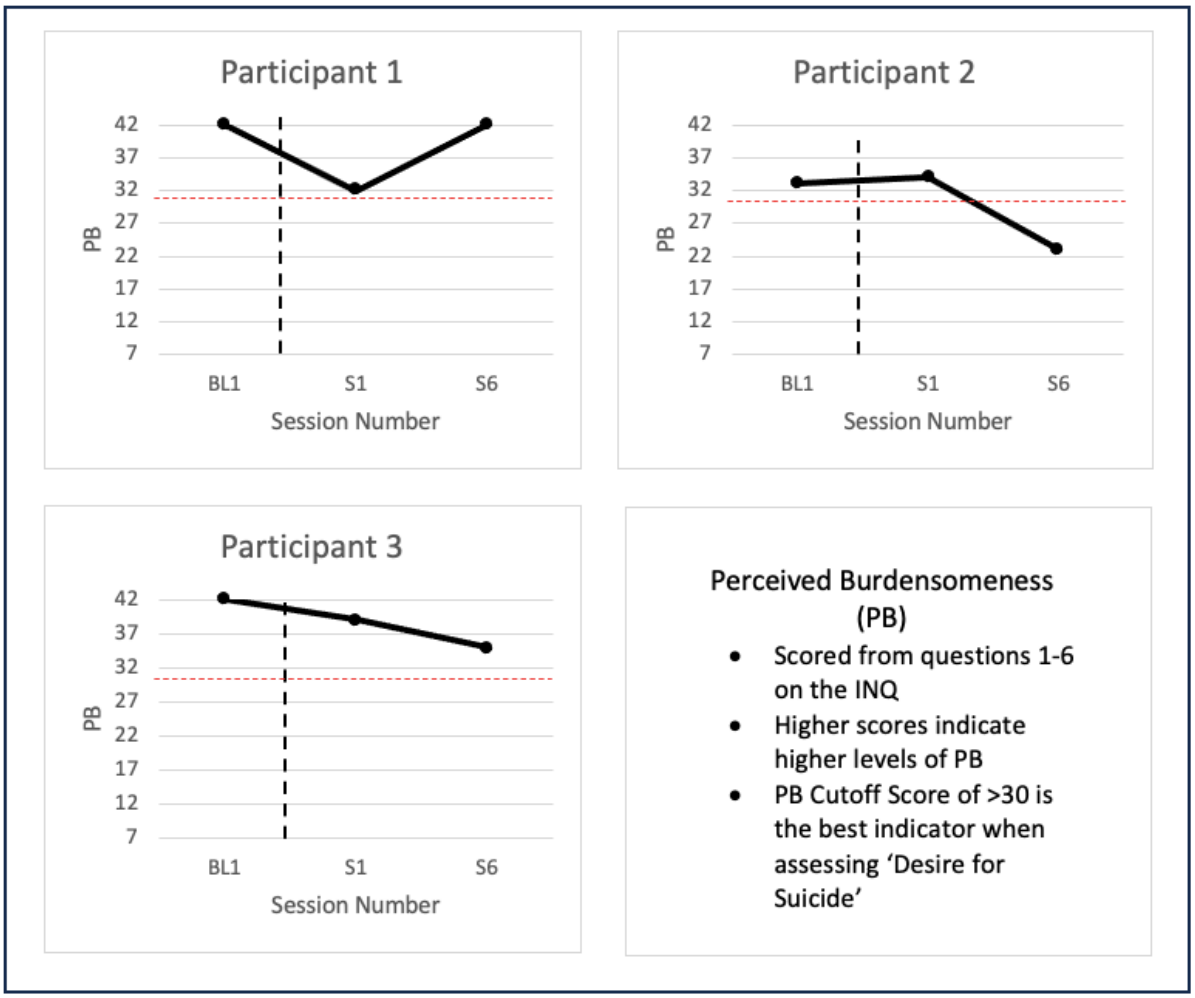


Figure 10

Thwarted Belonging Scores Across Baseline and Intervention Sessions

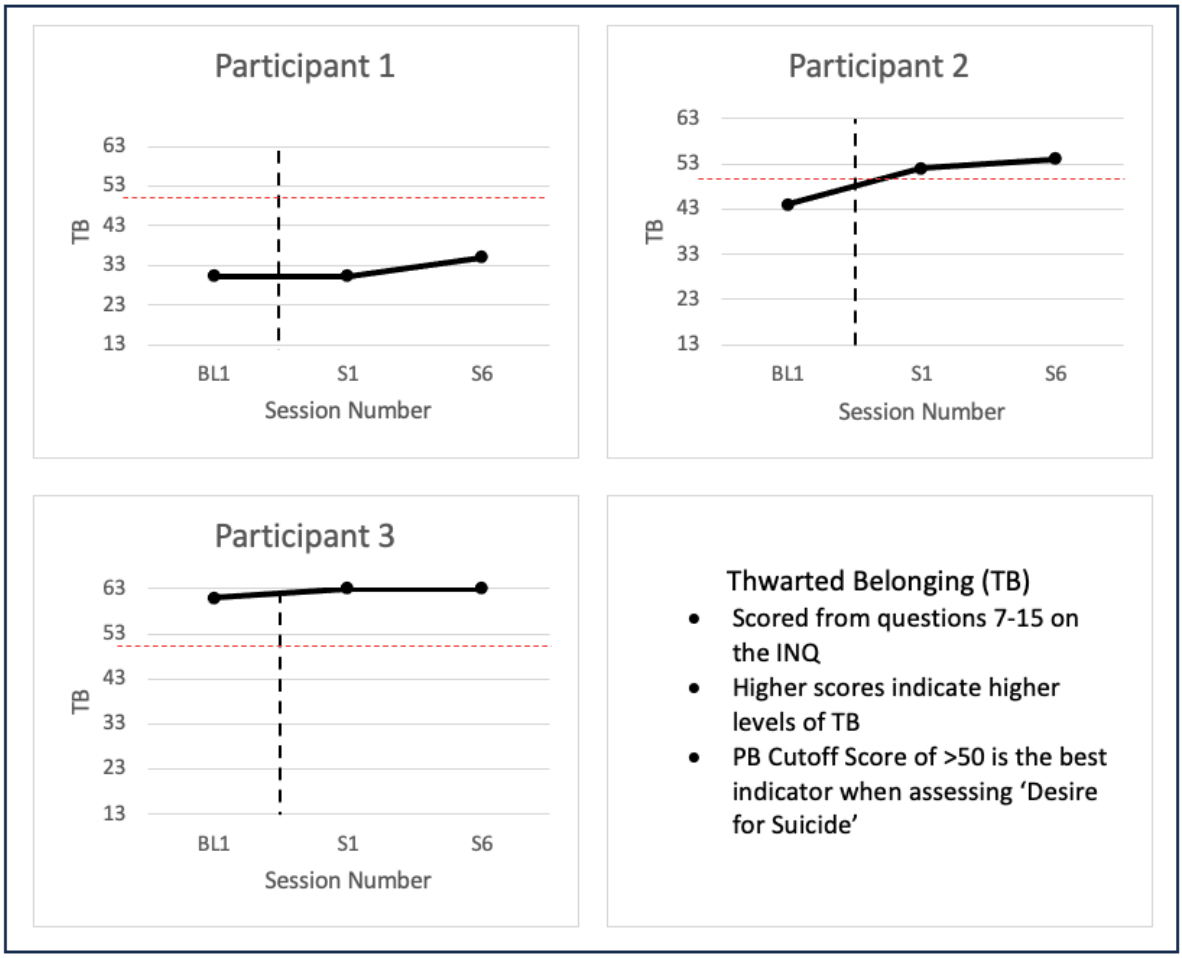
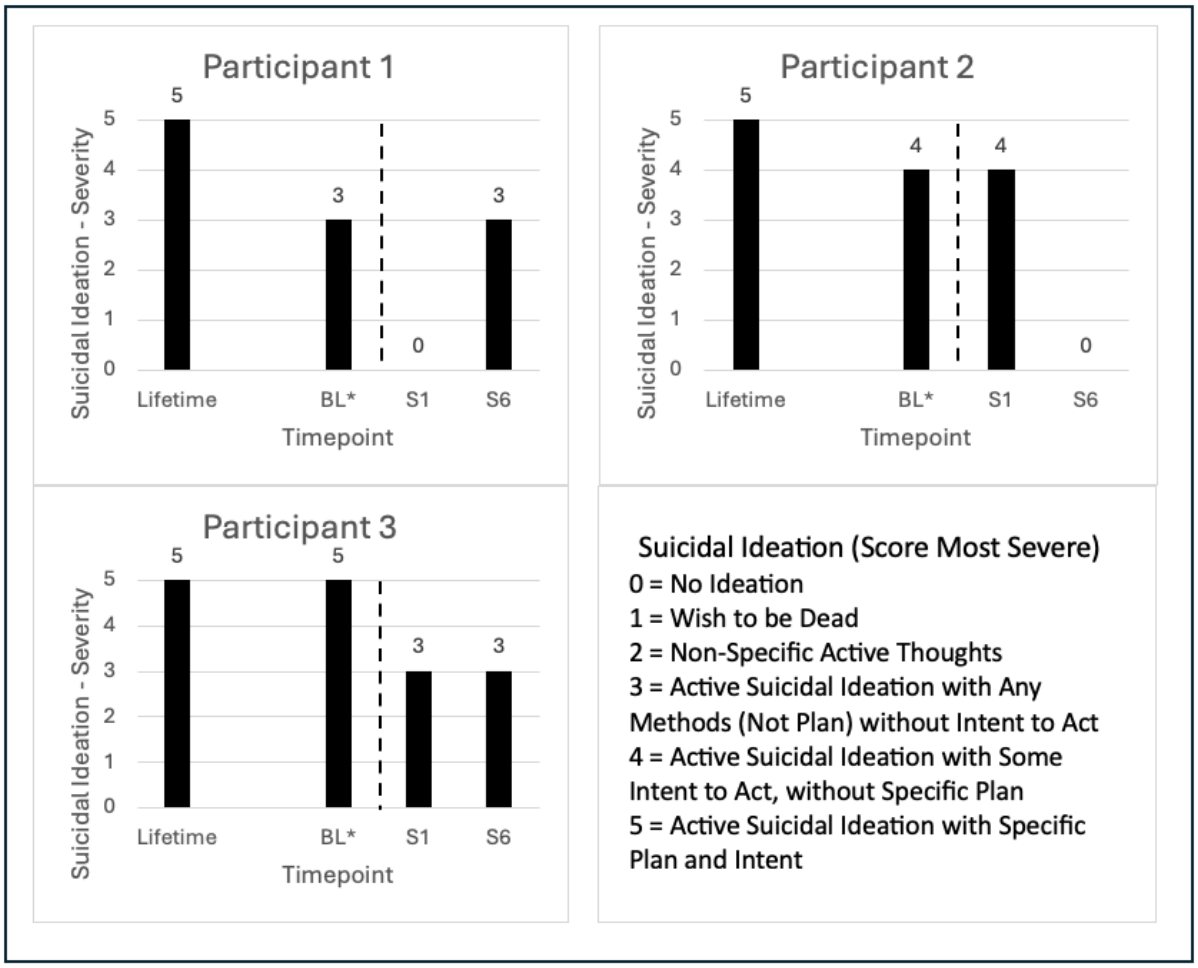


Figure 11

Suicidal Ideation Levels Across Baseline and Intervention Sessions



*BL scores assessed for the highest level of severity over the past month

Appendix A

TIDieR Guidelines

TIDieR Template for Intervention Description and Replication

The TIDieR (Template for Intervention Description and Replication) Checklist*:

Information to include when describing an intervention and the location of the information

Item number	Item	Where located **	
		Primary paper (page or appendix number)	Other † (details)
1.	**BRIEF NAME** Provide the name or a phrase that describes the intervention.	p2-14	
2.	**WHY** Describe any rationale, theory, or goal of the elements essential to the intervention.	p2-14	
3.	**WHAT** Materials: Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed (e.g. online appendix, URL).	p2-14 Table 1 plus appendices P, Q, and R	
4.	Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.		
5.	**WHO PROVIDED** For each category of intervention provider (e.g. psychologist, nursing assistant), describe their expertise, background and any specific training given.	p2-15	
6.	**HOW** Describe the modes of delivery (e.g. face-to-face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group.	p2-14	
7.	**WHERE** Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	p2-14	

	WHEN and HOW MUCH		
8.	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity or dose.	p2-14	
	TAILORING		
9.	If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how.	p2-14 to 2-15	
	MODIFICATIONS		
10.‡	If the intervention was modified during the course of the study, describe the changes (what, why, when, and how).	p2-19 and Table 5	
	HOW WELL		
11.	Planned: If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	p2-15	
12.‡	Actual: If intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.	p2-19	

** **Authors** - use N/A if an item is not applicable for the intervention being described. **Reviewers** – use '?' if information about the element is not reported/not sufficiently reported.

† If the information is not provided in the primary paper, give details of where this information is available. This may include locations such as a published protocol or other published papers (provide citation details) or a website (provide the URL).
‡ If completing the TIDieR checklist for a protocol, these items are not relevant to the protocol and cannot be described until the study is complete.

* We strongly recommend using this checklist in conjunction with the TIDieR guide (see *BMJ* 2014;348:g1687) which contains an explanation and elaboration for each item.

* The focus of TIDieR is on reporting details of the intervention elements (and where relevant, comparison elements) of a study. Other elements and methodological features of studies are covered by other reporting statements and checklists and have not been duplicated as part of the TIDieR checklist. When a **randomised trial** is being reported, the TIDieR checklist should be used in conjunction with the CONSORT statement (see www.consort-statement.org) as an extension of **Item 5 of the CONSORT 2010 Statement.** When a **clinical trial protocol** is being reported, the TIDieR checklist should be used in conjunction with the SPIRIT statement as an extension of **Item 11 of the SPIRIT 2013 Statement** (see www.spirit-statement.org). For alternate study designs, TIDieR can be used in conjunction with the appropriate checklist for that study design (see www.equator-network.org).

TIDieR checklist

Appendix B

Risk and Distress Protocol

Risk and Serious Adverse Events Protocol

Prior to the intervention:

The researchers have completed GCP training, and will be given additional risk and distress management training within clinical supervision.

Exclusion criteria will screen out individuals at imminent risk of harm to self or others.
Risk to self: current immediate intention and plan to end own life
Risk to others: an unmanageable risk of violence to researchers

A risk assessment must be completed by <<service name>> within the 3 months prior to the start of the intervention

In the initial assessment with the researcher:

Risk screening questions will be asked and the risk assessment form will be updated

Suicide prevention contact details will be shared

Confidentiality and its limits will be explained

Throughout the trial:

Criteria for SAEs:

In research other than CTIMPs, an SAE is defined by the Health Research Authority as an untoward occurrence that:

(a) results in death;
(b) is life-threatening;
(c) requires hospitalisation or prolongation of existing hospitalisation;
(d) results in persistent or significant disability or incapacity;
(e) consists of a congenital anomaly or birth defect; or
(f) is otherwise considered medically significant by the investigator.

The investigators will also consider the following adverse events as significant:

(a) Death by suicide
(b) Attempted suicide
(c) Suicidal crisis without attempt
(d) Severe symptom exacerbation

Assessing for SAEs:

The trainee clinical psychologist will assess for any SAEs and AEs arising between and within sessions. They will specifically ask about negative consequences of participating in the research. They will also monitor for changes in risk.

Questionnaires will also be used to assess for serious adverse events:

- CGI scale (≥6 as severe, and an increase of ≥3 as non-severe adverse event)

Changes on questionnaire scores will be followed by a verbal assessment to establish:

1) Current risk:
If the individual is at risk of imminent harm to self or others. Risk will be managed following the steps detailed below.

2) Risk linked to the intervention:
If risk is seen to have increased due to the intervention, sessions will cease and follow-up support will be discussed with ..service name..

Reporting SAEs:

Potential SAEs will be reported to the chief investigator (JK) as soon as possible

The chief investigator will collate all relevant information about the potential SAE. This will be recorded on the reporting template (*Report of Serious Adverse Event* – based on an HRA produced form) within 48 hours. This will be sent to all researchers on the trial.

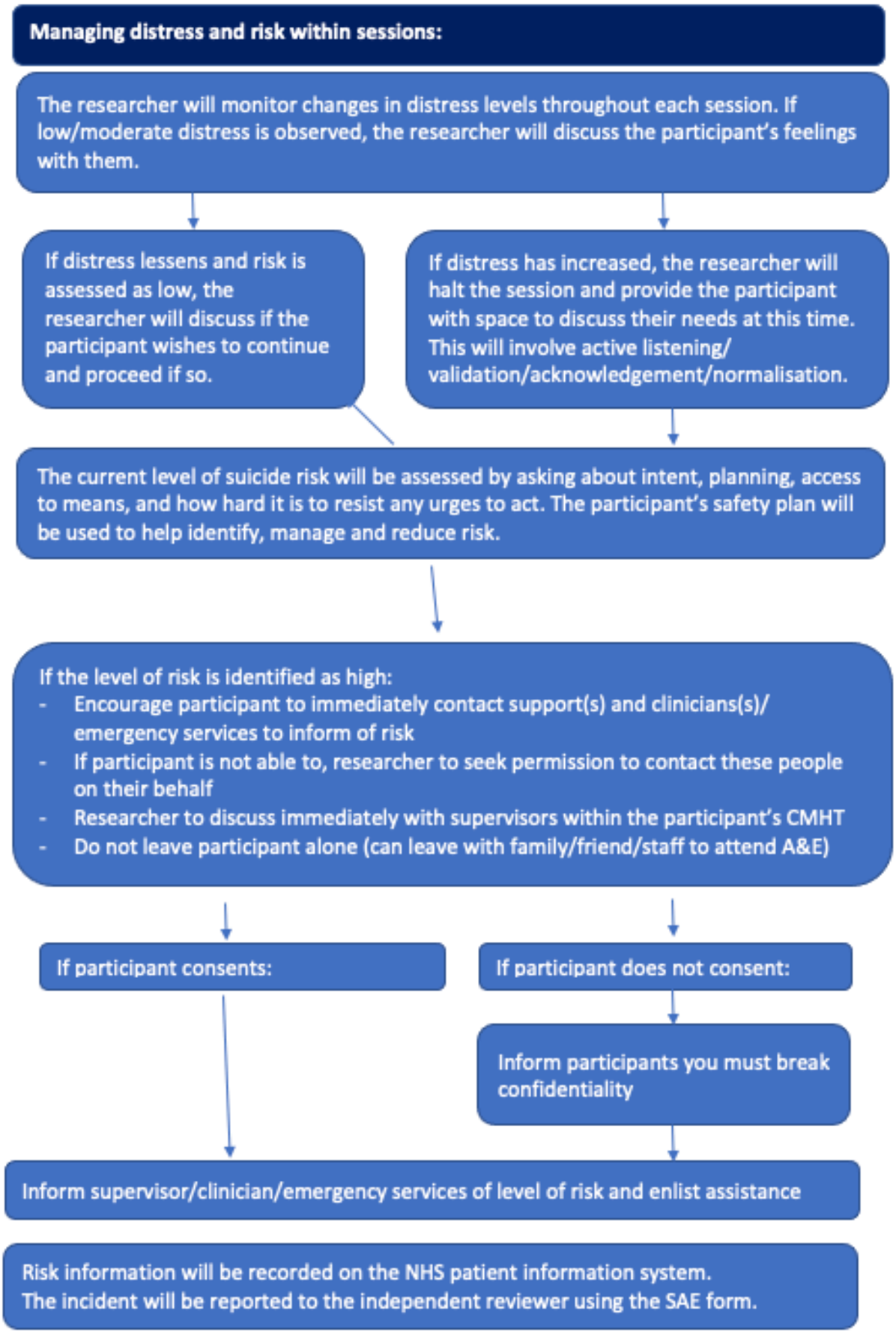
The chief investigator may pause the trial whilst investigations are ongoing if they have serious concerns about the safety of participants.

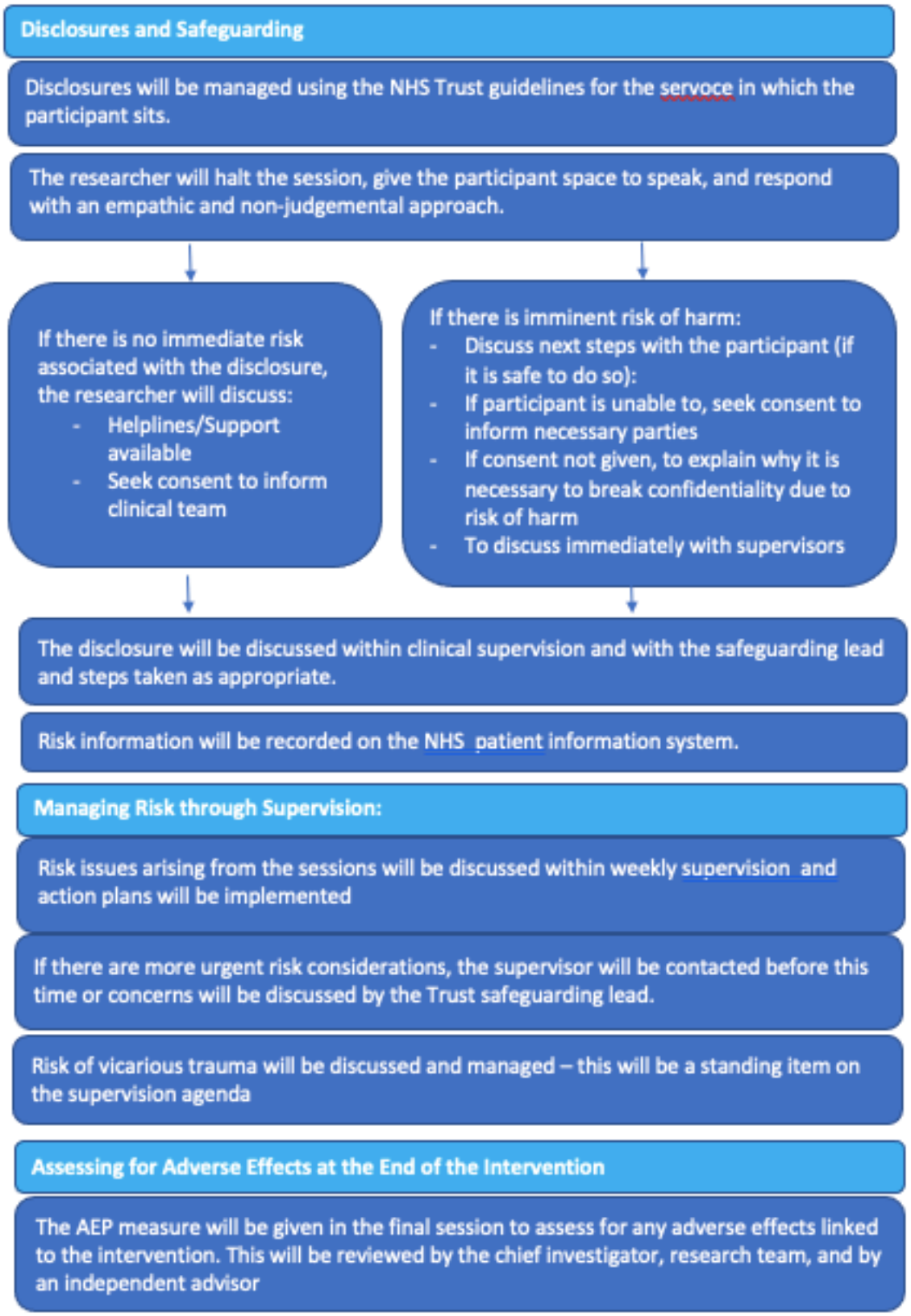
A copy of the SAE form will be sent to independent advisor Dr Cath Coogan and to Lancaster University sponsorship within 7 days of the CI being made aware of the potential SAE to review the expectedness and relatedness of the SAE to the trial.

If the event is deemed to be both related to the trial and unexpected by one of both of the CI and the independent reviewer, the SAE form will be sent to the Research Ethics Committee within 15 days of the CI being made aware of the event. This will also be sent to the GMMH Research and Innovation lead.

The REC should acknowledge this within 30 days. If not, the CI will follow this up ASAP.

If an adverse event does not meet the criteria of an SAE, it will be discussed in supervision, recorded on the SAE form, collated and summarised in the final research report.


Managing distress and risk within sessions:
The researcher will monitor changes in distress levels throughout each session. If low/moderate distress is observed, the researcher will discuss the participant's feelings with them.
If distress lessens and risk is assessed as low, the researcher will discuss if the participant wishes to continue and proceed if so.
If distress has increased, the researcher will halt the session and provide the participant with space to discuss their needs at this time. This will involve active listening/ validation/acknowledgement/normalisation.
The current level of suicide risk will be assessed by asking about intent, planning, access to means, and how hard it is to resist any urges to act. The participant's safety plan will be used to help identify, manage and reduce risk.
If the level of risk is identified as high:
- Encourage participant to immediately contact support(s) and clinicians(s)/ emergency services to inform of risk
- If participant is not able to, researcher to seek permission to contact these people on their behalf
- Researcher to discuss immediately with supervisors within the participant's CMHT
- Do not leave participant alone (can leave with family/friend/staff to attend A&E)
If participant consents:
If participant does not consent:
Inform participants you must break confidentiality
Inform supervisor/clinician/emergency services of level of risk and enlist assistance
Risk information will be recorded on the NHS patient information system.
The incident will be reported to the independent reviewer using the SAE form.


Disclosures and Safeguarding
Disclosures will be managed using the NHS Trust guidelines for the servoce in which the participant sits.
The researcher will halt the session, give the participant space to speak, and respond with an empathic and non-judgemental approach.
If there is no immediate risk associated with the disclosure, the researcher will discuss:
- Helplines/Support available
- Seek consent to inform clinical team
If there is imminent risk of harm:
- Discuss next steps with the participant (if it is safe to do so):
- If participant is unable to, seek consent to inform necessary parties
- If consent not given, to explain why it is necessary to break confidentiality due to risk of harm
- To discuss immediately with supervisors
The disclosure will be discussed within clinical supervision and with the safeguarding lead and steps taken as appropriate.
Risk information will be recorded on the NHS patient information system.
Managing Risk through Supervision:
Risk issues arising from the sessions will be discussed within weekly supervision and action plans will be implemented
If there are more urgent risk considerations, the supervisor will be contacted before this time or concerns will be discussed by the Trust safeguarding lead.
Risk of vicarious trauma will be discussed and managed – this will be a standing item on the supervision agenda
Assessing for Adverse Effects at the End of the Intervention
The AEP measure will be given in the final session to assess for any adverse effects linked to the intervention. This will be reviewed by the chief investigator, research team, and by an independent advisor

Appendix C

Clinical Global Impression

Clinical Global Impression (CGI)

1. **Severity of illness**
   Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?
   0 = Not assessed
   1 = Normal, not at all ill
   2 = Borderline mentally ill
   3 = Mildly ill
   4 = Moderately ill
   5 = Markedly ill
   6 = Severely ill
   7 = Among the most extremely ill patients

2. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to the current intervention
   Compared to his condition at admission to the project, how much has he changed?
   0 = Not assessed
   1 = Very much improved
   2 = Much improved
   3 = Minimally improved
   4 = No change
   5 = Minimally worse
   6 = Much worse
   7 = Very much worse

3. **Efficacy index:** Rate this item on the basis of the current intervention
   Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.
   EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient	09	10	11	12
Unchanged or worse		13	14	15	16

Not assessed = 00

Reproduced from Guy W, editor. ECDEU Assessment Manual for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health, Education, and Welfare

Appendix D

Working Alliance Inventory - Short Revised

NHS Greater Manchester Mental Health NHS Foundation Trust

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Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe___likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ___and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ___and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that___appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Appendix E

Participant Feedback Form

NHS Greater Manchester Mental Health NHS Foundation Trust

Health & Medicine | Lancaster University

Participant Feedback Form

Learning from you: **Understanding your experience of an autobiographical memory-based intervention**

Study ID: _____ **Date:** _____

Thank you for taking part in this study. To help us to understand more about what was helpful and what was less helpful about this intervention, we would like to know a bit more about your experience of this case series. This includes whether taking part has caused you any distress, or if you have found this helpful. This is to help us to improve the way we carry out similar interventions in the future.

If you could take the time to complete this questionnaire, we would be very grateful:

Please indicate the extent to which you agree with following statements:	Not at all	Very Little	A Little	Quite a Lot	Very Much
Taking part hasn't helped me with my problems.					
Taking part made my problems worse.					
Taking part made me feel more anxious.					
Taking part took up too much time.					
Taking part led to my mood becoming very low.					
Taking part made me feel more angry and irritable.					
I didn't feel ready to talk about my problems.					
Taking part made me think too much about bad things that have happened in the past.					
Taking part meant I stopped looking after myself properly.					
Taking part made me feel more suspicious.					
Taking part required too much energy or motivation.					
Taking part increased my thoughts of killing myself.					

Please indicate the extent to which you agree with following statements:	NOT AT ALL	VERY LITTLE	A LITTLE	QUITE A LOT	VERY MUCH
Taking part made my voices or visions worse (if applicable)					
Taking part was making me fall out with my family or friends.					
Taking part was having a bad effect on my self-esteem.					
Taking part was making me want to harm myself.					
I felt embarrassed talking about my problems with people I had not met before.					
Taking part made me have thoughts of harming other people.					
Taking part was making me feel hopeless about the future.					
Taking part meant I had to increase my medication in order to cope (if applicable)					
Taking part involved too much hard work.					
Taking part made me worry that people would think badly of me because of my diagnosis.					
Taking part made me fall out with my doctor or care team.					
Taking part made me worry about losing control of my mind.					
My problems have improved to the point whereby I no longer feel I need help.					

If you would like to describe your experience of taking part in this research in your own words, please use the following space. Direct quotes from this may be used by the researchers. These will be anonymised:

_____

_____

_____

_____

Many thanks for your help and participation

Appendix F

Acceptability Questionnaire

NHS Greater Manchester Mental Health NHS Foundation Trust

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Acceptability Questionnaire

.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I felt comfortable taking part in the intervention					
Taking part in the intervention required a lot of effort.					
The intervention was adapted to my individual needs and beliefs.					
The intervention has improved my overall wellbeing.					
The intervention has reduced my levels of suicidal thinking.					
I understand how to use the techniques introduced during the intervention.					
I was able to engage with the intervention.					
Receiving the intervention interfered with my other priorities.					
The intervention was acceptable to me.					

This questionnaire has been adapted from the following study:

Sekhon, M., Cartwright, M. & Francis, J.J. Development of a theory-informed questionnaire to assess the acceptability of healthcare interventions. *BMC Health Serv Res* **22**, 279 (2022). https://doi.org/10.1186/s12913-022-07577-3

Appendix G

Entrapment Scale – Short Form

The Entrapment Scale

For each of the following attitude statements, indicate the extent to which you think it represents your own view of yourself. Read each item carefully and circle the number to the right of the statement that best describes the degree to which each statement is 'Like You'. Please complete all 4 items.

Entrapment Scale – Short Form

	Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
1. I often have the feeling that I would just like to run away.	0	1	2	3	4
2. I feel powerless to change things.	0	1	2	3	4
3. I feel trapped inside myself.	0	1	2	3	4
4. I feel I'm in a deep hole I can't get out of.	0	1	2	3	4

Appendix H

Mood Rating Scale

Sessional Mood Scale

"What would you rate your mood out of 10 for the past week, where 0 is the worst you have ever felt, and 10 is the best?"

Appendix I

Interpersonal Needs Questionnaire - 15

NHS Greater Manchester Mental Health NHS Foundation Trust

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INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

		Not at all true for me			Somewhat true for me			Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7
4.	These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5.	These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6.	These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7.	These days, other people care about me	1	2	3	4	5	6	7
8.	These days, I feel like I belong	1	2	3	4	5	6	7
9.	These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10.	These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11.	These days, I feel disconnected from other people	1	2	3	4	5	6	7
12.	These days, I often feel like an outsider in social gatherings	1	2	3	4	5	6	7
13.	These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7
14.	These days, I am close to other people	1	2	3	4	5	6	7
15.	These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Appendix J

Columbia – Suicide Severity Rating Scale

The C-SSRS

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She/They Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Person endorses thoughts about a wish to be dead or not alive anymore or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and person reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she/they were feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you	____	____

(3) Uncertain that deterrents stopped you (0) Does not apply		
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act undertaken with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better,*** ***get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has person engaged in Non-Suicidal Self-Injurious Behavior?**	**Yes No** ☐ ☐ Total # of Attempts _____ **Yes No** ☐ ☐	**Yes No** ☐ ☐ Total # of Attempts _____ **Yes No** ☐ ☐
Interrupted Attempt: When person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*. Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted _____	**Yes No** ☐ ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____

Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____	**Yes No** ☐ ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Appendix K

Recruitment, Consent and Randomisation Protocol

Recruitment, Consent, and Randomisation Processes:

Stage 1 - Advertising trial to clinicians in community-based mental health teams

- A clinician information sheet explaining the study and participant inclusion/exclusion criteria will be disseminated
- Trainee clinical psychologist (LP) will attend the service's team meeting to explain study and answer any queries about this

↓

Stage 2 - Clinicians identify clients they consider eligible about study

- Clinicians within the services use the eligibility form to screen whether individuals meet the inclusion/exclusion criteria
- If there are any queries about whether an individual is eligible for the study, clinicians may discuss eligibility with the research team. Sensitive / identifiable clinical information would not be discussed until the EoI form is completed.

↓

Stage 3 - Clinicians approach clients they consider eligible

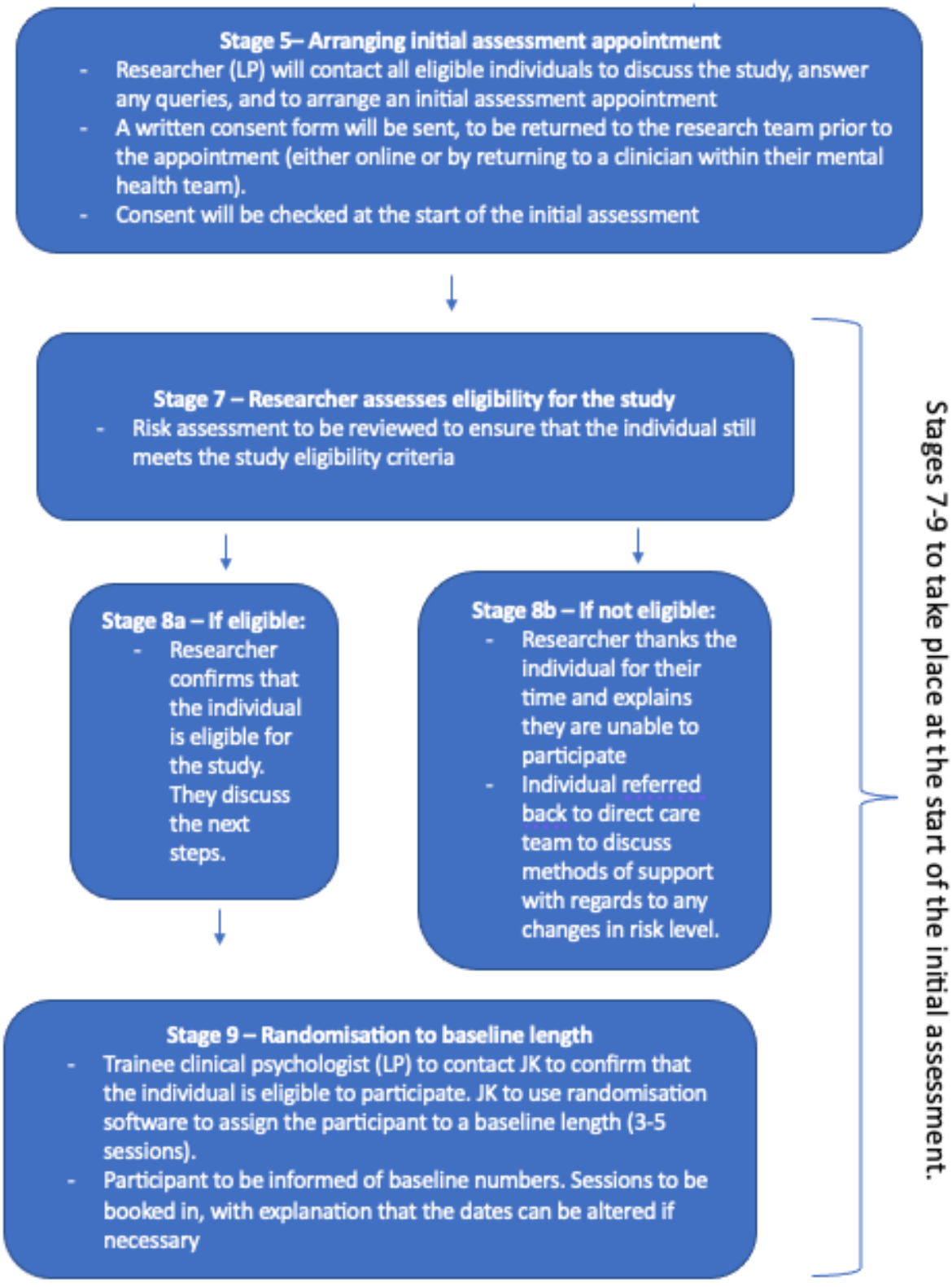
- Clinicians within the services speak to clients about the study and provide them with the participant information sheet
- Any clients who are interested in the study will be provided with an expression of interest form. This will be returned to the clinician to share with the research team.

↓

Stage 4 – Expression of interest (EoI) form completed by client

- The EoI form will give permission for the research team to contact the individual about the study
- There will be a disclaimer explaining that the clinician and research team may discuss the eligibility criteria prior to them being contacted. All information sharing will be verbal and the research team will not access patient records at this stage.
- The form will be added to the client's NHS online records by the clinician. A copy will also be held by the research team and stored on Lancaster University approved cloud storage (OneDrive).
- If, after further discussion, the client is not felt to meet the criteria for the study, this decision would be passed to the client by a member of trust staff involved in the study. The research team would destroy their copy of the EoI form.

↓



The study will then proceed, following the protocol for the baseline and intervention sessions

Appendix L

Clinician Information Sheet

NHS Greater Manchester Mental Health NHS Foundation Trust

Health & Medicine | Lancaster University

Clinician Information Sheet

Exploring the feasibility and acceptability of an autobiographical memory-based intervention for people with thoughts of suicide

My name is Lexy Powell and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University. Lancaster University are the sponsor for this project.

What is the study about?
We are considering whether an intervention which focuses on people's 'autobiographical memories' is suitable and effective for people with thoughts of ending their own life.

'Autobiographical memories' are memories which come from a person's own life. They may be associated with a range of emotions. This study will introduce techniques drawing upon:

- Neutral memories
- Positive memories
- Memories of 'exits' from suicidal thoughts
- Relaxation techniques

What is the structure and content of the study?
The study consists of 3-5 baseline sessions and 6 therapy sessions. In the first baseline session, a risk assessment will be carried out and the participant's current safety plan will be reviewed. During all baseline sessions, individuals will have a check in and be asked to complete questionnaires. Risk will be assessed and reviewed throughout.

The therapy sessions will involve:

- psychoeducation about the role of autobiographical memory
- identifying different memories, including neutral memories, positive memories, and memories of 'exits' from suicidal thoughts
- developing strategies based around these types of memory
- focusing on the strategies identified as most helpful by participants

The initial assessment session and the therapy sessions are all face-to-face at <<Recruitment Site>>. The follow up baseline sessions can take place face-to-face, via telephone, or online via Microsoft Teams based on the individuals' wishes.

Individuals will be funded £10 for attending the initial baseline session and £10 for attending the final therapy session (up to £20 total) as compensation for the time taken to complete additional measures in these sessions.

Who can take part in the study?
Inclusion criteria:

- Participants must have experienced **at least one** of the following:
  1) thoughts/images of ending their life within the past 3 months
  2) have attempted to end their life within the past 3 months
- Currently under the care of a community-based mental health team
- Have a risk assessment and safety plan reviewed/updated within the last 3 months
- 18-65 years old

Exclusion criteria:

- If the individual is at imminent risk of harm from themselves or others
- If they are currently receiving psychological treatment or participating in another research intervention
- If they have a moderate/severe learning disability, have experienced a brain injury which significantly impacts on their speech or language comprehension, or if they are experiencing acute psychosis
- If they have a history of violence or harm to others to a degree in which one-to-one sessions would be unsafe
- If they are they currently in an inpatient setting or open to a home-based treatment team
- If they are non-English speaking (as the intervention will take place in English)

How can clinicians support recruitment?
We are looking to recruit 5-7 individuals to take part in the study. We would appreciate it if you would:

1) Identify any individuals who you believe would meet the eligibility criteria to take part in this study, using the eligibility check sheet. You can speak to <<Researcher Name>> if you have any queries about the eligibility criteria
2) Approach these individuals about whether they would be interested in taking part
3) Provide them with the Participant Information Sheet to read through
4) Provide them with an Expression of Interest sheet to complete and return

What happens if an individual completes an Expression of Interest form?
If any individual completes an Expression of Interest form, this should be emailed on to Lexy (trainee clinical psychologist): a.powell6@lancaster.ac.uk. We would then set up a short meeting with you, in order to check that the individual meets the eligibility criteria.

If the individual is screened as meeting eligibility, the research team would then contact them to set up an initial meeting.

If the individual is excluded from the study, <<Researcher Name>> will pass this information on to them. They are welcome to contact the research team if they would like further information about this.

What information will be shared with the service?
Information from the study will be kept confidential within the research team. However, if a participant mentions something that makes me think that they, or someone else, is at

significant risk of harm, I will have to break confidentiality and speak to a member of <<service name>> about this. If possible, I will tell the participant if I have to do this.

Benefits and Risks

Potential benefits – Other interventions using positive autobiographical memories have been found to be effective in reducing distress for people experiencing a wide range of mental health difficulties. There have also been promising studies in adolescents and young adults suggesting that these benefits extend to people experiencing thoughts of suicide. Our hope is that these benefits will extend to a wider age-range and be experienced by participants in our study.

Potential risks - We do not expect there to be any risk to participants. Some people may experience distress when speaking about thoughts of suicide. However, our study aims to reduce this distress by redirecting the attention to positive autobiographical memories, thereby minimising the power attached to memories of suicidal thoughts. We will discuss and assess for potential risks during the study, and add to participants' safety plans. We will contact you to inform you if there has been any change in risk levels. Contact details for suicide helplines will also be provided to participants.

Research team

If you have any questions about the information on this form, please do not hesitate to contact members of our research team:

- **Lexy Powell** (Trainee Clinical Psychologist, Lancaster University): a.powell@lancaster.ac.uk
- **Dr James Kelly** (Clinical Psychologist, Researcher, Lancaster University): j.a.kelly@lancaster@ac.uk
- **Dr Nasur Iqbal** (Clinical Psychologist, Greater Manchester Mental Health NHS Foundation Trust)
- **Dr Aimee Cairns** (Clinical Psychologist, Greater Manchester Mental Health NHS Foundation Trust)

Appendix M

Participant Information Sheet

Participant Information Sheet

Exploring the feasibility and acceptability of an autobiographical memory-based intervention for people with thoughts of suicide

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is Lexy Powell and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University. Lancaster University are the sponsor for this project.

What is the study about?
We are considering whether an intervention which focuses on people's 'autobiographical memories' is suitable and effective for people with thoughts of ending their own life.

'Autobiographical memories' are memories which come from a person's own life. They may be associated with a range of emotions. This study will introduce techniques drawing upon neutral memories, positive memories, and memories of 'exits' from suicidal thoughts.

Why have I been approached?
A member of your care team has approached you because you have previously described having thoughts of suicide. You may therefore be eligible to take part in this study.

Do I have to take part?
No. This study is completely optional, and it's your choice whether or not you would like to take part. It will not impact your treatment or medical care in anyway if you do not take part. You can also decide to take part and then change your mind further down the line.

If you lose capacity to take part during your time within the study, we would not expect you to continue. Your time in the study would end and all personal/identifiable information held about you would be destroyed.

Who can take part in the study?
To be eligible to take part, you must:

- Have had thoughts/images of ending your life and/or have attempted to end your life within the past three months
- Be aged 18-65 years
- Be under the care of a community-based mental health team

There are also some reasons why you may not be suitable for the study:

- If you are at imminent risk of harm to yourself or others
- If you are currently receiving psychological treatment or participating in another research intervention
- If you have a moderate/severe learning disability, have experienced a brain injury which significantly impacts on your speech or language comprehension, or if you are experiencing acute psychosis
- If you do not speak English (as the intervention will be in this language)
- If you are currently being seen by the Home-Based Treatment Team or if you are currently in an inpatient setting.

What will I be asked to do if I take part?

If you express an interest in the study, we will call you to discuss this. If you decide to take part, you will be sent a consent form to read, complete and return. We will also book in an initial appointment.

In the initial appointment, we will ask you some questions to check whether you still meet the study's criteria. If you are still eligible, you will then be invited to continue to the main part of the study. This will consist of between **3-5 baseline sessions** and **6 therapy sessions**. We will do the baseline session at the same time as confirming eligibility.

The sessions will take place **either once or twice per week**, depending on what is most convenient for you. All sessions will take place with Lexy (trainee clinical psychologist).

During each session, you will be asked to complete a series of questionnaires. In the 6 therapy sessions, we will introduce you to memory-based strategies. We will practice these together. You will also be encouraged to use these strategies outside of the sessions.

Where will I need to go, and for how long?

<u>The initial baseline session:</u>

- **Time:** Approximately 60 minutes
- **Location:** Face-to-face at <<Recruitment Site>>

In this session, we will let you know how many baseline sessions you will have in total. This is randomly assigned by a clinical psychologist on the research team (Dr James Kelly). We vary the length of the baseline period to provide a more robust analysis when comparing this with the therapy period.

<u>The follow-up baseline sessions:</u>

- **Time:** Approximately 30 minutes
- **Location:** Either face-to-face at <<Recruitment Site>>, online via Microsoft Teams, or via telephone

<u>The 6 therapy sessions:</u>

- **Time**: Approximately 60 minutes each
- **Location**: Face-to-face at <<Recruitment Site>>

Will sessions be recorded?
We will ask for consent for the 6 therapy sessions to be audio and/or video recorded. We ask to record sessions to help us ensure the intervention protocol is followed. However, it is your choice whether we record the therapy sessions. Baseline sessions will not be recorded.

Recordings will be made on a password protected laptop and stored securely stored safely on Lancaster University approved secure cloud storage (OneDrive). Recordings will be deleted at the end of the study.

What will I need to take part?
You will need to be able to travel to <<Recruitment Site>> for face-to-face sessions once or twice per week.

If you wish to have the follow-up baseline sessions online or via telephone, you will need access to a phone or access a device from which you can access Microsoft Teams. However, if preferred, all sessions can take place face-to-face.

What if I change my mind or if I am unable to continue?
You do not have to take part in this study. If you agree to take part, you can withdraw from continued participation at any point without giving any reason. We would also withdraw you from the study if you lost capacity to consent to taking part. All personal/identifiable data would be destroyed.

At the start of the study, we will ask for your consent to keep any anonymised data about you if you were to leave the study prematurely. This is because the data cannot be withdrawn from the trial after it has been anonymised (e.g. outcome measures and questionnaires). Data will be anonymised within a week of being submitted.

How do I take part?
If you are interested in taking part, please complete an Expression of Interest form provided by a clinician within <<service name>>.

After this, Lexy (trainee clinical psychologist) will speak to a member of your clinical team to screen your eligibility to participate. If you meet the eligibility criteria, you will be invited to an initial session. If you do not meet the criteria, a member of trust staff who is involved in the project << (Researcher Name) >> will be in touch to let you know. He will be able to answer any questions you may have about this decision.

What will happen after I take part?
The results will be written up into a research report. It may also be submitted for publication in an academic journal. We would like people to be able to access the results easily. Therefore, we may write a blog post or do a presentation. You and your information will not be identifiable in any published or presented work. Anonymised quotes from the end of therapy feedback may be used. However, no direct quotes will be taken from the audio recorded sessions.

If you would like a copy of the results, you can either indicate your preference on the consent form you complete before taking part, or you can contact the researchers at any time. I would email any participants who have opted in when the research study has been written up and the results have been finalised.

Are there any risks?
We do not expect there to be any risk to you by taking part in this study. Some people may experience distress when speaking about thoughts of suicide. However, our study aims to reduce this distress by redirecting the attention to positive autobiographical memories, thereby minimising the power attached to memories of suicidal thoughts. We will discuss and assess for potential risks during the study, and develop a plan to help keep you safe. Contact details for suicide helplines are included at the end of this form. They will be provided again during the study.

Are there any benefits?
Individuals will receive a small payment to compensate the time/effort taken to complete the questionnaires used in the **first baseline session** and the **last intervention session.** You will receive £10 for attending each of these two sessions (£20 total for the study).

The study is investigating a new way of reducing thoughts of suicide. Other interventions using positive autobiographical memories have been effective in reducing distress for people experiencing a wide range of mental health difficulties. There have also been promising studies in adolescents and young adults suggesting that these benefits extend to people experiencing thoughts of suicide. We hope these will extend to a wider age-range.

Will my data be identifiable?
The information you provide will be kept confidential and stored safely on Lancaster University approved secure cloud storage (OneDrive). Your personal information will be kept securely and destroyed at the end of the project. Only the researchers conducting this study will be able to access the data.

During the study, we will collect some personal identifiable information about you: your name, age, gender, ethnic origin, employment status, marital status, sexual orientation, and information about your mental health history including any diagnoses, current medications, and previous inpatient admissions. This will be collected on a demographics form, which you can access prior to consenting. Risk information will also be collected. This information will be collected from 1) you, 2) clinicians within <<service name>>, and 3) your patient records.

To help protect your data, we have taken the following steps:

- The files on the computer will be encrypted, so no-one other than the researcher will be able to access them. The computer itself is also password protected.
- At the end of the study, all electronic information, such as questionnaire responses, will be stored anonymously and securely by the university for 10 years.
- All personal data will be confidential and stored separately from your questionnaire responses. Researchers will use a unique study number as a pseudonym so that they are able to recognise each participant's data during the study. The link document will be stored securely and separately to the research data.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Who will know I am taking part?

If you consent to take part, we will let <<service name>> know that you are taking part in the study, and also when the study has ended. We will also contact your GP about this if you consent. Information shared during baseline and therapy sessions will be kept confidential. Lexy (trainee clinical psychologist) will require access to your GMMH patient records so that she can access and update any information with regards to your risk and distress levels.

There are some limits to confidentiality. Throughout the study if you mention something that makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of your <<service name>> about this. If possible, I will tell you if I have to do this.

Who has reviewed the project?

This study has been reviewed and sponsored by Lancaster University, reviewed and approved by the Health Research Authority and had favourable ethical opinion from the East Midlands - Nottingham 1 Research Ethics Committee.

Please be aware that individuals from Lancaster University and from GMMH NHS Foundation Trust may look at our research records for monitoring and auditing purposes.

Research team

The research team has four members:

- **Lexy Powell** (Trainee Clinical Psychologist, Lancaster University): a.powell@lancaster.ac.uk
- **Dr James Kelly** (Clinical Psychologist, Researcher, Lancaster University): j.a.kelly@lancaster@ac.uk
- **Dr Nasur Iqbal** (Clinical Psychologist, Greater Manchester Mental Health NHS Foundation Trust)
- **Dr Aimee Cairns** (Clinical Psychologist, Greater Manchester Mental Health NHS Foundation Trust)

Insurance and Indemnity Arrangements

Lancaster University holds appropriate indemnity cover which includes but is not limited to Public Liability, Professional Indemnity and Employers Liability Insurance. If you are harmed whilst taking part in this study as a result of negligence by Lancaster University or its staff members, you may have grounds for legal action and should obtain independent legal advice. Non-negligent harm is not covered, and any claims that arise may be referred to the insurance provider for assessment. Should you require more information on the indemnity cover that Lancaster University holds, please contact the researcher

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith Tel: 01524 592282
Consultant Clinical Psychologist; Email: i.smith@lancaster.ac.uk
Department of Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973
Chair of FHM REC Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Suicide Helpline Contact Details

Organisation	Contact details	Opening times
Samaritans	08457909090 or 116123	24/7
Sane	0845 767 8000 or sane.org.uk/textcare	18:00-23:00 daily
CALM	0800585858	17:00–00:00 daily
Greater Manchester Mental Health Foundation Trust NHS Helpline	08009530285	24/7
North West Boroughs NHS	Wigan: 08000513253 Halton, Knowsley, St Helen's, Warrington: 08000511508	24/7

Appendix N

Expression of Interest Form

NHS Greater Manchester Mental Health NHS Foundation Trust

Health & Medicine | Lancaster University

Expression of Interest form

Study Title: Exploring the feasibility and acceptability of an autobiographical memory-based intervention for people with thoughts of suicide

We are conducting a research project delivering an autobiographical memory-based intervention for individuals with thoughts of suicide. More information about this study can be found on the Participant Information Sheet. If you do not currently have this document, this can be requested from a member of <<service name>>.

If you have read the Participant Information Sheet and you are interested in taking part in this study, please can you complete this Expression of Interest form and return it to a member of <<service name>>. The form will then be passed to the research team.

By completing this form, you are expressing your interest in taking part. You do not have to take part in this study. If you agree to take part, you may stop at any time without giving any reason.

Statements of consent	Please write your initials in each box separately
1. I consent to my name and contact details (recorded below) to be passed to the research team for this study.	
2. I understand that the researchers may speak to a member of my mental health team to check whether I meet the criteria to take part in this study. This will involve sharing information related to the inclusion/exclusion criteria, which can be found on the Participant Information Sheet. Information will be discussed verbally. No personal information from these conversations will be recorded by the research team.	
3. I consent to a member of the research team contacting me to discuss my participation in the study if I am screened as eligible.	

Name:_____

Preferred contact number:_____

Clinician name:_____

One copy to be kept by the researcher, to be destroyed when involvement in the study ends or the participant decides not to take part in the study. One copy to be retained in the medical records.

Version 1.3, 24/05/2023 IRAS ID: 316697

Appendix O

Consent Form

NHS Greater Manchester Mental Health NHS Foundation Trust

Health & Medicine | Lancaster University

Consent Form

Study Title: Exploring the feasibility and acceptability of an autobiographical memory-focused techniques for people experiencing thoughts of suicide

We are asking if you would like to take part in a research project that aims to assess how possible and acceptable an intervention is for people experiencing thoughts of suicide. Before you consent to participating in the study, please can you read the participant information sheet.

If you would like to take part in the study, please read through the following statements. If you are happy to consent to these statements, please add your initials in the box on the right. If you have any questions or queries before consenting, please speak to the lead researcher and trainee clinical psychologist - Lexy Powell.

Please complete and return this form prior to our initial appointment. This can be completed online, emailed to a.powell6@lancaster.ac.uk, or returned to a member of <<service name>>.

Statements of consent	Please add your initials to each box separately
1. I confirm that I have read the information sheet (<<ENTER VERSION AND DATE>>) and fully understand what is expected of me within this study	
2. I confirm that I have had the opportunity to ask any questions and to have them answered	
3. I understand that my participation is voluntary and that I am free to withdraw my continued participation at any time without giving a reason, and without my medical care or legal rights being affected. I can request for identifiable information held about me to be destroyed.	
4. All questionnaire data will be anonymised within a week of being submitted. I understand that once my data has been anonymised, this information cannot be withdrawn (even if I am no longer continuing to participate in the study) and will be included within the research.	
5. I agree to Lancaster University keeping all anonymised data (including questionnaire responses and session data) from the intervention for 10 years after the study has finished.	

6. I understand that any personal or identifiable information will be kept confidential and stored separately to my questionnaire responses and session data during the project.	
7. I agree to personal and identifiable information (e.g. name, contact details) being stored securely on Lancaster University approved secure cloud storage (One Drive). This information will be destroyed at the end of the project or when my participation within the project comes to an end.	
8. I understand that any information shared within baseline and therapy sessions will be kept confidential within the study's research team unless it is thought that there is a risk of harm to myself or others. In this case the trainee clinical psychologist will need to share this information with my clinical care team.	
9. I understand that the researcher will discuss information from the baseline and intervention sessions and questionnaire data with their supervisors as needed	
10. I agree to the trainee clinical psychologist having access to relevant parts of my GMMH patient records whilst I am taking part in the study, so that she can access and update risk information on this system.	
11. I agree to my therapeutic sessions being audio recorded for the trainee clinical psychologist's supervision purposes and to ensure model fidelity (optional).	Yes No
12. I agree to my therapeutic sessions being video recorded for the trainee clinical psychologist's supervision purposes and to ensure model fidelity (optional).	Yes No
13. I agree to my GP being informed of my participation (optional).	Yes No
14. I would like to receive a written summary of the overall findings from the study (optional).	Yes No
15. I understand that if I were to lose capacity to take part in the study, I would be withdrawn from the study. If this were to happen, <<service name>> would be informed so that they would be able to support me. All identifiable and personal data held by the research team would be destroyed. Any anonymised data	

(e.g. questionnaires) would be retained and used within the research, as well as information collected on the demographic form (attached).	
16. I agree to take part in the above study	

Name of Participant: _____ **Signature:** _____ **Date:** _____

Name of Researcher: _____ **Signature:** _____ **Date:** ____

One copy to be kept by the participant, one copy to be kept by the researcher and one copy to be retained in the medical records.

Appendix P

Session Structure – Overview

Intervention – Session Overview

General notes:

- The intervention aims for memories to be identified and practiced in session and within home tasks.
- Each session will start with measures and a review of the past session and tasks. It will be followed by the memory-focused work. The session will end with a review of the learning from the session, the participant's goals, and with setting a between session task.
- The memory focused work will broadly follow the 5 stages outlined in the broad-minded affective coping (BMAC) procedure (Tarrier et al., 2010; Johnson et al., 2013). However, whilst the BMAC focuses upon positive memories, this intervention will consider different autobiographical memories. It will also be scaffolded by different supporting information around its rationale.
- Session time limitations may mean that not all elements of the protocol may be delivered. In this case, we would recommend that elements such as reviewing goals are omitted (but then prioritised in the next session)
- Any departures from the protocol will be considered and noted at the end of each session

Structure:

Session 1 – Introduction and Familiarisation

Session 2 – Neutral Memories

Session 3 – Positive Memories

Session 4 – Memories of Moves Away from Suicidality

Session 5 – Practice of Preferred Memory

Session 6 – Continued Practice and Post-Intervention Planning

Session 1 - Introduction

Part 1:

- **Introduction to the intervention** - explain therapist's role and thank participant for taking part in the research study.
    - **Confidentiality**- discuss confidentiality and the limitations to this. Confirm the participant's named contact (primary clinician e.g. CPN) if mental health deteriorates or risk indicated.
    - **Consent to audio recordings** – confirm whether the participant is happy for the session to be recorded. Remind participant that this is for therapist's own learning and supervision. Written consent has previously been acquired.
- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, and session mood scale
- **Risk Assessment:** Complete the C-SSRS and check in on any additional changes in risk levels

Part 2:

- **Explaining the role and importance of memories:**
    - *PowerPoint slides* - go through the slides for session 1
    - *Memory Examples sheet* - Provide examples of neutral and positive memories

Part 3:

- **Review goals for intervention – SMART examples**
    - These should be specifically related to the participants experience of or relationship with their suicidality e.g.: To feel more in control when have suicidal thoughts or to reduce beliefs that suicidal experiences last forever, e.g. 8/10 in the moment to 2/10.

- **Review of the session:**
    - What is the take home message/key learning?
    - What are the implications for time when the participant feels very distressed/suicidal?

- **Between Session Tasks**
    - For the participant to begin to note down times when:
        - They feel less bad
        - They don't feel bad – 'neutral'
        - They feel good
    - Provide the slides from the session to look through

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Session 2 – Neutral memory

Part 1:

- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, and session mood scale
- **Risk Assessment:** Explore any changes in distress levels based and in suicidality during the week by 1) considering the measures and 2) having a general check-in
- **Review of last session:** identify any areas which need clarification or further exploration
- **Review of between session task:** how did the participant find this? Were they able to identify a memory? Could they recall details of this?

Part 2:

- **Memory task:** this will broadly follow the 5 stages outlined in the broad-minded affective coping (BMAC) procedure (Johnson et al., 2013), but with a focus on a neutral memory:
    - Preparation stage
    - Guided imagery of memory
    - Engaging the senses
    - Exploring emotions
    - Interrogating the memory

Part 3:

- **Review of the session:**
    - What is the take home message/key learning?
    - What are the implications for time when the participant feels very distressed/suicidal?

- **Review of goals**

- **Between Session Tasks**
    - For the participant to complete the neutral memories section of the identifying memories sheet

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Session 3 – Positive memory

Part 1:

- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, WAI-SR, and session mood scale
- **Risk Assessment:** Explore any changes in distress levels based and in suicidality during the week by 1) considering the measures and 2) having a general check-in
- **Review of last session:** identify any areas which need clarification or further exploration
- **Review of between session task:** how did the participant find this? Were they able to identify a memory? Could they recall details of this?

Part 2:

- **Memory task:** this will broadly follow the 5 stages outlined in the broad-minded affective coping (BMAC) procedure (Johnson et al., 2013), with a focus on a positive memory:
    - Preparation stage
    - Guided imagery of memory
    - Engaging the senses
    - Exploring emotions
    - Interrogating the memory

Part 3:

- **Review of the session:**
    - What is the take home message/key learning?
    - What are the implications for time when the participant feels very distressed/suicidal?

- **Review goals**

- **Between Session Tasks**
    - For the participant to complete the positive memories section of the identifying memories sheet.

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Session 4 – Memory of Moving Away from Suicide

Part 1:

- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, and session mood scale
- **Risk Assessment:** Explore any changes in distress levels based and in suicidality during the week by 1) considering the measures and 2) having a general check-in
- **Review of last session:** identify any areas which need clarification or further exploration
- **Review of between session task:** how did the participant find this? Were they able to identify a memory? Could they recall details of this?

Part 2:

- **Explaining the role and importance of memories about moving away from suicide:**
  - *PowerPoint slides* - go through the slides for session 1
  - *Memory Examples sheet* - Provide examples of memories about moving away from suicide
- **Memory task:** this will broadly follow the 5 stages outlined in the broad-minded affective coping (BMAC) procedure (Johnson et al., 2013), but with a focus on a memory of a time the participant has moved away from suicidal thinking:
  - Preparation stage
  - Guided imagery of memory
  - Engaging the senses
  - Exploring emotions
  - Interrogating the memory

Part 3:

- **Review of the session:**
  - What is the take home message/key learning?
  - What are the implications for time when the participant feels very distressed/suicidal?

- **Between Session Tasks**
  - For the participant to begin to note down times when:
    - They feel less bad
    - They don't feel bad – 'neutral'
    - They feel good
  - Provide the slides from the session to look through

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Session 5 – Practicing Memory of Choice

Part 1:

- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, and session mood scale
- **Risk Assessment:** Explore any changes in distress levels based and in suicidality during the week by 1) considering the measures and 2) having a general check-in
- **Review of last session:** identify any areas which need clarification or further exploration
- **Review of between session task:** how did the participant find this? Were they able to identify a memory? Could they recall details of this?

Part 2:

- Explore with the participant which of the three types of memory we have explored (positive, neutral, or moves away from suicidality) which they would like more practice of. This might be the memory they felt was most helpful or powerful, or it could be one where they feel less confident but they would like to acquire more skills. Be led by the participant's needs and preferences.
- Follow the same 5 step procedure as used in sessions 2-4

Part 3:

- **Review of the session:**
    - What is the take home message/key learning?
    - What are the implications for time when the participant feels very distressed/suicidal?

- **Review of goals**

- **Between Session Tasks**
    - For the participant to begin to note down times when:
        - They feel less bad
        - They don't feel bad – 'neutral'
        - They feel good

    - Provide the slides from the session to look through

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Session 6 – Practicing and Planning

Part 1:

- **Measures**: Complete the following – Entrapment scale (Short Form), INQ-15, CGI, and sessional mood scale
- **Risk Assessment:** Use the C-SSRS. Explore any changes in distress levels based and in suicidality during the week by 1) considering the measures and 2) having a general check-in
- **Review of last session:** identify any areas which need clarification or further exploration
- **Review of between session task:** how did the participant find this? Were they able to identify a memory? Could they recall details of this?

Part 2:

- **Memory task:** Continue practicing the participant's memory of choice, following the same 5 step procedure as used in sessions 2-5
- **Planning for the future:** Form a plan with the participant around how they continue to use these skills after the session has ended. Present this plan to the participant in their preferred medium.

Part 3:

- **Review of the session:**
    - What is the take home message/key learning?
    - What are the implications for time when the participant feels very distressed/suicidal?

- **Endings:** Thank the participant for their time. Summarise the work you have done, their key learning, and their next steps.

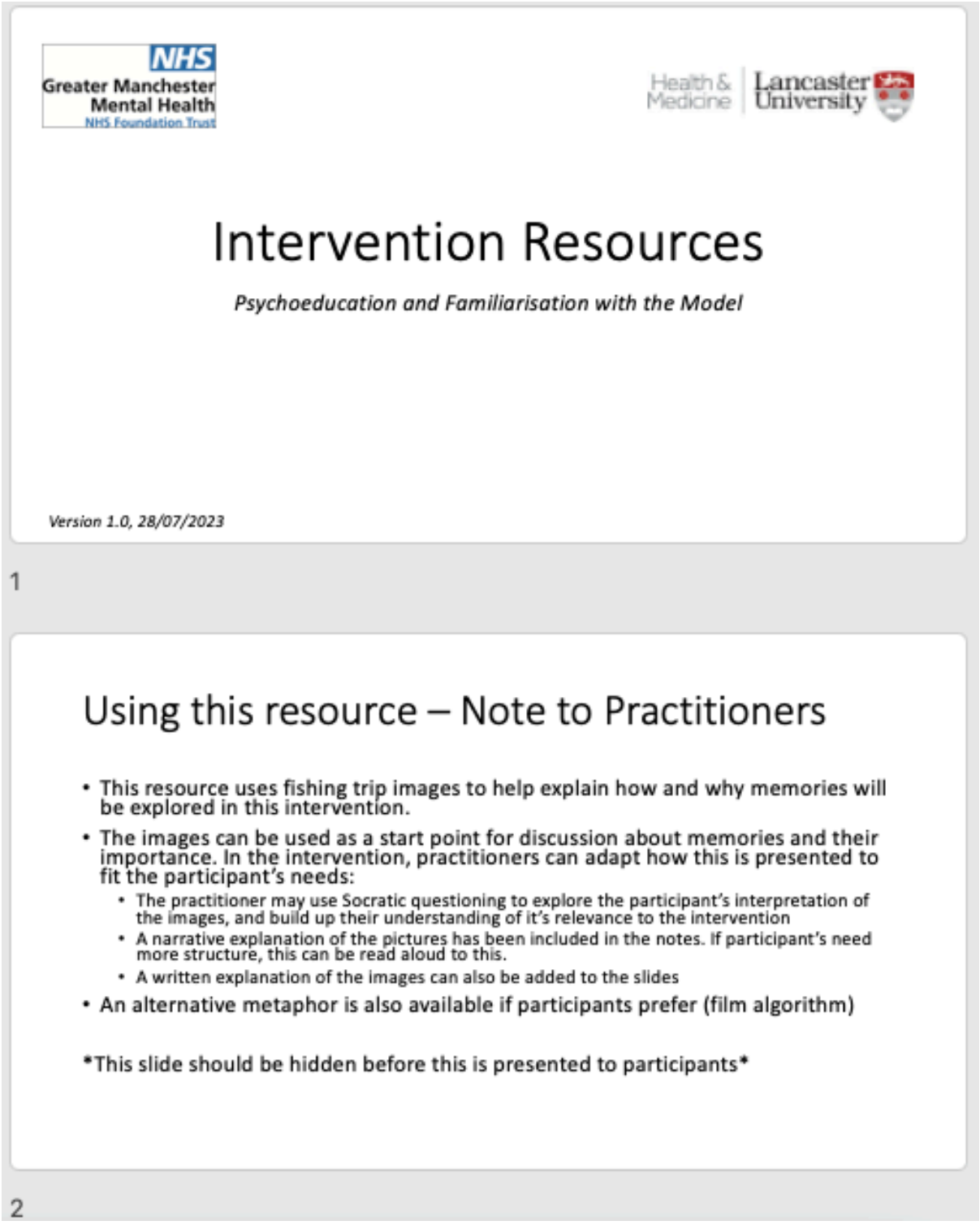
At the end of the session, the participant will complete the AEP and qualitative feedback questionnaire.

Post session: Researcher to note feasibility of protocol, and consider any areas of departure from the protocol

Appendix Q

Intervention Resource Presentations: Resources A and B

Intervention Resource A



Session 1 - Introduction

3

We all have many memories which are linked to different feelings. Some are positive, some are negative, and some are somewhere in the middle.

Like fish, we cannot always see these memories but they are always there beneath the surface.

Some are nearer the surface and some are further away. Some are bigger and some are smaller. This can impact on how easy they are to see and 'catch'.

4

When we feel a certain way – for example, happy or sad - certain memories which match this mood come closer to the surface.

It is a bit like throwing food into the water which only the red fish can eat. The red will come to the surface and they will get bigger and bigger as they eat more of this food. Meanwhile, the green and blue fish will get smaller and be pushed further away.

5

When we go 'fishing' for memories at these points, we are more likely to pick up the negative memories which are bigger and closer to the surface.

If we do this multiple times, we can begin to think that all the fish in the sea are red (or that all our memories are negative ones).

6

›

However, the other fish are still there! They are just a bit harder to get to in moments like this.

We might need to use other methods to get to the blue and green fish. We could use a fishing rod; we could try and find a different type of fish food; or we might need to cast our net a bit further.

Similarly, when memories are hard to get to, we can practice different strategies to try and reach them.

7

If we can learn to bring up other memories in these moments, our mood can begin to shift. This can make it easier to bring up even more neutral or positive memories, rather than only negative ones.

This is like giving the green fish the food they need, so that they come closer to the surface and become bigger and stronger.

8

The red fish will not go away, and sometimes we will still catch them – much like our negative memories will not disappear completely.

However, if we use these strategies, and feed all of our different 'fish', it will be easier to access the vast range of different positive, negative, and neutral memories we have experienced.

9

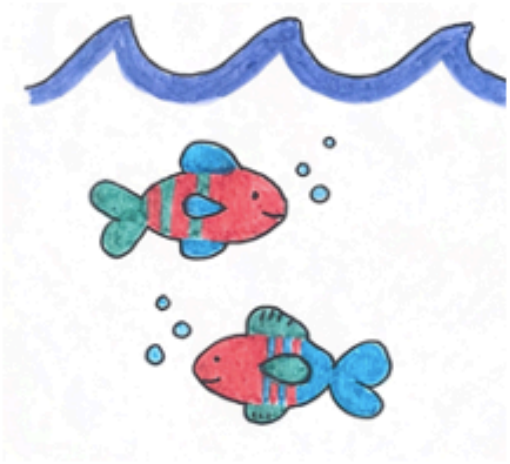
Session 4 – Moving Away from Suicide

10

In our first session, we spoke about ways of accessing different memories which are connected to different feelings.

We compared this to going fishing, and using different strategies to help us to bring up fish of all colours.

11



However, our memories are not always as simple as 'positive', 'negative', and 'neutral'. There are some memories which might be linked to negative feelings at the start, but have a shift to more neutral or positive feelings by the end. These are moments of change.

We can see these as multi-coloured fish – they initially seem to be one colour, but when we look closer they change from one to another.

12

These fish can be particularly good ones to catch. They show us that things can appear one thing, but that they can become another if we look closely enough.

We might assume a memory is purely negative, but if we stay with it we might be able to see positive or neutral feelings. This can be the case with certain memories connected to suicide.

13

On some of the occasions you have considered taking your own life, you have not gone through with this thought. Instead something has stopped you from doing this, and led you to take a different path.

Quite often when we think about these moments, we tend to focus on the difficult feelings that arise. We stop before we get to the point where these difficult feelings start to shift.

14

These moments are important for two reasons – they both show us that things can get better and how we can go about making them better.

We would like to spend some time focusing on these moments.

We will now go through some examples to give you an idea of what these moments might look like.

15

Intervention Resource B

NHS Greater Manchester Mental Health NHS Foundation Trust

Health & Medicine | Lancaster University

Intervention Resources 2

Psychoeducation and Familiarisation with the Model

Version 1.0, 28/07/2023

1

Using this resource – Note to Practitioners

- This resource uses film algorithm images to help explain how and why memories will be explored in this intervention.
- The images can be used as a start point for discussion about memories and their importance. In the intervention, practitioners can adapt how this is presented to fit the participant's needs:
  - The practitioner may use Socratic questioning to explore the participant's interpretation of the images, and build up their understanding of it's relevance to the intervention
  - A narrative explanation of the pictures has been included in the notes. If participant's need more structure, this can be read aloud to this.
  - A written explanation of the images can also be added to the slides
- An alternative metaphor is also available if participants prefer (fishing trip)

This slide should be hidden before this is presented to participants

2

Session 1

3

We all have many memories which are linked to different feelings. Some are positive, some are negative, and some are somewhere in the middle.

It can be helpful to imagine our memories as films. We have watched some films more than others and we are always making new films. However, there is a whole catalogue of films available for us to watch.

4

When we feel a certain way – for example, happy or sad - certain memories which match this mood become easier to find.

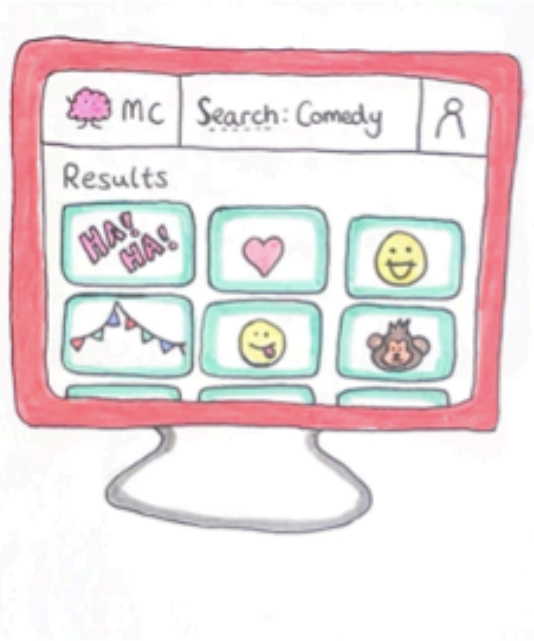
It is a bit like searching for a film, but only looking under horror or tragedy. You are unlikely to find many positive and uplifting films in these sections.

5

If we continue to exclusively watch films which are connected to negative feelings, our suggested films fill up with tragedies and horrors. It can be harder to find more uplifting films.

Similarly, if we only 'watch' memories which are connected to negative feelings, and stop watching the memories about happier times, we can begin to think all our memories are difficult ones.

6



However, the other films are still there! They are just a bit harder to find.

Rather than just scrolling through our recommended films, we might need to use other methods to get to these other types of film. For example, we could actively search for a comedy or ask someone for recommendations.

Similarly, when memories are hard to get to, we can practice different strategies to try and reach them.

7

If we can learn to bring up other memories in these moments, our mood can begin to shift. This can make it easier to bring up even more neutral or positive memories, rather than only negative ones.

This is like the way that, if we watch a few uplifting films, our recommendations also change so that we can see other similar films.

8

The horror films will not go away, and sometimes we will still find ourselves watching them – much like our negative memories will not disappear completely.

However, if we use these strategies, it will be easier to access the vast range of different positive, negative, and neutral memories we have experienced. This can help us to see the world and our life in a more balanced way.

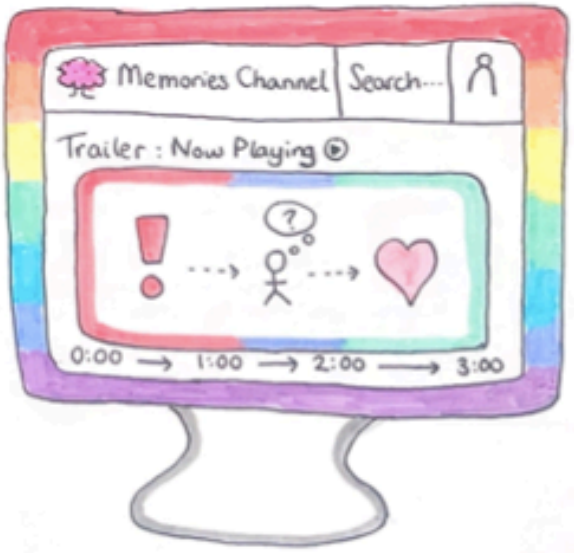
9

Session 4

10

In a previous session, we spoke about ways of accessing different memories which are connected to different feelings. We compared this to watching different films, and using strategies to help us to access all types of film, rather than only tragedy and horror films.

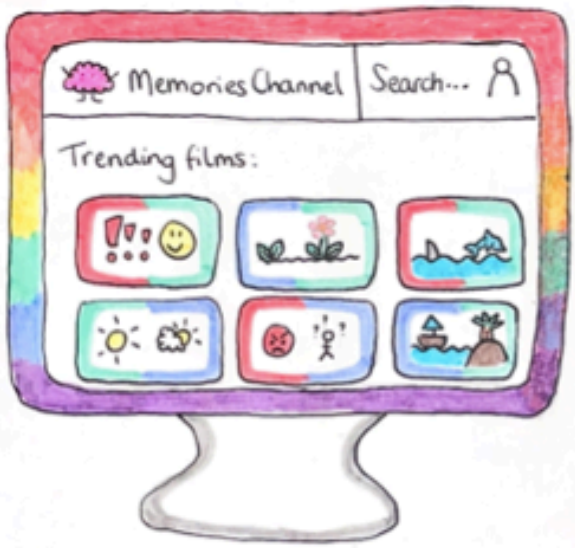
11



However, our memories are not always as simple as 'positive', 'negative', and 'neutral'. There are some memories which might be linked to negative feelings at the start, but have a shift to more neutral or positive feelings by the end. These are moments of change.

Similarly, many films do not just fit into one category. Some films might make us want to cry at the start, but have us laughing by the end.

12



These films can be particularly good ones to watch. They show us that things can appear one thing, but that they can become another if we watch for long enough.

We might assume a memory is purely negative, but if we stay with it we might be able to see positive or neutral feelings. This can be the case with certain memories connected to suicide.

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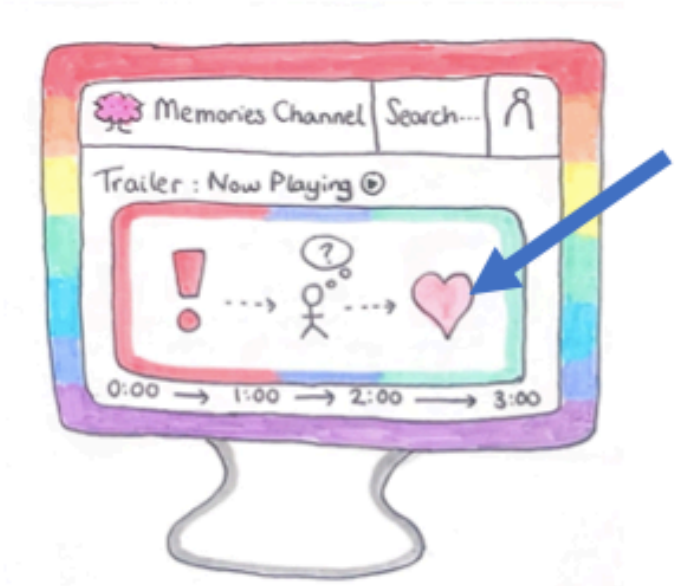
Quite often when we think about these moments, we tend to focus on the difficult feelings that arise. We stop before we get to the point where these difficult feelings start to shift.

14



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15

Appendix R

Intervention Resources: Identifying Memories Sheet

IDENTIFYING MEMORIES

Neutral memories:

Think of a recent event in your life that did not have strong emotions connected to it. Write down a short description below.

Where were you? Write down as many details as you can about where you were.

Who were you with? Write down all the people in the memory.

Version 1.0, 28/07/2023

What happened? Write down as much detail as possible.

How did you feel? Write down your emotions/feelings – try to remember them in as much detail as possible.

What went through your mind?

Version 1.0, 28/07/2023

[document repeated with 'neutral' memories swapped for 'positive' and 'exit' memories]

Section Three: Critical Appraisal

Word count (excluding references): 3981

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Main Findings

This research has looked at suicidality within a mental health context, to better understand people's experiences of suicidal thinking and to propose a psychological intervention to support suicidal individuals. Both elements of the research have considered psychological 'exits' from suicidal thinking with the hope that this will have relevance when supporting people clinically.

The meta-ethnography looked at how people with mental health difficulties experience suicidal thinking in the absence of an attempt. A river image was used to symbolise the key elements that people commonly go through: 1) experiencing something unbearable, 2) disconnecting from this, 3) experiencing the suicidal 'current', 4) in-the-moment exits from these thoughts, and 5) longer-term attitudes.

In the empirical research, we found that an autobiographical memory-based intervention was acceptable and feasible for people with suicidal thoughts in secondary mental health care. Despite recruitment challenges, participants engaged well with the intervention and its key concepts. Clinical improvements were observed in the outcome measures for one participant.

Within this critical appraisal, I share my reflections upon 1) the process of conducting this research and its challenges, 2) the strengths and limitations of the research, and 3) the implications of our findings upon future research.

Reflections on the Research Process

Recruitment

During my empirical research, there were unanticipated delays in the completion of the study (table 1). This series of delays were mainly outside of my control; there were elements which I could attempt to problem solve and mitigate, but other delays were

related to wider systemic factors. The accumulated delays impacted on the amount of time I could focus upon recruitment, something I believe contributed to the study not meeting its recruitment target. This led me to reflect upon systemic pressures and the impact of this upon both my research and on suicide research more widely.

A theme across the various delays I have faced has been a lack of resources or capacity within the systems and services I have been working with. One particular area where this was apparent was during recruitment. I had anticipated that recruitment would be a fast process, as I was aided by two supervisors who were embedded in these Community Mental Health Teams (CMHTs). Aware of their waiting list, I expected that a research trial offering a novel intervention would be appealing for clinicians.

I worked collaboratively with a staff member within a CMHT to consult with them about the process and resources needed but was surprised that recruitment was slow. Studies have been conducted to consider successful recruitment through clinicians (Patterson et al., 2014). One element – 'organisational preconditions' – seems to have been our greatest barrier. This involves factors such as resources, alongside a research friendly, progressive culture. Informal feedback from staff indicates these were not present; staff reported that they did not have the capacity to identify potential participants and to provide these individuals with the study information.

Clinicians are also more likely to approach potential participants if they think it is 1) in the client's good interests, 2) if they have a secure therapeutic alliance, and 3) if they believe their patient is 'well enough' (Patterson et al., 2014). Reflecting on this research, I have wondered whether the fact the study was recruiting a risky population may have made clinicians more hesitant to suggest the study to their clients. One senior clinician wondered whether a greater presence within the CMHTs could have helped, both by keeping the study

in the clinicians' minds, and enabling them to fully understand what the study involves. Unfortunately, this was not a possibility due to my own competing demands; a larger trial with more human resources may have had fewer challenges with recruitment for this reason.

Advertising the trial directly to service users may have increased our participant numbers. However, within CMHTs, referrals for psychological interventions are guided by clinical judgement, not through self-referral. By recruiting through clinicians, discussions around participant suitability were embedded into the recruitment process. This closely paralleled service practice, better enabling assessment of whether the intervention was acceptable to both clients and clinicians. These recruitment challenges provide a useful compass for anticipating potential barriers if this intervention was introduced into clinical practice. For the intervention to be successfully implemented, clinicians would need to see it as being in the client's best interests whilst complementing their own clinical practice.

Systemic Barriers and their Impact

Other delays were also linked to systemic issues and resource capacity. For example, my Research and Ethics Committee (REC) meeting was cancelled with short notice and rearranged to 6 weeks later. Low staffing levels led to delays in endorsement by the NHS trust. Reflecting upon the multiple barriers and their cumulative impact led me to consider the longer-term effects on clinical psychologists' enthusiasm and willingness to be involved in research. Indeed, despite it being a key component of clinical training, research activity in practice is notably low (Smith & Thew, 2017). Qualitative studies considering the challenges of conducting research within clinical psychology could facilitate a positive shift by identifying ways to overcome barriers, thus encouraging clinicians to embrace research alongside their practice.

Systemic attitudes towards risk were a further challenge; my overall impression was of a culture which is risk-averse. In particular, anxieties around conducting research into suicide pervades and has been seen in multiple cultures and countries (Hom, Podlogar, et al., 2017). For example, the university suspended support to clinical trials due to their fears around the perceived risk attached to such research. Consequently, convincing them to support this piece of research proved difficult. Similarly, some of the teams which I approached (e.g. specialist perinatal services) had their own concerns about potential suicide risks and requested changes to my protocol. There is a considerable body of research which moves away from being risk-averse towards the concept of harm minimisation (James et al., 2017; Sullivan, 2019); in response to risk-related fears, counterarguments have also been made concerning the 'ethics of doing nothing' (Omerov et al., 2014). Understandably clinicians and services continue to hold anxieties, and as a researcher I also noticed my own discomfort at times when holding risk. There is an external conflict between the wish to contribute to the research base alongside holding a process which has the potential to increase risk levels to the individuals involved (Blades et al., 2018).

The Emotional Impact of Suicide Research

Shortly after starting my research in this area, I read prominent suicide researcher Rory O'Connor's book 'When it is Darkest' (O'Connor, 2021). The book's introduction positions the research in terms of O'Connor's personal context – he writes: "I hadn't anticipated the emotional toll of doing a PhD that involved interviewing people who had attempted suicide […] I don't know why, it was obvious. Of course it would be draining" (O'Connor, 2021, p. 2).

These sentences resonated with me. Going into the research I felt motivated and driven to make a difference, and approached the topic as I might have done any other

academic pursuit. This was my first time researching suicidal ideation, and I thought I would be able to separate my emotional responses from my academic interest in the topic. However, the emotional impact of the research has been one of its biggest challenges, and reflecting upon these has been an invaluable part of the overall process.

My expectation of being able to separate my personal responses and my academic interest perhaps shows my psychological naivety upon beginning this project. During training, I have frequently reflected on my emotional responses within clinical work, which has been useful for my learning. This has led me to wonder how I could channel this within my research studies in a meaningful and helpful way.

Considering these feelings have both epistemic and ethical importance in suicide research (Boden et al., 2016). They have helped me to understand my participants' human responses, enabling me to attune to their emotional needs whilst providing an empathic response. They have also been a compass for making care-based judgements whilst delivering my intervention, for example when deviating from the protocol. Research has also suggested that emotional responses can be predictive of suicidality, reinforcing the importance of noticing rather than discounting these inner feelings (Ying et al., 2021).

Attuning to my own emotional responses has been essential for maintaining my own wellbeing; I was aware this was important so I could both conduct the research intervention and engage with the meta-ethnography. Aware of the potential for burnout, vicarious trauma, and compassion fatigue, I strove to avoid this (Newell & MacNeil, 2010; Rauvola et al., 2019). In particular, I was concerned that both hearing and reading about suicidal thinking and the events leading up to this could be vicariously traumatic. As a recent editorial on suicide research noted in it's title - 'it's not easy' (Chen et al., 2019).

Chen et al. (2019) noted how few studies have considered the impact that hearing or reading about details of suicidal ideation and behaviour has on researchers' wellbeing. An intervention for researchers was proposed involving a staff wellness group. Whilst this group had not been formally evaluated, attendees gave positive feedback on the process. My individual supervision often needed a restorative focus. However, if there had been a separate space dedicated to my wellbeing, this may have freed up more time to discuss the analysis itself. It would also have been helpful to have this peer support throughout the process.

In the absence of this support, I drew upon my knowledge of therapeutic models to draw out a CAT-informed formulation to help me understand my internal process (Appendix A). I identified that whilst at times I felt inspired and passionate, connecting to the values which led me to choose this topic, at other times I felt drained and overwhelmed. Mapping this process helped me to better understand and notice some of the cycles I was falling into. Something which struck me as interesting was that there were overlaps between my own experiences and the cycle depicted in my meta-ethnography; especially in relation to the movement between disconnection and reconnection. The feelings arising which are linked to connection ("feeling with") and disconnection ("feeling for") have been noted within other suicide researchers (Boden et al., 2016). I believe it would be interesting to explore suicide researchers' personal and emotional experiences, to better understand how this translates into the research they conduct.

Adherence to the Protocol

Prior to the intervention, I anticipated that the baseline sessions would be short and structured, with a quick check in around mood and risk. However, the reality was that sessions were longer than anticipated, lasting the full 30 minutes. For two participants I was

the first person they had spoken to in several days. Others reflected that they felt dismissed by other healthcare professionals and valued having a listening ear.

My meta-ethnography suggested feeling isolated and disconnected was a key element of suicidal thinking. Moreover, 'reaching out for support' was one of the exits in the synthesis. On reflection, I wonder whether some parallel process was occurring in the baseline sessions; my participants may have been attempting to reconnect, using my support to meet their needs in this moment. Whilst these sessions did not contain therapeutic content, my clinical experience and my knowledge of suicide meant I was likely to draw upon these pre-existing skills in listening and providing a caring, empathic response.

In the intervention sessions, I was largely able to adhere to the protocol, suggesting it is feasible to deliver. However, there were adaptations which were made with each participant to make it more person-centred. For example, one participant had a pre-existing physical health condition; she was often fatigued, needing to reschedule appointments. Whilst sessions were an hour, I shortened these to 45 minutes and on one occasion moved a questionnaire to the next session. The protocol also specified that sessions should be weekly or twice weekly, completed within 13 weeks; whilst we kept within the time window, missed sessions meant these were fortnightly. This suggests more flexibility is needed within the protocol to meet the needs of all participants.

This need for flexibility was repeated in a second participant who was awaiting an autism assessment. Again, I made slight changes to make the intervention person-centred. For example, more attention was paid to his sensory needs, more verbal support was given when introducing the intervention resources, and we drew upon the client's strong visual memory in a strength-based way.

It also proved necessary to respond in the moment within sessions and thereby to deviate from the protocol. A traumatic memory was triggered for one participant during the memory-based procedure; the participant had a dissociative experience and became distressed. Whilst I followed the distress protocol, I also drew upon my existing clinical knowledge to support the participant, using grounding techniques and psychoeducation to aid his understanding around what may have happened. Another participant struggled to access positive memories, and we spoke about the potential function of this in terms of his previous trauma. When developing the intervention, we considered whether it could be delivered by psychological wellbeing practitioners and assistant psychologists. However, delivering this intervention has required me to use a wide range of clinical skills in a flexible, needs-based way. This has led me to wonder whether, given the level of suicide risk and clinical complexity within this client group, a more experienced clinician would be needed. In connection to this, I have wondered whether linking a formulation component to the intervention could strengthen it by considering the needs of each individual in a proactive, person-centred way.

Strengths and Limitations of the Research

Strengths

A strength which was exhibited in both papers was the creativity in expressing ideas and in making potentially difficult concepts more accessible; thus, making them more clinically useful. In the article 'What makes a psychologist?', creativity is named by several contributors – not only in relation to clinical work, but also to research (Sutton & Pownall, 2019). There is also a movement towards more open science in psychology research, a part of which involves making complex ideas appear simple (Hesse, 2018). This intervention succeeds in marrying scientific concepts with artistic and accessible interpretations.

The meta-ethnography offers an innovative model which considers the cycle of disconnection and reconnection in suicidal thinking and encapsulates the dynamic nature of the process. Previous models have largely been one directional, considering the factors leading towards rather than away from suicidal behaviour (Joiner, 2007; Klonsky & May, 2015). The Integrated Motivational-Volitional (IMV) model acknowledges a sense of backward flow, with a bi-directional arrow between suicidal ideation and behaviour (O'Connor & Kirtley, 2018). However, the model in this study goes beyond this to consider how people can exit suicidal thinking to reconnect with life. Moreover, it aims to help people understand how they may re-enter the cycle, or alternatively how they may move away from suicidality in the longer-term. Thus, a more hopeful and fluid conceptualisation is offered.

The intervention protocol has strengths in being empathic – both to suicidal experiences and to individuals. Other autobiographical memory-based approaches which have had positive outcomes in this population have been more generic (Högberg & Hällström, 2018; Knagg et al., 2022). However, this intervention specifically considered a memory unique to suicidality – their 'exits' from suicidal thoughts. Participants expressed some anxieties about revisiting this memory and, as a clinician, I noticed discomfort in asking participants to discuss this difficult memory. However, the intervention had strengths in shifting conversations about these experiences from risk to resilience. Participants' fears were not realised; they noticed positively valenced feelings such as relief and connectedness during the intervention procedure. Thus, the intervention enabled both me and the participants to step out of our zone of proximal development, with promising outcomes (Vygotsky et al., 1978).

The intervention is brief and focused, and this structured, evidence-based support could be critical in a population holding high levels of risk and distress. Stretched services

often have long waiting lists; the brevity of this intervention means it could be used as interim support whilst not placing unmanageable demands on the service. There is also the potential for it to be a stand-alone intervention for individuals where suicidality is their main presenting concern; thereby creating an intervention that could meet the needs of services and, most importantly, service users.

Considering the barriers and anxieties which exist when carrying out research within this risky population and as a part of a clinical trial, a further strength has been the opportunity to add to the literature around this area. While challenges arose at various stages of the process, this study considers a number of ways in which these may be overcome in the future; thus, guiding the path of research to come.

Limitations

The small recruitment number was the main limitation of the project. Whilst the intervention appeared acceptable and feasible for the three participants who completed the study, it is difficult to know whether this is scalable. The participants were all white British, heterosexual, and cisgender; whilst the homogeneity of the sample is perhaps unsurprising given the small numbers, it nevertheless raises the question of who the intervention is feasible and acceptable for. However, the sample did include people with neurodiversity and physical health difficulties; men and women were both represented, and the age ranged from 36-52 years.

Connected to this, there were limitations to having a small research team to conduct a piece of interventional research. I developed the intervention protocol and was the only researcher involved in delivering this, thereby being particularly familiar with its aims and content. This therefore raises the question of whether this result would be replicated by

other clinicians. If this intervention was to be implemented in clinical practice it would need a robust training package to support it.

Whilst conducting the research, I also reflected upon the limitations of taking a psychological approach to suicide prevention. The participants named several social difficulties they were experiencing – in particular job security, financial worries, and housing issues. The extent of these concerns led me reflect upon whether psychological interventions can ever be enough, or whether social prevention needs to be the initial focus. Whilst this psychological intervention has the potential to help people develop coping strategies and to feel like they have more control over their internal world, the context of the social difficulties needs to be included in this process. Therefore, this highlights a need for an integrated approach where wider systemic issues are valued. Reflecting on potential adaptations, inspiration may be drawn from the IMV model (O'Connor & Kirtley, 2018). This provides a pre-motivational phase, where environmental factors, vulnerability, and life events are taken into consideration.

There have only been a small number of brief psychological interventions for suicidality previously conducted; a review published in the past decade found only 4 studies (McCabe et al., 2018). All were for patients following attendance at emergency departments; therefore, it could be assumed these people were in 'crisis', rather than experiencing chronic suicidal ideation. A recent meta-analysis (pre-publication) built upon this to identify 8 brief therapeutic interventions; however, the interventions had limited impact upon reducing suicidal thinking (Homan et al., 2023). My study has strengths in adding to this underdeveloped evidence base. However, this dearth of literature meant that whilst our protocol had strong theoretical underpinnings, there was little previous learning from interventions to build upon.

Implications of the Research

Use in Clinical Contexts

My empirical research and systematic literature review have been conducted with thought around how they can be translated or used within clinical practice. As reflected above, consideration was given as to who could be trained to deliver the intervention, specifically whether assistant psychologists or trainee psychological wellbeing practitioners could conduct this. The process highlighted that whilst this intervention is acceptable and feasible to deliver in a clinical context, practitioners with further clinical experience and skill are needed. However, assistant psychologists may still be able to provide support by using the psychoeducation resources developed for the intervention.

Psychoeducation has been used to positive effect within a secondary mental health population, and may be delivered as an intervention in its own right (Alhadidi et al., 2020; Srivastava & Panday, 2016). The resources used within our empirical research were acceptable to all three participants, who reported that they understood the key concepts of the trial. The resources provided useful metaphors for understanding why it can be hard to access positive memories, with negative memories dominating. Therefore, these tools have the potential to be used in a clinical context to support people with all-or-nothing thinking or overgeneral negative memory, enabling them to better understand their experiences.

As reflected previously, the comparative brevity of this intervention was tailored for use in services – both as a potential interim intervention or for stand-alone use. It benefits from including a psychoeducational component followed by clear, structured sessions, with room for flexibility, thus offering a containing approach. In a population who experience high levels of defeat and entrapment (P. J. Taylor, Wood, et al., 2010), the intervention directly

addresses this by building in opportunities for people to have some level of control over the focus of the sessions and to actively develop their own problem solving skills.

In the meta-ethnography, the final synthesis uses an accessible image to help depict the processes involved in suicidal thinking in the absence of an attempt. The synthesis provides a richer understanding of how people with mental health difficulties may experience both disconnection and reconnection from suicidal thoughts. This pictorial image may guide clinicians to formulate questions about experiences of suicidality, informing a joint and collaborative understanding of the client's suicidal thinking. Importantly, the synthesis includes information about exits from suicidal thoughts. This could be a helpful starting point for engaging clients in safety planning and thinking about how they might disrupt the cycle. It may also help staff to understand their clients' complex relationships with suicidal thinking, challenging myths and stigma around suicidal thinking (O'Connor, 2021).

Further Research

One of the key findings from the systemic literature review was the importance of a shift in perspective or an 'exit' after experiencing thoughts of suicide when no suicide attempt is made. An interesting area for further exploration would be around people's internal emotional and cognitive experiences of these exits. Whilst the literature did include this, the focus was often on what people did rather than how they internalised it. A conceptualisation from a compassion-focussed therapy (CFT) approach using the three systems model could support this understanding (Paul Gilbert, 2010). The in-the-moment exits noted were 1) fear-based shifts, mapping onto 'threat'; 2) reconnecting and reaching out for support, which both have links with 'soothe', and 3) regaining agency, which could be

understood within ‘drive’. With exploration and further research, there may be the potential for CFT principles to be integrated into psychological understanding of suicidality.

The empirical paper highlighted the potential for ‘exit’ memories to be used when supporting suicidal individuals. Further research is required to build upon this, considering whether an intervention focusing upon these memories can lead to clinical improvements. A larger trial is therefore needed, in which more formal and rigorous analysis can be conducted. The paper also highlighted challenges in recruitment for suicide trials; another area for further research is to better understand both the underlying barriers and how they can be addressed.

In both papers, the need for responses to be person-centred and individualised was key. The meta-ethnography highlighted that whilst there was an overarching universal process, people’s internal experiences of entering and exiting suicidal thoughts differed; thus, clinical responses needed to be attuned to these differences. Similarly, delivering the autobiographical memory-based intervention involved significant flexibility in order to deliver an intervention which sat within each person’s zone of proximal development (Vygotsky et al., 1978), maximising the impact of the intervention. Whilst the protocol was largely followed, no two interventions were the same. Future research would benefit from considering how manualised interventions can best incorporate person-centred values and flexibility.

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Tables and Figures

Table 1

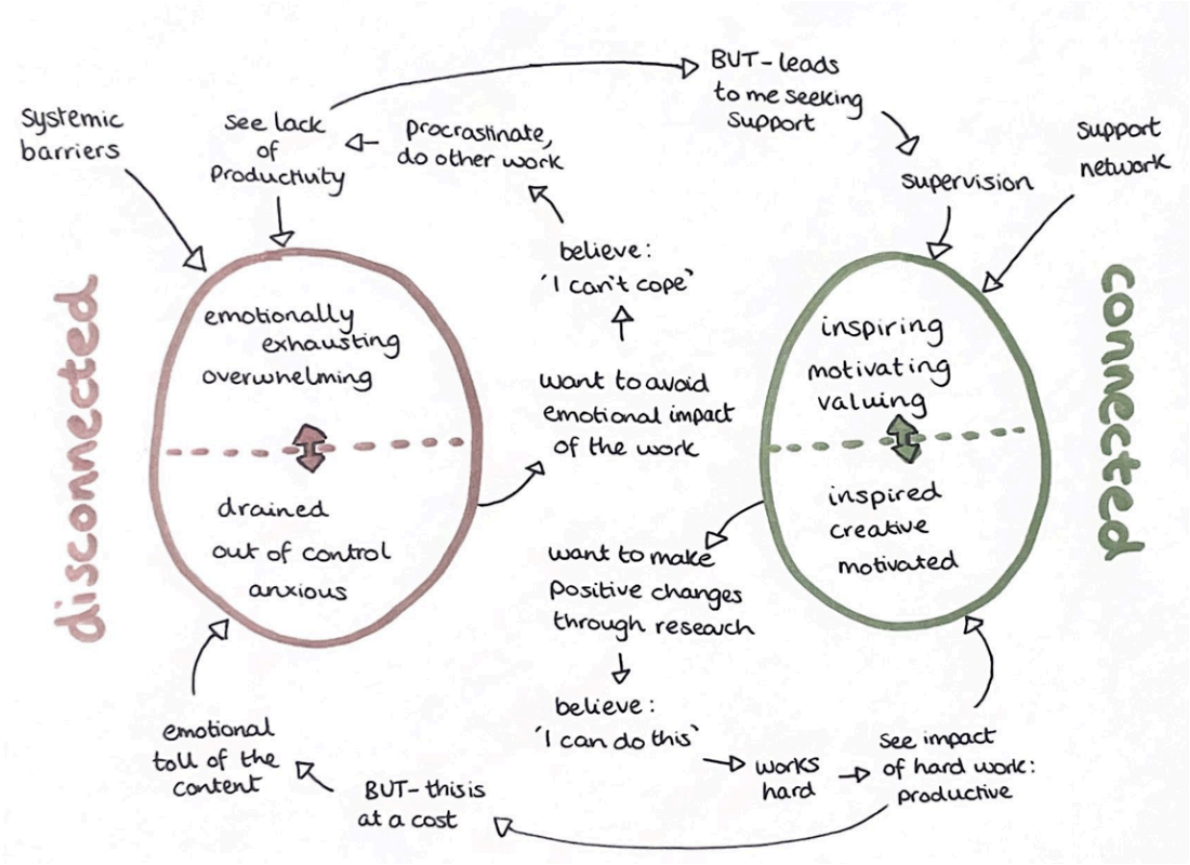
Summary of the Main Delays Faced During this Research Study

Stage of Research	Delay
Thesis project proposal form being accepted by Lancaster DClinPsy staff	Delays in both initial and resubmitted thesis proposal form being returned (administrative error)
Change in field supervisor	My original field supervisor unfortunately was unable to continue supporting the project; this led to significant changes to the intervention planned
University sponsorship acceptance	University sponsorship stopped sponsoring clinical trials; a number of meetings were needed to enable my project to go ahead
Gaining ethical approval	After submitting to NHS ethics, my selected REC meeting was cancelled. This was rearranged over a month later than planned
NHS site approval	Low staffing in the research and innovation department led to a 3 month delay
Recruitment challenges	We had challenges recruiting to the study, which led to recruitment taking longer than anticipated

Infrastructure issues	Flooding in one CMHT base led to delays as there were limited rooms at which to conduct the study
Adding additional community mental health teams	To manage recruitment challenges, we asked to recruit from additional community mental health teams, needing a minor amendment. Several factors increased delays: 1) risk management adapted to individual teams, 2) needing to wait for a slot to speak in team meetings

Appendix A

CAT-Based Formulation of my Experiences of Suicide Research



Section Four: Ethics Proposal

Ethics Proposal for the Empirical Study:

Autobiographical Memory-Based Intervention for Suicidality: A Case Series.

Word count (excluding references, tables and appendices): 5938

Alexandra C. Powell

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

September 2024

IRAS Form | Reference: 23/EE/0185 | IRAS Version 6.3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Autobiographical Memory-Based Intervention for Suicidality

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Ionising Radiation for combined review of clinical trial of an investigational medicinal product

( ) Ionising Radiation and Devices form for combined review of combined trial of an investigational medicinal product and an investigational medical device

( ) Clinical investigation or other study of a medical device

(●) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

( ) Basic science study involving procedures with human participants

( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

( ) Study involving qualitative methods only

( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

( ) Study limited to working with data (specific project only)

( ) Research tissue bank

( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Will the study involve the use of any medical device without a UKCA/CE UKNI/CE Mark, or a UKCA/CE UKNI/CE marked device which has been modified or will be used outside its intended purposes?

( ) Yes (●) No

2b. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ( ) Yes (●) No

b) Will you be taking new human tissue samples (or other human biological samples)? ( ) Yes (●) No

c) Will you be using existing human tissue samples (or other human biological samples)? ○ Yes ◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- ◉ England
- ○ Scotland
- ○ Wales
- ○ Northern Ireland
- ○ This study does not involve the NHS

4. Which applications do you require?

- ☑ IRAS Form
- ☐ Confidentiality Advisory Group (CAG)
- ☐ HM Prison and Probation Service (HMPPS)

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
This research project is an element for my doctoral thesis for my Doctorate of Clinical Psychologist. As a trainee clinical psychologist (student), I will be supervised by a member of the DClinPsy research team at Lancaster University. I will act as the lead researcher for this project, with my academic supervisor as chief investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Other clinical trial or investigation

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Autobiographical Memory-Based Intervention for Suicidality

Please complete these details after you have booked the REC application for review.

REC Name:
East of England - Cambridge South

REC Reference Number:
23/EE/0185

Submission date:
21/07/2023

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Autobiographical Memory-Based Intervention for Suicidality: A Case Series

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Alexandra	Powell
Address	Doctorate in Clinical Psychology, Health Innovation One		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YW		
E-mail	a.powell6@lancaster.ac.uk		
Telephone	07972446384		
Fax			

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	James	Kelly
Address	Doctorate in Clinical Psychology, Health Innovation One		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YW		
E-mail	j.a.kelly@lancaster.ac.uk		
Telephone	07972446384		
Fax			

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	Aimee	Cairns
Address	The Edenfield Centre		
	Bury New Road		
	Prestwich, Greater Manchester		
Post Code	M25 3BL		
E-mail	aimee.cairns@gmmh.nhs.uk		
Telephone	01613588500		
Fax			

Academic supervisor 3

	Title	Forename/Initials	Surname
	Dr	Nasur	Iqbal
Address	North Manchester General Hospital		
	Delaunays Road		
	Crumpsall, Manchester		
Post Code	M8 5RB		
E-mail	nasur.iqbal@gmmh.nhs.uk		
Telephone	01612710695		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Alexandra Powell	☑ Dr James Kelly ☐ Dr Aimee Cairns ☐ Dr Nasur Iqbal

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Dr	James	Kelly
Post	Clinical Psychologist		
Qualifications	Doctorate in Clinical Psychology (University of Manchester)		
ORCID ID			
Employer	Lancaster University		
Work Address	Doctorate in Clinical Psychology, Health Innovation One Lancaster University Lancaster		
Post Code	LA1 4YW		
Work E-mail	j.a.kelly@lancaster.ac.uk		
* Personal E-mail	j.a.kelly@lancaster.ac.uk		
Work Telephone	0152459353		
* Personal Telephone/Mobile	0152459353		
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Ms	Rebecca	Gordon
Address	Research and Enterprises Service Office B062 Bowland Main, Lancaster University		
Post Code	LA1 4YW		
E-mail	b.gordon@lancaster.ac.uk		
Telephone	0152465201		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	NA

Sponsor's/protocol number:	NA
Protocol Version:	1.0
Protocol Date:	01/05/2023
Funder's reference number (enter the reference number or state not applicable):	NA
Project website:	NA

Registry reference number(s):
The UK Policy Framework for Health and Social Care Research sets out the principle of making information about research publicly available. Furthermore: Article 19 of the World Medical Association Declaration of Helsinki adopted in 2008 states that "every clinical trial must be registered on a publicly accessible database before recruitment of the first subject"; and the International Committee of Medical Journal Editors (ICMJE) will consider a clinical trial for publication only if it has been registered in an appropriate registry. Please see guidance for more information.

International Standard Randomised Controlled Trial Number (ISRCTN):

ClinicalTrials.gov Identifier (NCT number):

Additional reference number(s):

Ref.Number Description	Reference Number

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

The project involves a short therapy intervention for people who are experiencing thoughts of suicide. The intervention will focus upon different memories from the person's life. These memories will vary in the emotions they evoke – some memories will be associated with neutral emotions, whereas others will bring up positive emotions. The intervention will have a particular focus upon people's memories of times when they moved away from thinking about suicide, with the aim of reinforcing memories of what helped them to reconnect with life. The intervention will also introduce relaxation techniques, in addition to involving a safety planning component. The project aims to consider whether this intervention is acceptable and feasible for this population.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

As the research involves working with a population experiencing suicidal ideation, there is a potential for suicide risk to increase during the study. Previous research has indicated that talking about suicide is more likely to reduce suicidal

ideation and improve people's mental health (Dazzi et al., 2017). The study will also implement the following processes to identify adverse events/outcomes associated with the intervention and to minimise risk:

- Require participants to have had a recent risk assessment (with 3 months) completed with the CMHT prior to the study beginning
- The study will include a baseline period where participants are assessed. This will include a written risk assessment.
- At the start of the study, participants will be provided with helplines/crisis numbers provided as a card (also provided on the participant information sheet)
- A risk protocol will be followed for managing both suicide risk and any distress across all participants (included in attached documents). This protocol includes details of actions to take when the assessment suggests that risk is imminent and preventative actions needs to be taken. The trainee will have access to trained members of staff on site and via telephone should these instances arise. Supervision will be provided for each case at a level appropriate for a Trainee Clinical Psychologist, from Dr Iqbal (who sits within the direct care team) or from Dr Kelly (employed by GMMH NHS Foundation Trust, and operating as a clinical supervisor). Supervision will be used to discuss any risk concerns related to participants. It will also be used to discuss distressing or upsetting content which might affect the trainee clinical psychologist whilst doing this research.
- One of my supervisors (Dr Kelly or Dr Iqbal) will be available to contact in order to check any risk information discussed in session and take appropriate action.
- Dr Kelly will also provide supervisory support in his role as academic supervisor. All matters relating to adverse events will be raised with him and with my field supervisors (Dr Iqbal and Dr Cairns), and appropriate action will be taken in accordance with the risk protocol
- Risk information will be recorded on the GMMH patient information system used by the CMHT in which the participant sits, to enable their clinical care team to have access to this. A member of the clinical care team will also be contacted to notify them about any changes in risk.

Data management -
- As sponsor, Lancaster University will act as the data controller for any personal information collected as part of this study. Data will be managed in accordance with their instructions. Participants will be made aware of this and provided with the webpage link explaining this www.lancaster.ac.uk/research/data-protection.
- Information provided by participants will be kept confidential and stored safely on Lancaster University approved secure cloud storage (OneDrive). Personal information will be kept securely and destroyed at the end of the project. Only the researchers conducting this study will be able to access the data.
- The files on the computer will be encrypted, so no-one other than the researcher will be able to access them. The computer itself is also password protected.
- At the end of the study, all non-identifiable electronic information, such as questionnaire responses, will be stored anonymously and securely by the university for 10 years.
- All personal data will be confidential and stored separately from questionnaire responses. This will be destroyed at the end of the study.
- Recordings of sessions will only be used for supervision of the trainee clinical psychologist and to ensure that the intervention protocol is followed. Recordings will be permanently deleted following completion of the study.

Confidentiality -
- Information would be kept confidential within the research team. Participants will be made aware that there are some limits to confidentiality. Throughout the study if the participant mentions something that makes me think that they, or someone else, is at significant risk of harm, I would break confidentiality and speak to a member of their CMHT about this. If it is safe to do so, I would tell the individual if I have to do this at the time.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- [x] Case series/ case note review
- [ ] Case control
- [ ] Cohort observation
- [ ] Controlled trial without randomisation
- [ ] Cross-sectional study
- [ ] Database analysis
- [ ] Epidemiology

- [x] Feasibility/ pilot study
- [ ] Laboratory study
- [ ] Metanalysis
- [ ] Qualitative research
- [ ] Questionnaire, interview or observation study
- [ ] Randomised controlled trial
- [ ] Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

Is an autobiographical memory-focused intervention:
a) feasible for people with suicidality in a secondary care setting?
b) acceptable for people with suicidality in a secondary care setting?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Do individuals' levels of suicidal ideation reduce during the intervention?

Do the risk factors of suicide (entrapment, perceived burdensomeness and thwarted belongingness) reduce from baseline to the end of the intervention?

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Psychological interventions targeting suicidal ideation are important for both reducing suicide risk and increasing mental wellbeing. Suicide is a widespread global problem, with around 700,000 people dying by suicide every year (World Health Organisation, 2021). Suicidal ideation is a risk factor of attempted suicide (Large et al., 2021), and it is also indicative of high levels of mental distress (Garlow et al., 2008). Research aiming to reduce suicidality and the psychological distress it causes is therefore needed.

Targeting autobiographical memory has the potential to help reduce the power of people's suicidal ideation and the distress associated with this. Autobiographical memory involves the recollection of past events in a person's own life, and has been linked to a person's sense of identity, goals, and orientation in the present (Williams et al., 2007). When memories are linked to strong positive or negative emotions, they are more easily and vividly remembered, and consequently hold more power (Williams et al., 2022). Negative memories have been shown to be both more durable and accessible; studies have suggested this is related to increased attention at the time of a 'negative' event, but also to the brain prioritising encoding when a memory is emotional (Talmi et al., 2008); Mather et al., 2016). Negatively valenced memories are therefore more vividly remembered and more frequently rehearsed and re-activated (Williams et al., 2022). Thus, memories connected to thoughts of suicide often hold a lot of power.

The power that memories of suicidal ideation or suicide attempts hold is concerning when considering that our past memories have an important role in guiding our future actions (Gershman, 2017). However, this also demonstrates the potential for powerful positive autobiographical memories to help people to move away from thoughts of suicide.

Several interventions have drawn upon positive autobiographical memories, with an aim of increasing the power of positive memories and reducing the power of negative memories (Miguel-Alvaro et al, 2021). This has included studies with people experiencing thoughts of suicide, suggesting that an autobiographical memory-focused intervention is both acceptable and feasible in this population. However, there is a need for further research in this area. The current studies looking at suicidality are in adolescents/young adults, and research is needed with a wider age range. Moreover, whilst these studies have shown promise in reducing suicidality, they were not developed with a suicidal population in mind. The current study therefore aims to develop an intervention specifically for people experiencing thoughts of suicide, where memories connected to suicidality are targeted.

One model of suicide proposes that entrapment underlies thoughts of suicide (O'Connor & Kirtley, 2014). It is hoped that by focusing on 'exits' from suicide - the points when people move away from considering suicide and reconnect

with life - people will move from a state of feeling trapped to one where they are empowered to see other options to suicide. These 'exits' have the potential to act with the 'Threat to Self Moderators' (TSM), which are proposed to moderate the progression from defeat and humiliation to entrapment within this model (O'Connor, 2021). Current TSMs include problem solving, memory biases and ruminative process; rehearsing 'exits' may help to reduce these difficulties by directing attention to re-connection and providing alternatives to aid problem solving. Another model suggests interpersonal factors such as perceived burdensomeness and thwarted belonging are key factors in suicidality (Joiner, 2007). An intervention focused upon memories of the point when people reconnect with life may also challenge people's perceptions of these interpersonal difficulties.

In the intervention, participants will be introduced to the different autobiographical memories - neutral, positive, and 'exits' - alongside relaxation techniques. They will be given the option of which feels most helpful, and this decision will inform the focus of the remaining sessions. Giving individuals the option again aims to reduce defeat and entrapment (O'Connor & Kirtley, 2014), and to help people feel empowered in their care (Sweeney et al., 2016).

The research will be conducted with a transdiagnostic population within secondary care community mental health teams. Most models of suicide are transdiagnostic (Joiner, 2007; O'Connor & Kirtley, 2014), suggesting that an intervention across diagnoses is appropriate. This approach will also increase the accessibility of the intervention to a wider group of people.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The study will use an experimental case series design, where a small group of individuals all receive the same intervention, and changes across the course of the intervention are observed. 5-7 individuals will be recruited to receive the intervention.

Individuals will be recruited by clinicians within their CMHT, who will identify those who meet the inclusion criteria and approach them to see if they are interested in taking part. Clinicians will provide individuals with the Participant Information Sheet and Expression of Interest (EoI) Form. If the individual returns the EoI to the clinician, the clinician would then contact the research team for an eligibility screening. Individuals screened as eligible will be invited to an initial meeting; individuals not screened as eligible would be informed of this by Dr Iqbal, who is both in the research team and in their direct care team.

A structure called a 'non-concurrent A-B multiple baseline design' will be used. This will involve a baseline assessment period and an intervention period. This enables there to be a 'control' period without needing to include separate 'control' participants in the study. In this structure, the baseline period varies in length between participants. In this study, it will be randomised to between 3-5 sessions. This is to:

1) enable the effects of treatment to be separated from the effects of time seen clinically and
2) enable the therapeutic relationship/ therapeutic value of contact to be controlled for.

Thus, the impact of the intervention itself can be more clearly demonstrated. The initial assessment will last approximately 60 minutes, and will take place face-to-face. The remaining baseline sessions will last up to 30 minutes each and must be completed within 5 weeks. These sessions can take place in person, online, or by telephone. Outcome measures will be completed in each session.

The intervention period will last 6 sessions, with each session lasting for approximately 60 minutes. These must be completed within an 8-week window. This time period enables the intervention to be conducted as an intensive therapy with multiple sessions per week, whilst allowing for flexibility for any time demands upon both participant and therapist. All sessions will be conducted face-to-face.

The possible contact that participants will have within the study is summarised here, with the key as follows (Key: A – initial assessment, B – baseline, I – intervention, F – final intervention session:

- A - B – B – I – I – I – I – I – F
- A – B – B – B - I – I – I – I – I – F
- A – B – B – B – B - I – I – I – I – I – F

To answer research question 1a ('feasibility'), we aim to consider recruitment to the study, whether the data can be collected as planned, the attendance and the therapy completion rates.

To answer research question 1b ('acceptability'), we aim to consider whether participants report that the intervention

seems suitable. We will also look at the therapeutic alliance, and assess for any adverse effects. To answer the secondary research questions, we will look at changes in the C-SSRS, INQ-15 and Entrapment Scales.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
We have involved a staff member with experience of working as a care coordinator within a CMHT. He has reviewed the clinician information sheet, eligibility check sheet, consent form, participant information sheet, and expression of interest form. This staff member made suggestions around how to improve these to best fit the needs of potential participants and of CMHT staff involved in the recruitment process.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth

☐ Respiratory
☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 65	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

- Experiences of suicidal ideation and/or suicidal behaviours within the previous 3 months: screened for by asking clinicians 'Has the individual reported thoughts of ending their life within the past 3 months AND/OR attempted to end their life within the past 3 months?'
Answering yes to either question will confirm eligibility in this factor.

- Currently under a Community Mental Health Team (CMHT) within which supervisory support can be arranged
- Has a recent risk assessment (completed within the past 3 months) from their CMHT
- Are 18-65 years old

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

- Moderate/severe learning disability
- Organic cerebral disease/injury which significantly affects language comprehension or expression
- Non-English speaking (intervention will be conducted in English due to resource limitations – no access to a translator)
- Acute psychosis which would affect engagement
- Receiving psychological treatment or participating in another research intervention
- Open to a home-based treatment team
- Currently being seen in an inpatient setting
- Has a history of violence or harm to others such that clinicians within their direct care team would advise against one-to-one sessions for safety reasons
- At imminent risk of acting upon thoughts of suicide or of harm to others. This will be screened for by assessing for the presence of active intent and plans to harm themselves or others within the next month. If an individual is not eligible for the study for this reason, they may consent to be contacted again after a month and for changes in risk to be assessed. If the individual met the eligibility criteria at this point, they would be invited to take part in the study. We would only follow-up once so that individuals are not continually approached about the study.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking Consent	1		15 minutes	Trainee clinical psychologist to provide form via email; consent to be checked in person at the CMHT base during the initial assessment
Randomisation to baseline number	1		2 minutes	Clinical psychologist (Dr James Kelly) and trainee clinical psychologist; communicated to participant face-to-face in CMHT base during initial baseline session

Initial baseline session	1	60 minutes	Trainee clinical psychologist; face-to-face in CMHT base
Follow-up baseline sessions	2-4	30 minutes	Trainee clinical psychologist; online/via telephone or face-to-face in CMHT base
Demographics Form	1	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base, during the initial assessment
Interpersonal Needs Questionnaire-15 (INQ-15)	3	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base during the initial assessment, first intervention session, and final session
Entrapment Scale - Short Form (ES-SF)	11	2 minutes	Trainee clinical psychologist; face-to-face in CMHT base during each session, and online/via telephone or face-to-face in CMHT base during baseline sessions
Clinical Global Impressions (CGI) Scale	11	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base during each session and online/via telephone or face-to-face in CMHT base during baseline sessions
Working Alliance Inventory - Short Revised Scale (WAI-SR)	1	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base during the 3rd intervention session
Sessional Mood Scale	11	2 minutes	Trainee clinical psychologist; face-to-face in CMHT base, during each session and and online/via telephone during baseline sessions
Adverse Effects in Psychotherapy (AEP) Scale	1	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base at the end of the final intervention session
Qualitative Feedback	1	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base at the end of the final intervention session
Columbia Suicide Severity Rating Scale (C-SSRS)	11	5 minutes	Trainee clinical psychologist; face-to-face in CMHT base during each session and online/via telephone or face-to-face in CMHT base during baseline sessions

A19. Give details of any clinical intervention(s) or procedure(s) to be received by participants as part of the research protocol. *These include uses of medicinal products or devices, other medical treatments or assessments, mental health interventions, imaging investigations and taking samples of human biological material. Include procedures which might be received as routine clinical care outside of the research.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days).
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Autobiographical Memory-Based Intervention for Suicidality	6	0	60	Trainee clinical psychologist; face-to-face at CMHT base
Initial Risk Assessment and Safety Planning	1	0	30	Trainee clinical psychologist; face-to-face at CMHT base
Follow-up risk assessments	10		10	Trainee clinical psychologist; face-to-face at CMHT base during intervention sessions; either via telephone, online or face-to-face at CMHT base during follow-up baseline sessions

A20. Will you withhold an intervention or procedure, which would normally be considered a part of routine care?

○ Yes ◉ No

A21. How long do you expect each participant to be in the study in total?

There will be between 9-11 contacts. The baseline sessions will take place within a 5-week window, and the intervention sessions will take place within an 8-week window.

The below diagram indicates the three possible configurations of sessions and measures participants will be randomised to.

Key: A – initial assessment, B – baseline, I – intervention, F – final intervention session
1) A - B – B – I – I – I – I – I – F
2) A – B – B – B - I – I – I – I – I – F
3) A – B – B – B – B - I – I – I – I – I – F

The third configuration indicates the maximum number of contacts with participants, with sessions taking place in a maximum of 13 weeks.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Potential risks =

- Increases in distress and suicidality:

It is not anticipated that the intervention will lead to an increase in suicidality or distress. A systematic review has indicated that talking about suicide can reduce suicidal ideation and improve people's mental health (Dazzi et al., 2017). However, we have taken steps minimise the potential for this.

1) Prior to participants beginning the study, they will have had a recent risk assessment (with 3 months) completed with the CMHT. This risk assessment would be updated during the baseline stage of the study.
2) At the start of the study, participants will be provided with helplines/crisis numbers.
3) Clinical supervision will be provided for each case at a level appropriate for a trainee. Supervision will be used to discuss any risk concerns related to participants.
4) Risk information will be recorded on the patient information system at GMMH, so that this can be accessed by the clinical care team.

- Assessing and managing distress during telephone/online sessions: previous trials have indicated that the delivery of online interventions - in which distress/risk were assessed and managed online - has been shown to be feasible/acceptable for people with mental health disorders such as schizophrenia (Cairns et al, 2023) and for people with thoughts of suicide (Smith et al., 2021). Management of risk and distress will draw from the distress protocol used in Cairns et al, 2023.

- Adverse events/ Serious Adverse events arising from the intervention: A protocol for managing risk and serious adverse events across all participants will be used (document attached), which provides details on the processes around management and minimisation of risk. An SAE reporting form (based on the HRA document) will be used to record and report any serious adverse events. This would be completed by the CI within 2 days of being reported and sent to the independent reviewer within 7 days. If the CI and/or the researcher assess an adverse event as unexpected and related to the trial, it will be sent to the REC within 15 days of first being reported.

GCP training has been completed by the researchers, so they are aware of the procedures which need to be in place to minimise further risks (e.g. knowing when to pause the study). Serious adverse effects of the intervention will be assessed for by using:
1) the Clinical Global Impressions Scale to assess for clinical changes
2) monitoring in the sessions;
3) using the Adverse Effects in Psychotherapy (AEP) Scale in the final session;
4) assessment by an independent reviewer (Dr Cath Coogan)

- Confidentiality: Confidentiality and its limits will be discussed within the first session. This will include discussions about information being anonymous within the research, and outline reasons confidentiality might be broken in

relation to risk and safeguarding concerns. Participants will be informed that they can withdraw from the study at any point if they wish. Information on this process will be outlined on the consent form.

Data protection: Data will be recorded and accessed on a password protected laptop provided by Lancaster University. It will be stored on Lancaster University approved cloud storage (OneDrive), which will require dual authentication. Identifiable/personal data will be stored separately to questionnaire responses. All questionnaire responses will be anonymised. The data will not be shared with anyone outside of the research team, unless there are concerns about risk. In this case, risk information will be shared with the individual's CMHT. Individuals will be asked to agree to this on the consent form.

Potential burdens =

- Time taken to complete measures: To minimise this, most measures will only be used in the initial assessment and at the start and end of the therapy intervention. Shorter versions of forms (e.g. the Entrapment Scale – Short Form) have been used where possible. £10 will be provided for both of these sessions (£20 in total). This reimbursement mirrors a trial which follows a similar structure (Taylor et al., 2020).

- Cost of travel: Participants are required to attend up to 11 sessions. To minimise travelling costs/time, there will be the option for follow up baseline sessions (baseline sessions 2-4) to take place online or via telephone. This will limit the number of required face-to-face sessions to 7. Participants will have to travel to [redacted] for these sessions; as we are assessing the feasibility of this intervention, this amount of travel reflects that which an individual would have to undertake if this intervention was undertaken as part of the care from their CMHT.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◉ Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Questionnaires will include ratings related to thoughts of suicide. It is possible that, when discussing autobiographical memories, disclosures requiring action could arise. As each participant will sit within a CMHT, we will follow their NHS Trust guidelines for managing any disclosures. Further details about this are provided in the risk and serious adverse events protocol. Confidentiality and its limits will be discussed with participants.

A24. What is the potential for benefit to research participants?

A systematic review has indicated that talking about suicide can reduce suicidal ideation and improve people's mental health (Dazzi et al., 2017). Other research has replicated this - a recent suicide intervention in an inpatient setting noted that most participants had unchanged or decreased distress levels (Carter et al., 2020), whilst a systematic review and meta-analysis focused on the impact of asking about suicide found that asking about suicide was not associated with harmful outcomes (Polihronis et al., 2020). It is hoped that the intervention itself will help to reduce suicide risk and associated distress. It is also hoped that the intervention will increase mental wellbeing by focusing upon positive autobiographical memories to make these more accessible.

A25. What arrangements are being made for continued provision of the intervention for participants, if appropriate, once the research has finished? *May apply to any clinical intervention, including a drug, medical device, mental health intervention, complementary therapy, physiotherapy, dietary manipulation, lifestyle change, etc.*

The intervention is intended as a brief standalone intervention so it would not be continued for participants after the intervention has finished. They will continue to access mental health support provided by their CMHT. Part of the intervention involves participants being encouraged to practice the techniques in between sessions and they may continue to do this once the research trial has ended.

A26. What are the potential risks for the researchers themselves? *(if any)*

As researchers will be working with individuals with thoughts of suicide, there is a likely emotional impact of the work. Discussing this within supervision will be used to manage the emotional demands of the work.

There is potential risk of physical harm as the intervention will be face to face. A risk assessment will be conducted and the researcher will only work with service users with documented risk to others if the risk management plan has

been judged to mitigate the risk of harm to the researcher. Interventions will take place at NHS sites where help can be called. De-escalation training and procedures will be followed.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants will be identified within the secondary care community mental health services in which my [redacted]

Recruitment would be supported by:
1) Attendance at team meetings in which the study would be explained/ clinicians would be asked to identify and discuss the study with any appropriate service users. They will be able to discuss whether clients are eligible with a member of the research team who is also a member of the individual's direct care team (NI)
2) Distributing a clinician information sheet and eligibility criteria sheet outlining the study and detailing the inclusion criteria to CMHTs;
3) Support from Dr Nasur Iqbal to encourage recruitment with his CMHT.

In the event of challenges with recruitment, an additional field supervisor would be sought, with a plan to recruit any additional participants within their team. Supervision would be provided by field/research supervisors attached to each team alongside Dr Kelly.

The full recruitment process is outlined in the 'Recruitment, Consent and Randomisation Processes' document.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

(●) Yes ( ) No

Please give details below:
Potential participants will be identified and approached by the client's direct care team, to minimise access of personal information outside of the direct care team during the screening process.

Any potential participants who are interested in the study will be asked to complete an expression of interest form. In this, they will share their name and contact details so that members of the research team can contact them. On this form, they will also be asked for permission for members of the research team to speak to their direct care team to support screening their eligibility (e.g. discussions about risk information), which will involve personal information being shared. Records will not be physically accessed by the research team at this point.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants.*Indicate what steps have been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected. Please consult the guidance notes on this topic.*

Potential participants will be identified and approached by the client's direct care team, to minimise access of personal information outside of the direct care team during the screening process.

Individuals interested in the study will be asked to complete an Expression of Interest form. In this, written consent will be requested for:
- their contact information being shared with the research team
- for the trainee clinical psychologist to speak to members of their CMHT about their eligibility, including the sharing of information around risk

The service user's patient records would not be physically accessed until the participant had consented to take part in the study. The Expression of Interest form would be stored on Lancaster University approved cloud storage, and destroyed if 1) the individual did not meet the eligibility criteria or 2) the individual decided not to take part in the study. Any additional personal information would be shared verbally, and no record of identifiable information would be taken.

If a participant consents to take part in the study, access to their GMMH patient records will be limited to the trainee clinical psychologist and the supervisor attached to the participant's direct care team (Dr Nasur Iqbal). After the participant has left the study, the trainee clinical psychologist will request that they no longer have access to this individual's patient records.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

(●) Yes ( ) No

A27-5. Has prior consent been obtained or will it be obtained for access to identifiable personal information?

(●) Yes ( ) No

If Yes, please give details below.

If participants express an interest in being involved in the study, clinicians in the CMHT them to complete an Expression of Interest form. This will provide consent for the potential participant's name and contact number to be passed to the research team. It will also enable the trainee clinical psychologist to speak to members of the individual's CMHT about whether they meet the eligibility criteria.

Participants will be required to complete a written consent form prior to attending their first session, in which they will consent to their GMMH patient records being accessed by the research team.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

( ) Yes (●) No

A29. How and by whom will potential participants first be approached?

They will be approached by clinicians within the CMHT where my supervisor Dr Nasur Iqbal works. They will be provided with an information sheet about the study, with the chance to think about whether they would like to be involved. The CMHT clinician will ask for individuals to complete an Expression of Interest form to enable their contact information to be shared with the research team. This form would also request consent for the trainee clinical psychologist to speak to a clinician within the CMHT to screen for their eligibility.

If the individual is screened as eligible, a member of the research team would contact them using the details from the Expression of Interest form to set up an initial meeting. If they are not eligible, the clinician in the CMHT would feed this back to the individual, with the reasons they did not meet the criteria. Individuals will have access to the researchers contact details if they have further questions about this.

A30-1. Will you obtain informed consent from or on behalf of research participants?

(●) Yes ( ) No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Informed consent will be obtained and recorded, in accordance with Mental Capacity Act Legislation (2005). The study information sheet will be provided to participants prior to them completing the Expression of Interest form.

Participants will then be contacted by the research team, where they will have the chance to ask any questions they may have about the study. A written consent form will be provided to participants in advance of the initial assessment. When the initial appointment is arranged, the trainee clinical psychologist will send the consent form to the participant to be returned prior to the appointment via the participant's preferred method (e.g. online qualtrics form or by returning to their CMHT clinician). Consent would then be confirmed in the meeting.

Consent will be recorded on the NHS clinical system and on the Lancaster University cloud system (OneDrive), with documents encrypted and stored securely.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

A participant who is approached about the study will be provided with a participant information sheet. If after reading this a potential participant is interested in taking part, an Expression of Interest form can be returned to the research team. They can do this at any point whilst recruitment is still ongoing.

The research team will contact a potential participant as soon as possible after an EoI form is returned, to discuss the study and answer any queries about taking part. A consent form will be sent out to any individuals who are still interested in taking part. The initial assessment appointment will be booked into a time slot which is a minimum of 48 hours after this phone call, in order to give the participant time to read the consent form and decide whether they wish to participate. The initial assessment appointment will be booked into a time slot within 2 weeks of this phone call, giving individuals up until this point to decide whether they wish to participate.

A32. Will you recruit any participants who are involved in current research or have recently been involved in any research prior to recruitment?

○ Yes
◉ No
○ Not Known

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

The intervention will be conducted in English, due to limited resources being available to acquire translators. Written information will be spoken aloud. There will be the possibility for participants to consent verbally to enable individuals with any reading difficulties to take part in the study.

A34. What arrangements will you make to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?

Participants would be contacted by the trainee clinical psychologist by phone if possible. If we were unable to contact participants in this way, or there were concerns that this contact could increase risk, we would speak to participants at the start of their face-to-face sessions.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

◉ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

◯ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

◯ The participant would continue to be included in the study.

◯ Not applicable – informed consent will not be sought from any participants in this research.

◯ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

An item is included on the consent form, specifically requesting consent to retain non-identifiable information already collected in the case of a participant losing capacity to consent during the study. It is also explained that, in this event, the participant's involvement in the study would end.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☑ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☑ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files (includes paper or film)
  - ☑ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☑ Laptop computers

Further details:

The trainee clinical psychologist would be given access to telephone numbers to contact individuals. Video recordings of the sessions will be taken on a university laptop, upon which they would be encrypted and stored securely. They would be recorded in order to ensure fidelity to the model/protocol. Recordings of sessions will be deleted as soon as they have been used for supervision purposes.

A37. Please describe the physical security arrangements for storage of personal data during the study?

All data will be recorded digitally on a password protected Lancaster University issued laptop. Data will be encrypted and stored on the university's secure cloud server (OneDrive). The laptops will be located in a locked secured building.

Recordings of sessions will be deleted as soon as they have been used for supervision purposes.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Personal data, notes, and recordings will all be encrypted and stored securely. Clinical data and research data will be recorded separately. Clinical risk information will be recorded on the GMMH NHS patient information system. No research information (e.g. questionnaires, session details) will be recorded on this system.

Research information will be anonymised and stored on Lancaster University's secure server, using laptops which are password protected and encrypted. Only the named researchers will have access to this information. Recordings of sessions will also be stored in this way, and deleted as soon as they have been used for supervision purposes.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The trainee clinical psychologist will have access to patient's personal data supervisor, as she will be delivering the intervention. Both Dr Nasur Iqbal (part of the participant's direct care team) and Dr James Kelly (who is employed by the trust and operating as a clinical supervisor) will also have personal data shared with them to support risk assessment, management and supervision. Consent will be sought for this data to be shared and accessed.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The data will be analysed on SPSS by the trainee clinical psychologist. This will be done on a Lancaster University issued laptop. The analysis will take place remotely at the researcher's home.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	James	Kelly
Post	Academic supervisor		
Qualifications	ClinPsyD University of Manchester		
Work Address	Health Innovation Campus		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YW		
Work Email	j.a.kelly@lancaster.ac.uk		
Work Telephone	01524592691		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- (●) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years

◯ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Identifiable research data will be destroyed after the study has ended. Non-identifiable data will be stored securely on Lancaster University approved cloud storage (OneDrive).

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

◉ Yes ◯ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Yes – Participants will be reimbursed for completion of outcome measures during the initial assessment and the final session at £10 for each. They will therefore receive a maximum of £20 during the study.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

◯ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

◯ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

◉ Yes ◯ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

A49-2. Will you seek permission from the research participants to inform their GP or other health/ care professional?

◉ Yes ◯ No

It should be made clear in the participant's information sheet if the GP/health professional will be informed.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

The UK Policy Framework for Health and Social Care Research sets out the principle of making information about research publicly available. Furthermore: Article 19 of the World Medical Association Declaration of Helsinki adopted in 2008 states that "every clinical trial must be registered on a publicly accessible database before recruitment of the first subject"; and the International Committee of Medical Journal Editors (ICMJE) will consider a clinical trial for publication only if it has been registered in an appropriate registry. Please see guidance for more information.

○ Yes ◉ No

Please give details, or justify if not registering the research.
No appropriate register was found to exist for our study. We aim to publish this pilot study in a peer reviewed journal.

Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☑ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Participants will be assigned unique study numbers, and questionnaire information will only be identifiable through this number.

When publishing, pseudonyms/participant numbers will be used when reporting on individual data. Demographic information may be presented as a whole, but will not be linked to each participant's research data.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
Participants can opt in to being informed about the study results on the consent form. They will also be given an email contact so that they can contact the researchers if they would like information regarding the outcome of the trial. I would email any participants who have opted in when the research study has been written up and the results have been finalised.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group

☑ Review within the Chief Investigator's institution or host organisation

☐ Review within the research team

☑ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The thesis proposal was initial written by the trainee clinical psychologist (Lexy Powell), and reviewed and approved by the chief investigator (Dr Kelly). The proposal was them sent to Professor Bill Sellwood (Lancaster University Doctorate of Clinical Psychology - Programme Director). He made some suggested modifications, after which he reviewed the proposal again. He sent a response confirming he felt the project was appropriate to go ahead on 2nd December 2022. After I made a couple of adjustments, Professor Sellwood also approved these modifications with an email on 5th May 2023.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

☐ Review by independent statistician commissioned by funder or sponsor

☐ Other review by independent statistician

☐ Review by company statistician

☐ Review by a statistician within the Chief Investigator's institution

☐ Review by a statistician within the research team or multi−centre group

☑ Review by educational supervisor

☐ Other review by individual with relevant statistical expertise

☐ No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

	Title	Forename/Initials	Surname
	Dr	James	Kelly
Department	Lancaster DClinPsy Programme		
Institution	Lancaster University		
Work Address	Doctorate in Clinical Psychology		
	Health Innovation One, Lancaster University		
	Bailrigg, Lancaster		
Post Code	LA1 4YG		
Telephone	01524592691		
Fax			
Mobile			
E-mail	j.a.kelly@lancaster.ac.uk		

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

Feasibility, measured by attendance rates, recruitment rates, and completion rates.

Acceptability, measured by therapeutic alliance, adverse effects and qualitative feedback.

A58. What are the secondary outcome measures? *(if any)*

Intervention outcomes, including changes in suicidality (measured using the C-SSRS), entrapment (using the E-SF), and perceived burdensomeness/thwarted belonging (using the INQ-15)

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 7
Total international sample size (including UK): 7
Total in European Economic Area: 7

Further details:
The study plans to recruit between 5-7 participants.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

5 is the smallest number of participants required for a study to be classed as a case series. We intend to recruit up to 7 participants to allow for any individuals who do not complete the trial. Due to practical time constraints, a larger sample is not possible.

A61. Will participants be allocated to groups at random?

(●) Yes ( ) No

If yes, please give details of the intended method of randomisation:
Yes- Although all participants will receive the same number of intervention sessions, the baseline sessions will be randomised to 3-5 sessions (including the initial assessment). This will be done using a web-base randomisation programme (Sealed Envelope) by chief investigator Dr James Kelly. A pseudorandom number generator, PRNG, will be used to enable this to be done anonymously.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Visual inspection will be used - this is considered the standard method for case series analysis (Ledford et al., 2017). Visual inspection enables consideration of whether there is a functional relation in the results and the characteristics contributing to this. Effect sizes will also be calculated to measure treatment effect, allow for comparison with other studies, and enable inclusion in meta-analyses.

Other methods considered included trend analyses and reliable change index. Autocorrelation in trend analysis has been shown to threaten the validity of parametric statistics (Shadish et al., 2013) and reliable change index relies on clinical cut-off scores, but the C-SSRS, Entrapment Scale and INQ do not have these. Therefore, these methods were rejected in preference of visual inspection alongside effect sizes.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title	Forename/Initials	Surname
Dr	Nasur	Iqbal

Post	Clinical Psychologist
Qualifications	Doctorate in Clinical Psychology (Clin.Psy.D.), The University of Manchester
Employer	GMMH NHS Foundation Trust
Work Address	Department of Clinical Psychology North Manchester General Hospital Delaunays Road, Crumpsall, Manchester
Post Code	M8 5RB
Telephone	01612710695
Fax	
Mobile	
Work Email	nasur.iqbal@gmmh.nhs.uk

Title	Forename/Initials	Surname
Dr	Aimee	Cairns

Post	Clinical Psychologist
Qualifications	Doctorate in Clinical Psychology (DClinPsy), Lancaster University
Employer	GMMH
Work Address	Edenfield Centre Prestwich Manchester
Post Code	M25 3BL
Telephone	
Fax	
Mobile	
Work Email	aimee.cairns@gmmh.nhs.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation Lancaster University
Given name Becky

Family name	Gordon
Address	Department: Research and Enterprise Services Office: B062, B - Floor, Bowland Main
Town/city	Bailrigg, Lancaster
Post code	LA1 4YW
Country	United Kingdom
Telephone	0152465201
Fax	
E-mail	sponsorship@lancaster.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation	
Given name	
Family name	
Address	
Town/city	
Post code	
Country	
Telephone	
Fax	
E-mail	

A65. Has external funding for the research been secured?

Please tick at least one check box.

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ◉ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

◯ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

◯ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	Ms	Jennifer	McRoberts
Organisation	Greater Manchester Mental Health NHS Foundation Trust		
Address	1st Floor Harrop House		
	Bury New Road, Prestwich		
	Manchester		
Post Code	M25 3BL		
Work Email	jennifer.mcroberts@gmmh.nhs.uk		
Telephone	01613571258		
Fax			
Mobile			

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/09/2023
Planned end date: 30/08/2024
Total duration:
Years: 0 Months: 11 Days: 30

A71-1. Is this study?

◉ Single centre
◯ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?

○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	1
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☐ Educational establishments	
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

Lancaster University as a sponsor has procedures in place for monitoring and auditing, and this study may be included in the annual audit plan. The intervention and research will also be monitored through supervision meetings, and video recordings of the sessions will be used to check model fidelity.

A75-1. What arrangements will be made to review interim safety and efficacy data from the trial? Will a formal data monitoring committee or equivalent body be convened?

An independent reviewer (Dr Cath Coogan), a clinical psychologist who works within a community mental health setting and has expertise in this field will review the trial procedures and data to assess for any adverse effects of the intervention.

If a formal DMC is to be convened, please forward details of the membership and standard operating procedures to the Research Ethics Committee when available. The REC should also be notified of DMC recommendations and receive summary reports of interim analyses.

A75-2. What are the criteria for electively stopping the trial or other research prematurely?

Trial staff will report any adverse events and serious adverse events as soon as possible using a set reporting template, to be sent to Lancaster University sponsorship and to independent reviewer Dr Cath Coogan. SAEs will be defined as any immediate and clear concerns about participant's health and safety, or to the safety of other's around them. In these cases, the chief investigator Dr James Kelly may stop the study immediately, employ immediate safety measures, and notify the research ethics committee as soon as possible via telephone. Dr Nasur Iqbal and trainee clinical psychologist Lexy Powell will also be involved in discussions around potential SAEs. If SAEs are believed to be unexpected and related to the trial and there are concerns about the safety of participants, the chief investigator may immediately stop the study. They would notify the research ethics committee (REC) immediately. The researcher would also notify the REC through a written report, following HRA guidance.

Given that the population within the study have experienced thoughts of suicide and have secondary mental health needs, we would expect that if there are any SAEs during the trial, these might relate to suicide and self-injury related behaviour (e.g. attempted, completed suicide, self-injury resulting in hospitalisation). The research team and sponsors will monitor and review SAEs. If SAE rates are higher than expected, the study may be paused whilst this is investigated, and stopped completely if necessary.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** in this question to NHS Indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover.

NHS indemnity will apply for NHS participants.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at

these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover.

Please enclose a copy of relevant documents.

A77. Has the sponsor(s) made arrangements for payment of compensation in the event of harm to the research participants where no legal liability arises?

○ Yes ◉ No

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

◉ Yes ○ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	(●) NHS/HSC Site ( ) Non-NHS/HSC Site	Forename: Nasur Middle name: Family name: Iqbal Email: nasur.iqbal@gmmh.nhs.uk Qualification (MD...): DClinPsy (University of Manchester) Country: United Kingdom

Organisation name: GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST
Address: PRESTWICH HOSPITAL
BURY NEW ROAD
PRESTWICH MANCHESTER
Post Code: M25 3BL
Country: ENGLAND

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. I understand that the main REC or its operational managers may share information in this application or supporting documentation with the Medicines and Healthcare products Regulatory Agency (MHRA) where it is relevant to the Agency's statutory responsibilities.
13. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

- ◯ Chief Investigator
- ◯ Sponsor
- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr James Kelly on 14/07/2023 09:52.

Job Title/Post:

Organisation:

Email:

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 14/07/2023 12:02.

Job Title/Post:	Associate Director of Research Services
Organisation:	Lancaster University
Email:	y.fox@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Nasur Iqbal on 17/07/2023 13:15.

Job Title/Post:	Clinical Psychologist
Organisation:	GMMH
Email:	Nasur.Iqbal@gmmh.nhs.uk

Academic supervisor 2

This section was signed electronically by Dr Aimee Cairns on 14/07/2023 11:33.

Job Title/Post:	Clinical Psychologist
Organisation:	GMMH
Email:	aimee.cairns@gmmh.nhs.uk

Academic supervisor 3

This section was signed electronically by Dr James Kelly on 14/07/2023 09:53.

Job Title/Post:	
Organisation:	
Email:	

Appendix A

Ethics Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr James Kelly
Doctorate in Clinical Psychology, Health Innovation One
Lancaster University
Lancaster
LA1 4YW

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

02 November 2023

Dear Dr Kelly

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Autobiographical Memory-Based Intervention for Suicidality: A Case Series**
IRAS project ID:	**316697**
Protocol number:	**NA**
REC reference:	**23/EM/0211**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **316697**. Please quote this on all correspondence.

Yours sincerely,

Helen Poole
Approvals Specialist
Email: approvals@hra.nhs.uk

Copy to: *Ms Rebecca Gordon*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Contract/Study Agreement template [mNCA]	1.0	07 July 2023
Copies of materials calling attention of potential participants to the research [Expression of Interest Form]	1.2	24 May 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance certificate]		28 July 2023
GP/consultant information sheets or letters [GP letter templates]	1.1	07 July 2023
Interview schedules or topic guides for participants [Explaining the intervention - PowerPoint slides for participants (Example)]	1.0	28 July 2023
Interview schedules or topic guides for participants [Intervention structure]	1.0	28 July 2023
Interview schedules or topic guides for participants [Identifying memories - record sheet]	1.0	28 July 2023
IRAS Application Form [IRAS_Form_21072023]		21 July 2023
Non-validated questionnaire [AEP with Qualitative Feedback]	1.2	12 October 2005
Non-validated questionnaire [Demographics form]	2.2	23 September 2023
Non-validated questionnaire [Sessional mood scale]	1	28 July 2023
Non-validated questionnaire [AEP with Qualitative Feedback]	1.1	07 July 2023
Organisation Information Document [OID]	1.7	28 July 2023
Other [Intervention Resource 1]		
Other [Intervention Resource 2]		
Other [Acceptability form]	1.0	01 October 2023
Other [Response to HRA Assessment Queries]		30 October 2023
Participant consent form [Consent form]	1.5	12 October 2023
Participant information sheet (PIS) [PIS]	1.5	05 October 2023
Research protocol or project proposal [Protocol]	1.2	12 October 2023
Sample diary card/patient card [Suicide Helpline Card]	1.1	01 April 2023
Schedule of Events or SoECAT [Schedule of Events]		28 July 2023
Summary CV for Chief Investigator (CI) [CV for Chief Investigator]		
Summary CV for student [Trainee CV form]		
Summary CV for supervisor (student research) [CV for AC]		28 July 2023
Summary CV for supervisor (student research) [CV for NI]		28 July 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Recruitment Protocol]	1.0	09 June 2023
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Risk Protocol]	1.1	07 July 2023
Validated questionnaire [C-SSRS]		
Validated questionnaire [CGI]		
Validated questionnaire [Entrapment Scale - Short Form]		
Validated questionnaire [WAI - SR]		
Validated questionnaire [INQ - 15]		

Appendix B

Amendment 1

Amendment Tool
v1.6 06 December 2021

For office use
QC: No

Section 1: Project information

Short project title*:	Autobiographical Memory-Based Intervention for Suicidality
IRAS project ID* (or REC reference if no IRAS project ID is available):	316687
Sponsor amendment reference number*:	NSA01
Sponsor amendment date* (enter as DD/MM/YY):	23 November 2023
Briefly summarise in lay language the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study. If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained (note: this field will adapt to the amount of text entered)*:	The proposed change is to add a Clinician Information Sheet as a resource to be used to introduce the study to clinicians that may be supporting recruitment locally. The document is made of pre approved information and wording from the participant information sheet (PIS), but also includes some information from the approved protocol. Clinicians within the CMHT are involved in identifying individuals who fit the study criteria already, so this is not changing any recruitment methods or information. The second change we would like to make is to remove any specific named trusts or locations in the participant facing documents and protocol, in order to allow any service within the approved trusts to recruit participants or to allow for addition of new sites via an amendment, should any new sites be interested to take part. All processes, participant information, and recruitment will remain the same. The third change is to remove the version number of the PIS listed on the consent form to leave a space to enter this when it is being used, to ensure the correct version is written by the person consenting.

Project type (select):	**Specific study**			
	Research tissue bank			
	Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?:	**Yes**		No	
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable? (select):	**NHS/HSC REC**			
	Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a **modified amendment** (i.e. a substantial amendment previously given an unfavourable opinion)?	Yes		**No**	
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?:	England	Wales	Scotland	Northern Ireland
	Yes	No	No	No
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?:	Yes		**No**	
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?:	Yes		**No**	
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?:	Yes		**No**	
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?:	Yes		**No**	
Did the study involve adults lacking capacity OR does the amendment introduce this?:	Yes		**No**	
Did the study involve access to confidential patient information outside the direct care team without consent OR does the amendment introduce this?:	Yes		**No**	
Did the study involve prisoners or young offenders who are in custody or supervised by the probation service OR does the amendment introduce this?:	Yes		**No**	
Did the study involve children OR does the amendment introduce this?:	Yes		**No**	
Did the study involve NHS/HSC organisations prior to this amendment?:	**Yes**		No	
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?:	Yes		**No**	
	England	Wales	Scotland	Northern Ireland
Lead nation for the study:	**Yes**	No	No	No
Which nations had participating NHS/HSC organisations prior to this amendment?	**Yes**	No	No	No
Which nations will have participating NHS/HSC organisations after this amendment?	**Yes**	No	No	No
Was this a "single site, self sponsored" study in England or Wales prior to this amendment?	Yes		**No**	

Section 2: Summary of change(s)

Please note: Each change being made as part of the amendment must be entered separately. For example, if an amendment to a clinical trial of an investigational medicinal product (CTIMP) involves an update to the Investigator's Brochure (IB), affecting the Reference Safety Information (RSI) and so the information documents to be given to participants, these should be entered into the Amendment Tool as three separate changes. A list of all possible changes is available on the "Glossary of Amendment Options" tab. To add another change, click the "Add another change" box.

Change 1	
Area of change (select)*:	Study Documents
Specific change (select - only available when area of change is selected first)*:	Other minor change to study documents (e.g. information sheets, consent forms, questionnaires, letters) that can be implemented within existing resource in place at participating organisations - Please specify in the free text below
Further information In particular, please describe why this change can be implemented within the existing resource in place at the participating organisations (free text - note that this field will adapt to the amount of text entered)*	1. This change is to firstly introduce a new information sheet for clinicians who may be involved in recruiting patients, to use as an introduction and reminder of the study/study criteria. This document does not introduce any new information or impact procedures in anyway, it has been developed using pre approved wording from both the patient information sheet and protocol. No additional resource arrangements needed from participating organisations. 2. While making this change, we would also like to remove any specific references to named trusts, locations or services in the participant facing documents, including the participant information sheet (PIS) and make this generic, so that when sites are added to the study, the documents can be localised specific to that trust without needing an amendment to change the document. 3.Finally, we would also like to update the consent form to remove any specific version of the PIS listed, and instead leave a gap for the person consenting to enter the version of the PIS the participant was consented from.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Remove all changes below	

Change 2	
Area of change (select)*:	Study Documents
Specific change (select - only available when area of change is selected first)*:	Protocol - Non-substantial changes (e.g. not affecting safety or the scientific value of the trial)
Further information (free text - note that this field will adapt to the amount of text entered):	This change is to remove any specific references to trusts, locations and services and instead refer to them as sites, to allow for new trusts and services to recruit participants to the study.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Add another change	

Section 3: Declaration(s) and lock for submission

Declaration by the Sponsor or authorised delegate

- I confirm that the Sponsor takes responsibility for the completed amendment tool
- I confirm that I have been formally authorised by the Sponsor to complete the amendment tool on their behalf

Name [first name and surname]:	Helen Brace
Email address:	sponsorship@lancaster.ac.uk

Lock for submission

Please note: This button will only become available when all mandatory (*) fields have been completed. When the button is available, clicking it will generate a locked PDF copy of the completed amendment tool which must be included in the amendment submission. Please ensure that the amendment tool is completed correctly before locking it for submission.

Lock for submission

After locking the tool, proceed to submit the amendment online. The "Submission Guidance" tab provides further information about the next steps for the amendment.

Section 4: Review bodies for the amendment

Please note: This section is for **information only**. Details in this section will complete automatically based on the options selected in Sections 1 and 2.

	Review bodies																	
	UK wide:						England and Wales:				Scotland:				Northern Ireland:				
	REC	Competent Authority MHRA - Medicines	Competent Authority MHRA - Devices	ARSAC	Radiation Assurance	UKSW Governance	REC (MCA)	CAG	HMPPS	HRA and HCRW Approval	REC (AWA)	PBPP	SPS (RAEC)	National coordinating function	HSC REC	HSC Data Guardians	Prisons	National coordinating function	Category:
Change 1:						(Y)				(Y)									C
Change 2:						(Y)				(Y)									A
Overall reviews for the amendment:																			
Full review:						N				N									
Notification only:						Y				Y									
Overall amendment type:	Non-substantial, no study-wide review required																		
Overall Category:	A																		

Appendix C

Amendment 2

Amendment Tool
v1.6 06 December 2021

For office use
QC: No

Section 1: Project information

Short project title*:	Autobiographical Memory-Based Intervention for Suicidality
IRAS project ID* (or REC reference if no IRAS project ID is available):	316697
Sponsor amendment reference number*:	NSA02
Sponsor amendment date* (enter as DD/MM/YY):	05 April 2024
Briefly summarise in lay language the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study. If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained (note: this field will adapt to the amount of text entered)*:	The current protocol and original IRAS had specific references to specific names of teams in the NHS site where the recruitment would take place. This amendment is to remove those, so that recruitment can take place within other teams in the same NHS trust site. Changes have also been made to the design and protocol, as the original protocol and IRAS stated that a member of the research team, who is also in the potential participant's direct care team will be available to 1) discuss individual's eligibility with clinicians prior to completing an Expression of Interest (EoI) form and 2) feedback to the client if they had completed an EoI form, but did not meet the study criteria. The proposed amendment is to reflect that the researcher available to discuss the above, and feedback to participants can be someone outside of the direct care team, who is also a member of the research team and employee at the research site. With this amendment, clinicians identifying and approaching suitable participants would still be able to discuss the eligibility criteria with a member of the research team, but will not discuss identifiable client information until an expression of interest and consent to contact had been obtained. If a potential participant did not meet the study criteria, they would be contacted by a member of the research team who is employed by the NHS Trust, but only after consent to contact the participant has been given and the participant has provided their own contact details to the research team. This amendment is also to update a typo an error relating to whether scores on the CGI would be classified as an SAE (where ≥3 should have read "an increase of ≥3"). Finally the protocol and all materials have been updated to reflect all of the above changes.

Project type (select):	**Specific study**			
	Research tissue bank			
	Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?:	**Yes**		No	
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable? (select):	**NHS/HSC REC**			
	Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a **modified amendment** (i.e. a substantial amendment previously given an unfavourable opinion)?	Yes		**No**	
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?:	England	Wales	Scotland	Northern Ireland
	Yes	No	No	No
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?:	Yes		**No**	
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?:	Yes		**No**	
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?:	Yes		**No**	
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?:	Yes		**No**	
Did the study involve adults lacking capacity OR does the amendment introduce this?:	Yes		**No**	
Did the study involve access to confidential patient information outside the direct care team without consent OR does the amendment introduce this?:	Yes		**No**	
Did the study involve prisoners or young offenders who are in custody or supervised by the probation service OR does the amendment introduce this?:	Yes		**No**	
Did the study involve children OR does the amendment introduce this?:	Yes		**No**	
Did the study involve NHS/HSC organisations prior to this amendment?:	**Yes**		No	
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?:	Yes		**No**	
	England	Wales	Scotland	Northern Ireland
Lead nation for the study:	**Yes**	No	No	No

Which nations had participating NHS/HSC organisations prior to this amendment?	**Yes**	No	No	No
Which nations will have participating NHS/HSC organisations after this amendment?	**Yes**	No	No	No
Was this a "single site, self sponsored" study in England or Wales prior to this amendment?	**Yes**		No	

Section 2: Summary of change(s)

Please note: Each change being made as part of the amendment must be entered separately. For example, if an amendment to a clinical trial of an investigational medicinal product (CTIMP) involves an update to the Investigator's Brochure (IB), affecting the Reference Safety Information (RSI) and so the information documents to be given to participants, these should be entered into the Amendment Tool as three separate changes. A list of all possible changes is available on the "Glossary of Amendment Options" tab. To add another change, click the "Add another change" box.

Change 1	
Area of change (select)*:	Study Design
Specific change (select - only available when area of change is selected first)*:	Other minor change to study design that can be implemented within existing resource in place at participating organisations - Please specify in the free text below
Further information In particular, please describe why this change can be implemented within the existing resource in place at the participating organisations (free text - note that this field will adapt to the amount of text entered)*	This minor change to the study protocol and the recruitment protocol is to enable recruitment from teams outside of the team where the researcher is employed (but within the same NHS Trust). This is also to confirm that the researcher availble to discuss eligibility and inform participants they were not selected to take part will no longer be a member of the direct care team, but will be research site employees. With this change, we would like to clarify that no identifiable information would be shared outside of the direct care team until potential participant completes an expression of interest form.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Remove all changes below	

Change 2	
Area of change (select)*:	Study Documents
Specific change (select - only available when area of change is selected first)*:	Other minor change to study documents (e.g. information sheets, consent forms, questionnaires, letters) that can be implemented within existing resource in place at participating organisations - Please specify in the free text below
Further information In particular, please describe why this change can be implemented within the existing resource in place at the participating organisations (free text - note that this field will adapt to the amount of text entered)*	Changes to the PIS and CIS to reflect the process described in change 1. A typo error relating to what score on the CGI would be classified as an SAE (where ≥3 should have read 'an increase of ≥3') is also amended in the risk protocol.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Remove all changes below	

Change 3	
Area of change (select)*:	Study Documents
Specific change (select - only available when area of change is selected first)*:	Protocol - Non-substantial changes (e.g. not affecting safety or the scientific value of the trial)
Further information (free text - note that this field will adapt to the amount of text entered):	Changes to the protocol document to reflect the above changes in change 1 and remove references to direct care team, where this will no longer be the case, and remove specific CMHT team names.

Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Add another change	

Section 3: Declaration(s) and lock for submission

Declaration by the Sponsor or authorised delegate

- I confirm that the Sponsor takes responsibility for the completed amendment tool
- I confirm that I have been formally authorised by the Sponsor to complete the amendment tool on their behalf

Name (first name and surname):*	Helen Brace
Email address:*	sponsorship@lancaster.ac.uk

Lock for submission

Please note: This button will only become available when all mandatory (*) fields have been completed. When the button is available, clicking it will generate a locked PDF copy of the completed amendment tool which must be included in the amendment submission. Please ensure that the amendment tool is completed correctly before locking it for submission.

Lock for submission

After locking the tool, proceed to submit the amendment online. The "Submission Guidance" tab provides further information about the next steps for the amendment.

Section 4: Review bodies for the amendment

Please note: This section is for **information only**. Details in this section will complete automatically based on the options selected in Sections 1 and 2.

	Review bodies																	
	UK wide:						England and Wales:				Scotland:				Northern Ireland:				
	REC	Competent Authority MHRA - Medicines	Competent Authority MHRA - Devices	ARSAC	Radiation Assurance	**UKSW Governance**	REC (MCA)	CAG	HMPPS	**HRA and HCRW Approval**	REC (AWIA)	PBPP	SPS (RAEC)	National coordinating function	HSC REC	HSC Data Guardians	Prisons	National coordinating function	Category:
Change 1:						(Y)				(Y)									C
Change 2:						(Y)				(Y)									C
Change 3:						(Y)				(Y)									A
Overall reviews for the amendment:																			
Full review:						N				N									
Notification only:						Y				Y									
Overall amendment type:	Non-substantial, no study-wide review required																		
Overall Category:	A																		

Appendix D

Amendment 3

Amendment Tool
v1.6 06 December 2021

For office use
QC: No

Section 1: Project information

Short project title*:	Autobiographical Memory-Based Intervention for Suicidality
IRAS project ID* (or REC reference if no IRAS project ID is available):	316697
Sponsor amendment reference number*:	NSA03
Sponsor amendment date* (enter as DD/MM/YY):	13 May 2024
Briefly summarise in lay language the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study. If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained (note: this field will adapt to the amount of text entered)*:	The current documents have removed references to CMHTs in all of the documents, replacing this with either the specific service name or refering to 'community-based mental health teams'. The reason for this change is that several of the secondary care community-based mental health teams within the NHS trust are not named as 'CMHTs' (for example, the Early Intervention in Psychosis team). However, we wish to recruit from these services. We have therefore updated the wording on the documents to reflect this.

Project type (select):	**Specific study**			
	Research tissue bank			
	Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?:	**Yes**		No	
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable? (select):	**NHS/HSC REC**			
	Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a **modified amendment** (i.e. a substantial amendment previously given an unfavourable opinion)?	Yes		**No**	
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?:	England	Wales	Scotland	Northern Ireland
	Yes	No	No	No
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?:	Yes		**No**	
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?:	Yes		**No**	
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?:	Yes		**No**	
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?:	Yes		**No**	
Did the study involve adults lacking capacity OR does the amendment introduce this?:	Yes		**No**	
Did the study involve access to confidential patient information outside the direct care team without consent OR does the amendment introduce this?:	Yes		**No**	
Did the study involve prisoners or young offenders who are in custody or supervised by the probation service OR does the amendment introduce this?:	Yes		**No**	
Did the study involve children OR does the amendment introduce this?:	Yes		**No**	
Did the study involve NHS/HSC organisations prior to this amendment?:	**Yes**		No	
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?:	Yes		**No**	
	England	Wales	Scotland	Northern Ireland
Lead nation for the study:	**Yes**	No	No	No
Which nations had participating NHS/HSC organisations prior to this amendment?	**Yes**	No	No	No
Which nations will have participating NHS/HSC organisations after this amendment?	**Yes**	No	No	No
Was this a "single site, self sponsored" study in England or Wales prior to this amendment?	**Yes**		No	

Section 2: Summary of change(s)

Please note: Each change being made as part of the amendment must be entered separately. For example, if an amendment to a clinical trial of an investigational medicinal product (CTIMP) involves an update to the Investigator's Brochure (IB), affecting the Reference Safety Information (RSI) and so the information documents to be given to participants, these should be entered into the Amendment Tool as three separate changes. A list of all possible changes is available on the "Glossary of Amendment Options" tab. To add another change, click the "Add another change" box.

Change 1				
Area of change (select)*:	Study Documents			
Specific change (select - only available when area of change is selected first)*:	Other minor change to study documents (e.g. information sheets, consent forms, questionnaires, letters) that can be implemented within existing resource in place at participating organisations - Please specify in the free text below			
Further information In particular, please describe why this change can be implemented within the existing resource in place at the participating organisations (free text - note that this field will adapt to the amount of text entered)*	The name CMHT has been replaced in all documents to reflect that we are recruiting from secondary care community-based mental health teams which do not specifically refer to themselves as 'CMHTs'. We have instead used 'community-based mental health team' or the specific service name.			
Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Remove all changes below	

Change 2				
Area of change (select)*:	Study Design			
Specific change (select - only available when area of change is selected first)*:	Inclusion/exclusion criteria - Minor change unlikely to affect safety or scientific value of study			
Further information (free text - note that this field will adapt to the amount of text entered):	A minor change to wording in the inclusion criteria, as detailed above to state 'Currently under the care of a community-based mental health team' rather than 'under the care of a CMHT'.			
Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Remove all changes below	

Change 3				
Area of change (select)*:	Study Documents			
Specific change (select - only available when area of change is selected first)*:	Protocol - Non-substantial changes (e.g. not affecting safety or the scientific value of the trial)			
Further information (free text - note that this field will adapt to the amount of text entered):	The protocol has also been updated to reflect the change in wording detailed above to community based mental health teams not CMHTs.			
Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Add another change	

Section 3: Declaration(s) and lock for submission

Declaration by the Sponsor or authorised delegate

- I confirm that the Sponsor takes responsibility for the completed amendment tool
- I confirm that I have been formally authorised by the Sponsor to complete the amendment tool on their behalf

Name [first name and surname]:	Helen Brace
Email address:	sponsorship@lancaster.ac.uk

Lock for submission

Please note: This button will only become available when all mandatory (*) fields have been completed. When the button is available, clicking it will generate a locked PDF copy of the completed amendment tool which must be included in the amendment submission. Please ensure that the amendment tool is completed correctly before locking it for submission.

Lock for submission

After locking the tool, proceed to submit the amendment online. The "Submission Guidance" tab provides further information about the next steps for the amendment.

Section 4: Review bodies for the amendment

Please note: This section is for **information only**. Details in this section will complete automatically based on the options selected in Sections 1 and 2.

	Review bodies																	
	UK wide:						England and Wales:				Scotland:				Northern Ireland:			
	REC	Competent Authority MHRA - Medicines	Competent Authority MHRA - Devices	ARSAC	Radiation Assurance	UKSW Governance	REC (WCA)	CAG	HMPPS	HRA and HCRW Approval	REC (AWA)	PBPP	SPS (RAEC)	National coordinating function	HSC REC	HSC Data Guardians	Prisons	National coordinating function	Category:
Change 1:						(Y)				(Y)									C
Change 2:						(Y)				(Y)									A
Change 3:						(Y)				(Y)									A
Overall reviews for the amendment:																			
Full review:						N				N									
Notification only:						Y				Y									
Overall amendment type:	Non-substantial, no study-wide review required																		
Overall Category:	A																		

Appendix E

Amendment 4

Amendment Tool
v1.6 06 December 2021

For office use
QC: No

Section 1: Project information

Short project title*:	Autobiographical Memory-Based Intervention for Suicidality
IRAS project ID* (or REC reference if no IRAS project ID is available):	316887
Sponsor amendment reference number*:	NSA05
Sponsor amendment date* (enter as DD/MM/YY):	26 June 2024
Briefly summarise in lay language the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study. If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained (note: this field will adapt to the amount of text entered)*:	We propose to extend the study duration to 31/10/2024. This is due to the recruitment period taking longer than originally planned. This extension will provide time for the intervention sessions to be completed and the data to be analysed.

Project type (select):	**Specific study**			
	Research tissue bank			
	Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?:	**Yes**		No	
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable? (select):	**NHS/HSC REC**			
	Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a **modified amendment** (i.e. a substantial amendment previously given an unfavourable opinion)?	Yes		**No**	
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?:	England	Wales	Scotland	Northern Ireland
	Yes	No	No	No
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?:	Yes		**No**	
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?:	Yes		**No**	
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?:	Yes		**No**	
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?:	Yes		**No**	
Did the study involve adults lacking capacity OR does the amendment introduce this?:	Yes		**No**	
Did the study involve access to confidential patient information outside the direct care team without consent OR does the amendment introduce this?:	Yes		**No**	
Did the study involve prisoners or young offenders who are in custody or supervised by the probation service OR does the amendment introduce this?:	Yes		**No**	
Did the study involve children OR does the amendment introduce this?:	Yes		**No**	
Did the study involve NHS/HSC organisations prior to this amendment?:	**Yes**		No	
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?:	Yes		**No**	
	England	Wales	Scotland	Northern Ireland
Lead nation for the study:	**Yes**	No	No	No
Which nations had participating NHS/HSC organisations prior to this amendment?	**Yes**	No	No	No
Which nations will have participating NHS/HSC organisations after this amendment?	**Yes**	No	No	No
Was this a "single site, self sponsored" study in England or Wales prior to this amendment?	**Yes**		No	

Section 2: Summary of change(s)

Please note: Each change being made as part of the amendment must be entered separately. For example, if an amendment to a clinical trial of an investigational medicinal product (CTIMP) involves an update to the Investigator's Brochure (IB), affecting the Reference Safety Information (RSI) and so the information documents to be given to participants, these should be entered into the Amendment Tool as three separate changes. A list of all possible changes is available on the "Glossary of Amendment Options" tab. To add another change, click the "Add another change" box.

Change 1				
Area of change (select)*:	Study Design			
Specific change (select - only available when area of change is selected first)*:	Extension to study duration that will not have any additional resource implications for participating organisations - Please specify in the free text below			
Further information In particular, please describe why this change can be implemented within the existing resource in place at the participating organisations (free text - note that this field will adapt to the amount of text entered)*	We would like to extend the study due to the recruitment period taking longer than planned. The extension will involve the secondary mental health care services providing rooms for additional weeks - however, this will involve a change to the timing of these rooms being provided (rather than an additional resource burden). Participating organisations will also continue to be informed and to support regarding any clinical changes or increases in risk, in accordance with the standard care they would offer within the service			
Applicability:	England	Wales	Scotland	Northern Ireland
Where are the participating NHS/HSC organisations located that will be affected by this change?*:	**Yes**	No	No	No
Will all participating NHS/HSC organisations be affected by this change, or only some? (**please note** that this answer may affect the categorisation for the change):	**All**		Some	
			Add another change	

Section 3: Declaration(s) and lock for submission

Declaration by the Sponsor or authorised delegate

- I confirm that the Sponsor takes responsibility for the completed amendment tool
- I confirm that I have been formally authorised by the Sponsor to complete the amendment tool on their behalf

Name [first name and surname]:	Helen Brace
Email address:	sponsorship@lancaster.ac.uk

Lock for submission

Please note: This button will only become available when all mandatory (*) fields have been completed. When the button is available, clicking it will generate a locked PDF copy of the completed amendment tool which must be included in the amendment submission. Please ensure that the amendment tool is completed correctly before locking it for submission.

Lock for submission

After locking the tool, proceed to submit the amendment online. The "Submission Guidance" tab provides further information about the next steps for the amendment.

Section 4: Review bodies for the amendment

Please note: This section is for **information only**. Details in this section will complete automatically based on the options selected in Sections 1 and 2.

	Review bodies																	
	UK wide:						England and Wales:				Scotland:				Northern Ireland:				
	REC	Competent Authority MHRA - Medicines	Competent Authority MHRA - Devices	ARSAC	Radiation Assurance	UKSW Governance	REC (MCA)	CAG	HMPPS	HRA and HCRW Approval	REC (AWA)	PBPP	SPS (RAEC)	National coordinating function	HSC REC	HSC Data Guardians	Prisons	National coordinating function	Category:
Change 1:						(Y)				(Y)									C
Overall reviews for the amendment:																			
Full review:						N				N									
Notification only:						Y				Y									
Overall amendment type:	Non-substantial, no study-wide review required																		

Overall Category:	C