Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

June 2024

Doctoral Thesis

A qualitative exploration of recovery from suicidality.

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Word Count

	Main Text	Appendices (inc. tables, references, abstract, footnotes and title pages)	Total
Thesis Abstract	226	-	226
Literature Review	8,000	9,510	17,510
Research Paper	7,901	6,868	14,769
Critical Appraisal	3,746	1,119	4,865
Ethics Section	4405	9,763	14,168
Total	24,278	27,260	51,538

Thesis Abstract

This thesis consists of two parts focusing on experiences of recovery from suicidality. The systematic literature review was a meta-ethnography containing fourteen qualitative papers relating to experiences of recovery from suicidality from a LGBTQ population. This review highlighted micro, meso, and macro level influences on recovery from suicidality, incorporating self-acceptance, connection to allies and communities, and a commitment to changing unhelpful societal narratives regarding LGBTQ communities. The review findings indicate the need for more qualitative research into the experiences of recovery from suicidality within this population.

The empirical paper explored the views of eight participants from the general population, who had previously experienced suicidal states but had experienced momentary reductions in suicidal states. Thematic Analysis was used to analyse the data from semi-structured interviews. Five overarching themes were developed, which were: (1) Recognising impact on others; (2) Interpersonal relationships; (3) Doing something different; (4) Leaving no room for suicide; and (5) Sense of self. Findings from this paper indicate that exits from suicidal states are accessible and important for the theoretical understanding of preventing suicide. Moments of transition out of suicidal states can be forgotten, therefore memory-based interventions may be helpful in recognising recovery factors and processes.

The critical appraisal contains a summary of the research, including strengths, limitations and clinical implications. It also provides personal reflections on the researcher’s journey throughout the research.

Declaration

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

Name: SOPHIE THOMAS

Date: 20th June 2024

Acknowledgements

Firstly, I would like to thank all participants who took part in this research. It felt a privilege to hear their stories and reflections, and I hope that I have served them well in the write up of this thesis.

Thank you to James Kelly, my research supervisor for this project. Your guidance and support have been immeasurable, and you have given me hope, inspiration, and the tools I needed to complete such a challenging thesis. Thank you to Lee Fitzpatrick and Peter Taylor, for your support and enthusiasm throughout this project. I would also like to thank Will Curvis for his unwavering support and time throughout the doctorate.

Thank-you to all my colleagues on the course. We have helped each other to get through some of the more difficult times, and you have provided laughter when it was needed most!

To my parents, thank you for always believing in me, for your love, care and support throughout my entire journey into clinical psychology. To my Nanny and Grandad, thank you also for always believing in me, for giving me lots of wonderful and positive thoughts, and for being my biggest fan. Thank you to my dog Crumpet, you have been beside me, giving me cuddles and love throughout the entire doctorate.

Finally, to my wife, Becca. Thank you for always being there, for your care, support and cups of tea! Thank you for your patience, belief and wonderful kindness and understanding. This project would not have been possible without you.

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Section One: Systematic Review

First-hand experiences of recovery from suicidality in LGBTQ populations: A meta-ethnography of qualitative research.

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Abstract

Introduction: LGBTQ communities are overrepresented in the suicide epidemic. Understanding recovery from suicidality is important to learn what may help others. This systematic literature review explored experiences of recovery from suicidality in LGBTQ populations.

Method: Fourteen studies were synthesised using meta-ethnography.

Results: Four themes highlighting key aspects of recovery from suicidality were Connection to Self; Connection to Allies; Connection to Community; and Connection to/Defiance against Society.

Conclusion: Findings suggest recovery from suicidality comes from micro-level influences: lack of internalised homophobia; realisation of identity and self-acceptance; meso-level influences: connection to allies and community; and macro-level factors: positive role-models and defiance.

(100/100)

Keywords: Suicide, LGBTQ, Recovery

Introduction

Suicide is a tragedy that occurs throughout the world, throughout the lifespan, and has long-lasting effects on the people left behind, with over 703,000 people taking their own life worldwide every year [1]. There are approximately 6,000 deaths by suicide per year in the UK [2], and it has been suggested that 33% of all adults will have suicidal thoughts at some time during their lives [3].

Whilst suicide impacts many people, LGBTQ[1] communities are overrepresented in the epidemic [7]. It has been consistently found throughout the literature that LGBTQ individuals are at an increased risk of mental health difficulties and suicidality when compared to their heterosexual or cisgender peers [8,9,10,11].

Suicidal ideation has been found to be approximately three times more prevalent in gay men compared to heterosexual men [12]. In the UK, 46% of transgender individuals, and 31% of LGBTQ individuals (who did not identify as transgender) reported suicidal ideation in the previous 12 months [13]. Suicidal rates among transgender individuals are considerably

[1] Throughout the literature, there are multiple definitions and ways of describing people who are gender and sexual minorities (GSM). People who identify as a sexual minority (i.e. lesbian, gay, bisexual, transgender, queer or questioning) are referred to using the acronym LGBTQ. GSM is an umbrella term that encompasses all individuals whose gender identity and/or sexual orientation fall outside of the cisgender (i.e. identifying with the sex assigned at birth), heterosexual majority [4]. Two-spirit individuals are defined as indigenous sexual and gender minority people [5]. Whilst there are many different expressions and terminologies used within the literature, for the purposes of this report, the umbrella acronym of LGBTQ is used for consistency. Inclusion of the 'Q' which refers to 'queer' felt pertinent, which refers to all gender and sexual identities that are non-binary or non-heterosexual, and which has been reclaimed by the LGBTQ community [6]. However, it is important to acknowledge that there are many identities and self-expressions that fall within the sexual and gender identity spectrum, and this report may not represent all of these within the LGBTQ acronym.

higher compared to the general population [14]. Gay, bisexual and two-spirit men are four times more likely to attempt suicide compared to heterosexual men [15].

It should be recognised that LGBTQ individuals may not be innately vulnerable to suicidality because of their sexual orientation or gender identity. Rather, the greater incidence of suicidality within LGBTQ populations could reflect the systemic inequalities that this group faces [16]. It is suggested that LGBTQ individuals are often impacted by the sociocultural factors that are associated with being a member of this community, and it is the traumatic experiences that increase the likelihood of suicide risk [17]. It is possible that generic models of causes of suicide do not consider specific factors faced by LGBTQ communities.

The minority stress theory

The minority stress model [18] suggests that people from a sexual minority background experience stressful events that are unique to this group, including anti-LGBTQ discrimination and stigma, and these stressors negatively impact mental and physical health [19]. The model suggests that these unique stressors are on a continuum from distal (such as discrimination and harassment) to proximal events (internalised cognitions). The internalisation of these events can cause expectations of rejection, homophobia, and transphobia, concealment of one's minority identity, and can impact pathways to suicide [20,21].

Empirical evidence has supported that minority stress can contribute to suicidality among transgender populations [22], and LGBTQ populations [23]. It has also been found that greater minority stress can be associated with lower suicide-related disclosure [24].

A study by Green, Price, and Dorison [25] found that greater experiences of minority stress are associated with increased risk of attempting suicide with LGBTQ young people.

Those who experienced four types of minority stress were 12 times more likely to attempt suicide than peers who had experienced none, suggesting that intersectionality has a compounding effect.

<u>The interpersonal theory of suicide</u>

The interpersonal theory of suicide [26] is useful to understand suicidal experiences. It is a generic model explaining suicide, whereas the model above is a generic model explaining stress for people within a minority group. The theory suggests that thwarted belongingness (a perception of lack of social interaction, caring relationships, and social support) and perceived burdensomeness (the belief that one is flawed and therefore they are a hindrance to others) both need to be present lead to a motivation to kill oneself. Therefore, if an individual does not feel a burden, or feels connected, they are not motivated to complete suicide.

The interpersonal theory of suicide may explain the specific experiences of people who identify as gay, lesbian, and transgender [27,28]. As such, connectedness may create a sense of belonging, which would therefore buffer against the risk of suicidal behaviour. However specific feelings of connectivity with a similar community, which holds shared worldviews and adversities specific to minority status, may be particularly relevant for this minority group [29,30]. The minority stress theory in combination with the interpersonal theory of suicide allows for a more detailed understanding of the causes of suicide, however, there remains a gap in knowledge about how LGBTQ individuals may move away from suicidal experiences.

Recovery Literature

One of the most widely cited definitions of recovery of mental illness is ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or

roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.' [31 p.15]. Recovery in suicidality remains a complex challenge to conceptualise. A Delphi study exploring definitions of recovery from people with lived experience of suicidality found the largest consensus was "being able to take part in life at your own pace and on your own terms rather than trying to live by standards set by society", highlighting the important of the individual defining their own recovery. [32 p.8,11].

It has been suggested that suicide predictions have remained relatively unchanged in the last 50 years [33], caused by a lack of models that demonstrate an understanding of the transition from suicidal thoughts and feelings to suicide attempts. Research has tended to focus on the causation of suicidality, rather than protective factors [12]. Despite the high prevalence of suicidality among LGBTQ individuals, the literature exploring the unique aspects of recovery from suicidality is limited, and LGBTQ groups have rarely been the focus of suicide prevention efforts [8].

However, research to date has found that key sources of resilience for transgender individuals are social support [34], community belonging [35], the ability to live authentically [36] and social connectedness [37]. Research has also highlighted how family support and acceptance can have a positive impact on the wellbeing of transgender youth and adults [38,39,40].

Furthermore, connectedness has been found to moderate the relationship between perceived stigma and suicidal behaviour [41]. Connectedness to the LGBTQ community, or a general sense of belonging with other sexual and gender minorities, has been shown to be associated with reduced psychological distress among marginalised communities [29, 42].

Savin-Williams [43] referred to a ‘suffering suicidal script’, which stressed LGBTQ unhappiness, suffering and death. However, literature has now started to caution against emphasising only the negative associations of LGBTQ identification [44]. Whilst there is limited research exploring how LGBTQ individuals resist the suicidal script in the context of suicidality research [41], it felt pertinent to explore literature that has done this.

Aims

This review will focus on first-hand experiences of recovery from suicidal experiences from people who identify as LGBTQ. By privileging the voices of LGBTQ individuals, it is hoped to offer further and more detailed insights into this phenomenon. To the author’s knowledge, there has been no review of the experiences of recovery from suicidality in LGBTQ adults.

It should be noted that within-group differences exist within the LGBTQ population, including differences in specific risk and protective factors for suicidality, due to the population being nonhomogeneous [45]. However, the aim of this review is to focus on the whole community. Due to the limited research data available in this area, it was believed there would not be enough data to conduct a review on a single subset of this group.

Materials and Methods

Search strategy

An initial scoping search was completed using Google Scholar and PsychINFO to assess the suitability of the review topic, allowing identification of previous literature reviews in this area. No existing literature reviews, or registered reviews on Prospero exploring recovery from suicidality within LGBTQ populations were found. A Prospero form was completed and accepted (REF: CRD42023487092).

A systematic literature search of six databases (PsycINFO; Web of Science; Academic Search Ultimate; Pubmed; Cinahl; and Socindex) was performed between 16th and 29th September 2022. Boolean methodology was used, based on the Medical Subject Heading (MeSH) system, or equivalent specific to each database. The search strategy was reviewed and discussed with a specialist librarian at Lancaster University. The search terms included key words relating to suicide; LGBTQ; and recovery (Appendix 1-A). A description of the numbers of results from each search can be seen in Appendix 1-B.

Inclusion criteria and systematic search

Inclusion and exclusion criteria for the review can be seen in Table 1.

Table 1. Inclusion and Exclusion Criteria

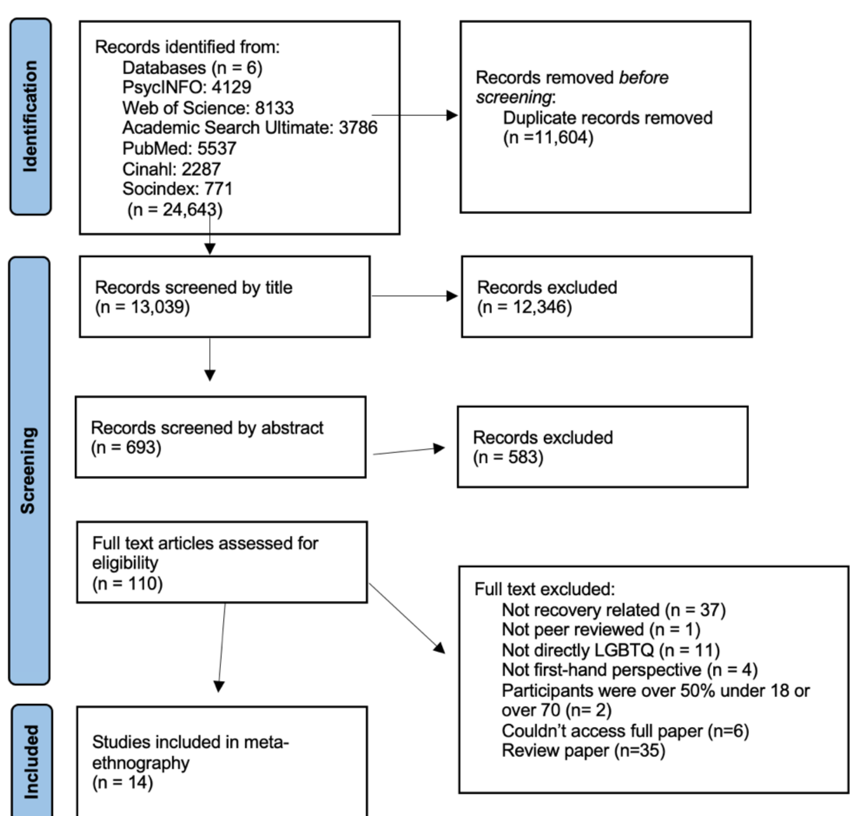
Inclusion Criteria	Exclusion Criteria
The study was qualitative	The study did not use a qualitative methodology, or used a mixed methodology
The study was published in the English language	Study participants were under the age of 18 or over the age of 70
The study was submitted in a peer-reviewed journal	Unpublished articles, conference papers, theses, dissertations, or systematic reviews
The study sample consisted of participants between the ages of 18 and 70	Studies that were not related to suicidality
The study sample consisted of participants who self-identified as being LGBTQ	Studies that did not include first-hand perspectives of participants
The study included information focused on recovery from suicidality	Studies that related specifically to school-based contexts
	Studies that were not relevant to LGBTQ populations
	Studies that were solely focused on risk factors for suicidality

Where studies used multiple ages of participants, over 50% of participants were required to be within the inclusion age range. All qualitative research designs were included. All studies were assessed using the inclusion and exclusion criteria, and only studies that met these requirements were included in this review.

Following the systematic search, the title of each paper was screened for relevance, including the methodology and presence of the topic of interest. Abstracts of papers were then screened, and following this the full text of the remaining papers were assessed for eligibility against the inclusion and exclusion criteria. Reference lists of the full text papers were also searched for additional relevant papers.

The PRISMA procedural steps are represented in a PRISMA diagram (Figure 1).

Figure 1. PRISMA Diagram



Data Extraction

Data included in this review was extracted using a standardised extraction form. The information extracted included: (1) the author(s) and year of publication; (2) location and setting of the study; (3) aims of the study; (4) study design and methodology; and (5) participant demographics and characteristics (including participants' self-defined sexuality). Data extraction and details of studies included for analysis can be seen in Appendix 1-C.

Critical appraisal of data

To quality assess the studies, including the validity of the results of the studies, the reviewer and an independent reviewer assessed the studies based on the Critical Appraisal

Skills Programme (CASP) qualitative checklist tool (Appendix 1-E). Responses from the two reviewers were collated at both a study and an outcome level.

The CASP has been described as a non-specific tool, which is used for a varied range of qualitative research approaches. As such, this tool may not provide a complete assessment of the quality of the research papers [46]. The CASP scores were therefore not used to include or exclude papers, but rather to understand the strengths and weaknesses of each paper.

Analysis and synthesis of data

Synthesising qualitative data has been described as bringing together findings on a particular topic based on published findings rather than primary data [47]. The approach of synthesising has been found to be appropriate for examining phenomena from first-hand perspectives of those impacted by the phenomena, and the surrounding context. It also considers the conclusions of those exploring the phenomena [48].

The method of synthesising the qualitative data was a meta-ethnography [49]. This was defined into 7 phases [50].

Phase 1: Identifying an area of interest.

The aim of this review was to explore first-hand experiences of LGBTQ populations on recovery from suicidality. A meta-ethnography was chosen to allow for a robust way of exploring participants' experiences and to develop an understanding of recovery from suicidality from their perspectives. The approach was deemed to be suitable as the researchers were interested in a theoretical understanding of a phenomenon [50]. This approach enabled retention of the context and meaning of both the original participants' and the authors' voices, which felt important whilst developing a new understanding [51].

Phase 2: Deciding what is relevant.

This phase included defining the focus of the review, locating relevant studies, deciding which studies to include and appraising the quality of those studies. It included defining the focus of the synthesis, which was first-hand experiences of recovery from suicidality within LGBTQ populations. As qualitative research in this area was under researched, all available qualitative studies were able to be included.

Phase 3: Reading the studies

This phase involved repeatedly re-reading the included studies and familiarising with key concepts. Raw data (quotes) and author interpretations were extracted from the studies using a standardised extraction form (Appendix 1-F). The data was extracted verbatim to avoid losing important data [52].

Phase 4: Determining how the studies are related.

This phase included considering the relationships between the key concepts of each paper, by creating a list of themes and creating new, relevant categories from these themes, whilst also considering the context surrounding each paper (see Appendix 1-G for an example of creating newly formed categories). This process resulted in the development of four original themes.

Phase 5: Translating the studies.

During this phase, concepts from each paper were compared to each other, highlighting the similarities and differences between each paper (Appendix 1-H).

Phase 6: Synthesising the translations.

During this phase, relationships between the themes were explored. Similarities and differences between the themes were examined, which led to the creation of a line of, argument synthesis, described as a 'whole' among a set of parts [49].

Phase 7: Expressing the synthesis.

This phase included using the eMERGE reporting guidance [53] to report on the findings.

Results

Four themes were identified throughout the fourteen studies. These were Connection to Self; Connection to Allies; Connection to Community; and Connection to and Defiance Against Society. Details of which studies contributed to each theme can be seen in Appendix 1-I.

Connection to self

This theme represented participants accepting their sexual/gender identity, a process that supported participants to recover from suicidality. Studies referred to the concealment of one's sexual identity as being linked to suicidality, [54,55,56,57], and therefore protective aspects to suicidality came from becoming themselves and living authentically. This theme described a process from realisation of one's identity, to accepting one's identity/sexuality/gender, to expressing, including 'coming out' and/or transitioning.

Several studies found suicidality reduced when a participant understood their identity [58,59,60]. Moody, Fuks, Peláez, and Smith [59] explored transgender individuals' experiences, and noted that upon realisation of their gender, one participant had a transformative experience: *"Grasping that the issue was gender identity and that something could be done about that has been transformative".* One participant stated: *"Now that I understand who I am, I don't want to think about not being here."*

Following the understanding of identity, studies noted that a lack of internalised homophobia, and a self-acceptance was protective against suicidality [58,59,61,62].

In a study [58] exploring the experience of gay males, one participant reflected *"I thought well fuck it I'm not going to be sorry for who I am, and the way I want to live… and I'm not going to make excuses for it, or come from that kind of position and I thought that it's not my responsibility for them to come to terms with it in a way it's up to them to that and they have a responsibility to do that…and I wasn't going to commiserate with them, I wasn't going to mourn with them."*

Diamond et al. [62] also found this within their study, which included participants with mixed sexualities: "*There is nothing wrong with me! Being gay is part of who I am",* and *"Being gay is the happiest thing in my life".* Some transgender participants found that this acceptance was a process, something they had to pursue rather than something that came naturally to them [61]. Despite this, some participants could move along this process towards acceptance, and this helped them in their recovery. For example, one participant stated *"I've found that being myself is what keeps me alive. If I'd given in and gone the way of making myself socially acceptable, it would have killed me […] For me, being this outsider is what kept me alive […] I suppose it's a way of self-love, but I think also self-actualisation."* Participants were able to achieve this through living authentically and making connections with others.

Studies described the 'coming out' process as an important step towards recovery from suicidality [55,58,59,60]. Participants found before disclosing, they experienced suicidal ideation and behaviour, however upon disclosing to meaningful others, this suicidality decreased, particularly if met with acceptance from others. One participant stated, *"how can I become myself if I'm dead?"* [59]. For one male, 'coming out' was aided by a local gay health organisation. The experience of acceptance of his sexuality helped to heal his

suicidality: *"Actually it was [local gay health organization] that really helped me to come out, that it was OK. It was, it felt, it was so much easier than I thought it was going to be. I was talking to a friend of mine a couple years ago, and he said, "why are you still here today?" and I said "because I know I'm gay." I said "the only reason I'm here is because I know I'm gay. I'm very proud of that. I'm happy with that."* [60].

The idea of safety was referenced in Marlin, Lewis and McLaren [56] where the process of expressing one's sexuality/gender identity to others was made easier by a sense of belonging or acceptance. As one participant stated *"Belonging would be feeling comfortable and accepted in a setting or group. And not feeling like you need to change who you are… Having that sense of security and safety."*

For studies that looked specifically at transgender populations [57,59,61], the process of transitioning was vital. As one participant stated *"Since my first physical changes and the start of my full-time life in my new identity, my suicidal ideation has disappeared. The happiness of being myself outweighs my suicidal thoughts."* [59]. Participants described becoming themselves "*makes every moment worth living for",* with the recognition that "*If I had not transitioned, I would probably not been able to break intensive cycles of suicidality and depression."* For many participants, the process of disclosing and expressing their true selves allowed them to connect with others, feel better about themselves and their bodies, and decreased the distress they were experiencing, which in turn led them away from suicidality.

This theme highlighted that understanding, accepting, and expressing one's sexual or gender identity was pertinent to living an authentic life and moving away from suicidality to escape distress.

Connection to Allies

This theme represented being accepted and supported by loved ones, and the positive impact this had on participants' suicidal experiences. This theme talked specifically about being supported by people who are not part of the LGBTQ community, but form allies to the cause. Participants found support from family members [55,57,58,59,61,62] and friends [55,58,59,62,63].

<u>Family support</u>

Despite high numbers of participants noting negative reactions from family members impacted their suicidality, some talked about straight family members who provided support, particularly parents. Caring family relationships were important, particularly when participants had difficult life events, and responsive support from parents could be lifesaving [57]. One participant noted their father accepting their sexuality as a gay male, although covertly stating this: *"I talked to my dad once before I came-out, when I was self-labelled and he was saying stuff like, why do people make such a big deal about your [lesbian] cousin, like you know if it was my child it would be fine, and stuff like that, I'm sure he was fishing for me to come-out, but I didn't, anyway that made me feel really cool*." [58]. This suggested that acceptance from others can bolster self-esteem and increase individuals' resilience to suicidality.

Similarly, participants were able to resist suicidal thoughts following positive relationships with their family: *"The only person in my life who actually made a difference was my sister."* [55]. Participants stated "*My mom had a talk with me and let me know good things…that she supported me. That it doesn't matter, she still loves me no matter what and that I'm still her child.*" [62], emphasising the importance of family support in protecting from suicidality.

Participants also reflected that this support could be learnt, and that a process of families growing was also healing for them [59]. One participant said: *"My dad totally changed. He went from being, you know, a father to now such a nurturing guy. Always, 'Whatever you need, talk to me.' Before, he was always like, 'Oh, you know, things will be okay.' He was the type of dad that joked around a lot and now he was always wanting to be there."* [55]. Furthermore, some participants spoke of the financial and practical support afforded by family, even if emotionally they did not feel supported, was crucial for resilience, to allow participants to navigate their own identities in a space of safety [58].

<u>Peer support</u>

Straight peer support acted as a protective factor against suicidality among some participants, due to the context of a heteronormative society, *"…the support of other gay people is really important, and supportive straight people too, because they are the people who aren't in the same boat as you, I think it was really important to tell straight people who I was and for them to accept me, I think that was really important because we live in a predominantly straight world."* [58]. Handlovsky et al. [63] found that developing and sustaining relationships with peers acted to anchor individuals to something other than their own struggles, which provided a sense of being cared for and unconditionally accepted, as discussed by one participant: *"Part of my wisdom is like 'well, you can never really kind of forget that you're depressed.' For me it just doesn't go away but I can mitigate it, I can ameliorate it, I can deal with it and, so one of the ways is just to make sure and continue to be actively involved with my friends."* For the men in this study, this value in friendships came from diminishing a sense of sadness, and alleviating loneliness. Positive relationships also provided support in a crisis, such as suicide attempts [63].

Furthermore, having positive relationships with heterosexual friends protected against the internalisations of stigma coming from the social environment [55].

The importance of peer support was often noted as one of the key forms of protection against suicidality: *"The fact that I have lots of really supportive friends and a number of friends with whom I have really meaningful relationships has made all the difference. Without this, I would for sure already be dead."* [59].

<u>Responsibility to others</u>

Some studies found that considering the impact of their potential suicide on loved ones served as a protective factor [59,63,64]. One participant described: *"I have too many family and friends who would be incredibly impacted by my death and why would I ever want to bring them such pain by just wanting to eliminate mine?"* [59]. Similarly, for one participant, taking on a caring role for his mother established a responsibility and diminished thoughts of suicide: *"I believe I'm here because I am taking care of my Mom. And that's what I do. I really don't have any time or the thoughts about suicide. And it's not an option because my Mom needs my help. I'm the kind of person that needs to feel needed. And if I feel needed, I'm happy."* [63]. This also came through in one study: *"If I die, how my mum can survive? I told myself that I should not think about it [suicide] anymore…my parents were getting old…I need to think about my families." [64]*

This theme highlighted the importance of heteronormative allies, particularly within family and friend networks. As the social context that we live in continues to be

heteronormative, being accepted and cared for by those not in the same minority group can serve to bolster self-esteem, challenge the internalisation of homophobia and transphobia, and ultimately protect against suicidality.

Connection to community

This theme represented the importance of finding peer support and connecting with people in the community. Peer support within this theme is conceptualised by finding, being supported by, and supporting other people who identify as LGBTQ [54,55,56,58,60,61,62,65,66,67], and is also about connecting to other people who have experienced suicidality [55,65]. Making positive associations with others who have also shared a stigmatised identity, and as such experiencing a sense of belonging, had a protective influence over suicidal feelings by creating a sense of collective identity [54].

For one participant, a turning point in their suicidality came from meeting an openly gay person: *“it was a pretty major thing at 16, um, and that was just really good meeting other young gay people, and we talked a lot, and I read a lot of books and got a lot of information that just wasn’t given to me, and that was just the turning point.”* [58]. For some participants, this sense of community came from being with others who were LGBTQ, *“Relationships are kind of universal in some ways, but only my gay and lesbian friends can understand it fully.”* [55]. For others, this came from being with others who had experienced suicidality, “*Only someone who’s tried suicide can really get it.”* [55].

This shared experience, the recognition that others have lived through similar difficulties and sharing knowledge was an important factor to reduce suicidality, that many

studies referenced. For example, Marlin et al. [56] noted *"If there aren't other people that have the same [experiences]…I just don't know how you can truly connect. I feel like you do need some people that belong, or that prescribe to the same tribe as you".* Similarly, Ferlatte et al. [66] noted *"I find one of the most useful things that I've done too, is like, talking with other people who have had similar experiences to me….it just feels like validating hearing somebody else talk about things. You're like, "I get that, too".*

Studies referenced the emotional benefit of having friendships with other LGBTQ people, and the level of safety that was created through these relationships, which allowed for resilience within individuals. Being with similar others allowed participants to be vulnerable and countered the feeling of 'otherness' that was common within the population [67]. For studies exploring men's perspectives, participants also discussed these relationships creating a dialogue to talk about mental health, facilitating help-seeking. For example, one participant commented *"Ask for help. Have an advocate. Peer navigation. People taking care of people. It's a gift. My need for help doesn't mean there is anything wrong with me. It actually means we're in a help and healing process together."* [65]. Connection to community allowed for sharing and the ability to learn from each other, which was mutually beneficial: *"There is nothing so therapeutic as one person going through one thing, helping someone going through the same thing."* [55]. This idea of learning was also seen, where participants spoke of learning about sexual education and LGBTQ issues [58].

For some, this social network of similar others was invaluable to their recovery and was necessary due to their own family and friends not accepting their sexuality or gender identity. As Williams et al. [55] found, having a social network where participants could be

"accepted me for who I was without thinking that I was not worth being alive" was pertinent to their recovery.

Studies also explored the ways in which communities came together, including formalised and informal groups. Some studies recognised the importance of professional support groups encouraging normalisation of a "*gay identity"* and led to people feeling "*very comfortable coming out to these guys."* [60]. However, others recognised that peers provided more trust than professionals, *"What I really needed was someone I can emotionally depend on or trust. So I think friends and family is better than a counsellor."* [66].

This theme highlighted the value of being with others who have shared similar experiences, both within LGBTQ communities, and others who have experienced suicidality. Participants felt heard, validated, and expanded their learning. Having access to supportive communities enabled individuals to feel safe to express themselves, to learn to seek help, and to feel less isolated.

Connection to and defiance against society

It was evidenced throughout most of the studies, that participants believed homophobia, biphobia, and marginalisation of LGBTQ was related to suicidal experiences [54,55,56,58,59,60,62,63,65,66,67], and therefore needed to be addressed to prevent suicide among LGBTQ populations. As such, this theme centred around participants who had a desire to change societal narratives and discrimination about LGBTQ populations. This came through in two ways; a sense of defiance against societal beliefs [59,65,66,67] and through becoming a positive role model to others [55,58,59,63,66].

The sense of defiance and collective action that LGBTQ groups created to go against the negative values held by society was seen across multiple studies. This was particularly

relevant where sexual minority women spoke about reclaiming resilience by gathering marginalised groups to contest their subordination: *"I think queer women rock, we're the hell raisers, the no-shit takers, and we're figuring it out. The patriarchy we don't even need it."* [67]. Defiance and refusing the identity of a victim helped participants to move away from suicidality, as evidenced by one participant: *"I feel like the only reason I'm alive today – is in a sense that defiance."* [67].

Similarly, some men believed marginalisation needed to be addressed to prevent suicide, and this could be done through *"creating community awareness"* [66]. Participants reflected on campaigns they had witnessed to do this: *"Probably the only student ever in our senior high to be openly gay, and he started this thing called the pink shirt campaign where people supporting would wear a pink shirt and say that gay is ok…so I think that was huge just because there was nothing like that."* This quote illustrates the acts of defiance, of going against the system to effect change [66].

Defiance also came in the context of challenging stereotypes about mental health: *"Teaching people that there is no stigma, that mental health is no different than a sore foot or bad kidneys…teaching people that they can and should talk about it; that they can approach other people. It's the shame; getting rid of the shame is a big part of it, and somehow communicating that to the populous, that you can."* [66].

Similarly, participants spoke of holding in mind the abuse and discrimination they had faced in relation to their gender identity and using defiance to step back from suicidal thoughts: *"If I want to kill myself, or whenever I am severely depressed, I kick my own butt, especially if I'm thinking back on the abuse or trans bashings. If I live in fear, pain or equivalent, then the perpetrators may as well still be right there crushing me. I deserve better than just surviving to live trapped in past horror memories. So I find it in me to*

trust others again, love my family unconditionally (without that costing me self-dignity and respect) and aim for an even better tomorrow." [59].

Communities coming together to advocate for their needs and facilitate recovery was also seen, where participants spoke about their collective efforts during the AIDS crisis: *"when the really deep rationality of it was how community came together in the face of any crisis, but certainly the AIDS crisis, and we made it up. In doing so, we had meaning, purpose and belonging. Which induced health, which included a sense of mobilisation."* Participants recognised the powerful protective process of coming together and transcending discrimination, and how this allowed healing from suicidality [65].

Several studies acknowledged that becoming a positive role model to others in the community was a protective factor. Participants reported being known and respected in the trans community created a reason for not acting on their suicidal ideation: *"A reason not to kill myself that is specific to being queer and trans is that I've seen the impact of queer and/or trans people killing themselves on the people they've left behind. And I know that there can be ripple effects or copy-cat effects. For me, given my network of relationships, given that I've been told by trans folks that they see me as a role model, and as I play a leadership role in the trans communities, I have a responsibility to others to model good self-care. I cannot steal other people's hope, and I wouldn't want to take others with me by killing myself!"* [59].

Participants also highlighted that their wish to change the world and create social change that would benefit themselves and others in their community, stops them from acting on suicidal thoughts: *"My GI [gender identity] is the reason that I experience such oppression and social marginalisation. So it's mostly the reason that I think about suicide. But knowing that dead trans folk cannot change the world keeps me from doing it. That and*

knowing that, with the amount of privilege I have, I would do my trans brethren a great disservice to end my life and not exercise my access to resources for social change." [59].

Helping others was also seen where participants felt that being a voice for those whom society had silenced, kept them alive: *"If just one person hears me say that this day will pass – and the next day it will be better – if just one person hears that, that's all that matters."* Participants wanted to be "*open about my experiences with mental health because I think it has been so stigmatised and it's so misunderstood"* to provide validation and destigmatisation to others within their community [55]. Similarly, contributing to the lives of others helped men to embody a supportive role they had wished from others, which created a desire to stay alive: *"I think in terms of my coping or resilience with some of the more challenging times in life…making a difference and mattering in the world…when I feel like I'm making a difference or mattering is when I'm engaged in some form of relief of suffering. Almost everything I do is centred in that in some way."* The support they offered allowed them to rewrite narratives held by society regarding help-seeking, particularly for mental health challenges within men [63].

Positive mass media representations also helped to refute negative stereotypes of LGBTQ people: *"I knew there were stable gay people out there who lead full on lifestyles, and that they could be out and happy, and live like that and not be closeted…like it provides you with an option, and, and um, a role model that you know, that there is something out there that you can live that lifestyle…"* [58]. This was pertinent within this study where participants in rural settings struggled to receive positive information about minority sexualities.

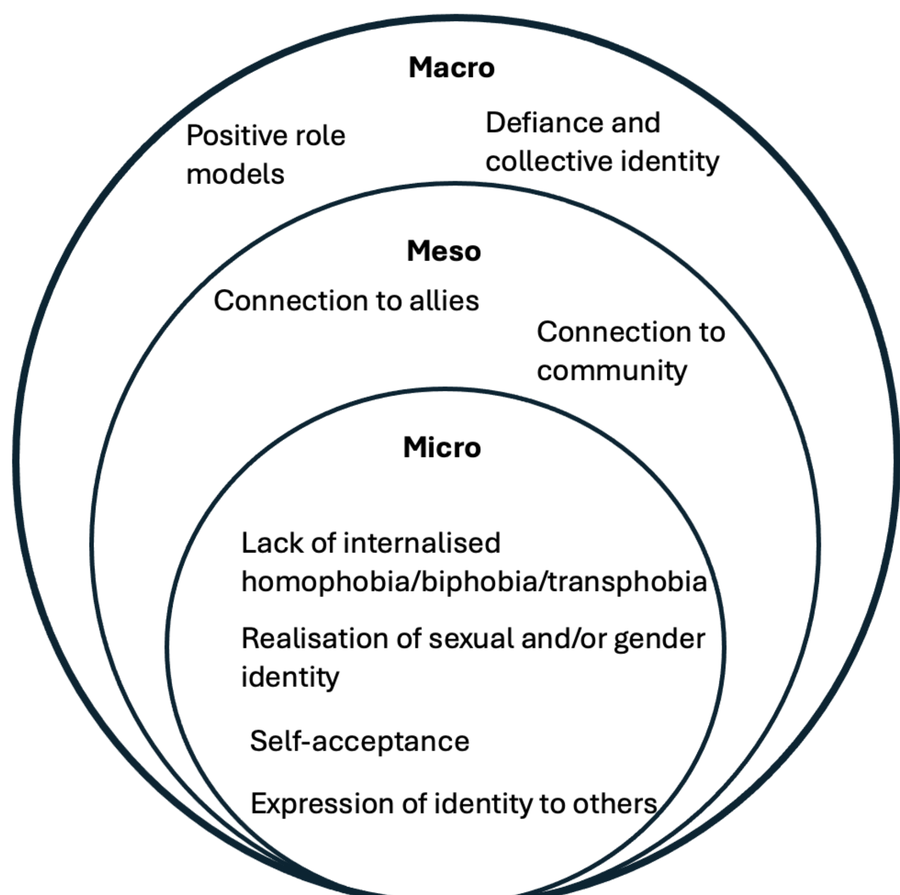
This theme highlighted the role of negative societal views on suicidality. Acts of defiance against gender and sexual stereotypes served as a rejection of harmful attitudes in

society, giving an alternative identity to a victim, and protecting against internalisation and self-hatred [65,67]. Becoming a positive role model and giving a voice to the silenced was pertinent for some individuals, whereby there were able to be the support they did not have; and provide guidance and support to those suffering.

Line of argument synthesis

As the studies included in this review identify different aspects of the topic, ideas were drawn together in a new interpretation, creating a line of argument synthesis [68], represented in Figure 2. The structure of this was influenced by Bronfenbrenner's ecological model [69], which suggests that interconnected systems make up an individuals' environment, and that all systems interact to influence. Throughout all levels, safety was seen as an influential contextual factor, described by one participant: *"safety is the most major aspect for me … It's certainly, definitely, physical literal safety, [knowing that] violence isn't going to happen to you, and then a certain level of … emotional and relationship security and understanding … I suppose that's a base level, or maybe even a prerequisite for belonging is safety."* [56].

Figure 2. A visual representation of level of influences on recovery from suicidality.



Micro level influences

From the data, the experience of internalised homophobia or transphobia may impact individuals' sense of themselves and thus impact their suicidality. This review found a lack of internalised homophobia was protective against suicidality, a sense of self-acceptance allowed individuals to express themselves and live authentically.

Meso level influences

Relationships form an important part of individuals' experience of suicidality. For some, support came from friends and families who were seen as allies, those who accepted and did not discriminate. For others, this came from a sense of community with others who

share experiences of both LGBTQ issues and suicidal experiences. How an individual interacts with communities may be important in its impact on social identity formation [70]. If individuals feel connected to and accepted by their community, suicidality is reduced.

Macro level influences

The data suggests societal norms may inform each level – from assumptions around sexuality, to the visibility of LGBTQ people, to the knowledge and acceptance around various sexualities and gender identities, and as a suicide survivor identity. Broader power structures and intersectionality issues such as homophobia and stigma around mental health, as well as many other forms of discrimination can all have influence over recovering from suicidal experiences.

Discussion

The aim of this synthesis was to explore the experiences of recovery from suicidality within LGBTQ populations. The findings of this review provide an insight into how individuals within an LGBTQ community understand their experiences of recovery from suicidality.

This review is the first to consider first-hand perspectives of suicide recovery factors within this population, synthesising fourteen studies, using a meta-ethnography approach. Four themes were developed: (1) Connection to self; (2) Connection to Allies; (3) Connection to Community; and (4) Connection to and Defiance against Society. As these themes were created based on the primary data rather than prior knowledge of the topic area, it is believed the review is true to the meta-ethnographic method.

The theme of 'connection to self' highlighted the value of understanding, accepting and expressing one's sexual or gender identity, and the ability to do this serving to support individuals to recover from suicidality. Studies highlighted that lack of self-

acceptance due to internalisation of stigmatised attitudes can lead to suicidality, linking with the minority stress model [18]. Studies referenced the importance of understanding one's identity [58,59,60], and having transformative experiences based on the realisation of one's sexuality [59]. Participants found ways to accept themselves through living authentically and making close connections to others [61], linking with research suggesting concealment of one's identity is associated with suicidal experiences [20,21], and that living authentically can lead to recovery from suicidality [36]. Furthermore, acceptance from others when expressing sexual identity was made easier by a sense of safety [56].

The theme of 'connection to allies' suggested the importance of having non-LGBTQ support networks, particularly within friends and family systems. Support from non-LGBTQ others may help to limit internalisation of homophobia and transphobia, bolster self-esteem and self-acceptance, and ultimately protect against suicidality. Studies spoke of the life-saving effect of support from parents [57]. For some, this acceptance and support was always there from families [58]. For others, acceptance of their child's sexuality came with time and through learning [55]. Support from peers allowed individuals to anchor themselves to something other than their own struggles [63], created meaningful relationships [59], alleviated loneliness, and created someone to turn to in a crisis [63]. Taking on a caring role and having responsibility for others also acted as a protective factor [63,64]. The value of social support [34] and social connectedness [37] has also been shown within the literature.

The theme of 'connection to community' highlighted the value of being around others who had experienced something similar, both within LGBTQ issues and experiences of suicidality. Having access to these communities allowed participants to gain a sense of acceptance and safety and created a less isolating experience. Communities offered

important information and guidance, such as safe sex education, and enabled participants to have a voice. There was a sense of a collective identity [54], a sense of connection [56], and of feeling immediately accepted by others [60] within the community. A sense of mutual benefit was discussed as being an important factor [55], that individuals were able to help as well as be helped. This also connects to other research which suggests that community belonging plays an important role in recovery from suicidality [35].

Whilst peer support was seen throughout both theme 2 and theme 3, the former referenced peer support in relation to feeling a sense of acceptance and tolerance from straight allies, something which was important within a heteronormative society. Alternatively, theme 3 conceptualised peer support as a sense of collective identity and a feeling of belonging.

The final theme of 'connection to and defiance against society' highlighted the sense of defiance, and non-conforming to oppression and discrimination that was often experienced by LGBTQ participants. Individuals challenged stigma and created awareness [66], coming together to advocate for their rights, and campaigning for a better future [65]. This theme suggested that becoming a positive role model and providing a voice to the silenced [55] allowed individuals to become the support they did not have [66]. Positive representations of LGBTQ individuals in the media also provided a sense of community and alleviated feelings of isolation [61].

Ideas from this review were discussed in relation to level of influences, including micro-level such as internalised heterosexism; realisation of sexual and/or gender identity; self-acceptance and expression of identity. Meso-level influences included connection to community and allies. Macro-level influences included having and being a positive role model and creating defiance through collective action.

Findings from this review map onto Joiner's interpersonal theory [26] by suggesting that connection to others and a sense of acceptance of oneself is protective against suicidality, however there may be other more distinct processes involved with LGBTQ population, and connection to others who have experienced similar adversities may be particularly relevant [29,30].

Strengths and Limitations

A key strength of this research is that it contains first-hand perspectives of individuals, something which has not been shown within a systematic review previously. It is the hope that the findings from this review enhance interactions between clinicians and participants, by understanding the participants' perspectives [71].

As this meta-ethnography was conducted by one researcher, it is possible interpretations could be biased. However, quotes from participants were used verbatim, as well as author interpretations to try and mitigate against this.

A framework was not used to create inclusion and exclusion criteria for the review. Using a framework such as the SPIDER framework, particularly the phenomenon of interest criterion may have encouraged a more explicit understanding of 'recovery'.

A further limitation is that only three of the included studies included transgender participants. Furthermore, most participants were from Western countries, where understanding, acceptance and societal values may differ from non-Western countries. Although the aim of a meta-ethnography is to find theoretical concepts [70], the findings of this review are limited to those interviewed within the studies, therefore further research is needed to expand on these findings.

Implications and Future Research

Findings may provide a useful map for clinicians and individuals considering the various influences for the journey of recovering from suicidality within LGBTQ populations. The review suggests that the presence of internalised negative beliefs about oneself may play an important role in suicide risk, and that self-acceptance is a protective factor. This links with Baumeister's 'escape from self' theory [72], which suggests that suicide is driven by a desire to escape oneself. Guidelines from the American Psychological Society [73] for psychological interventions with LGBTQ individuals suggest improving self-acceptance by creating supportive, bias-free environments to explore relevant issues. It has been suggested that helping LGBTQ individuals to explore their sexuality, how it relates to their social context, challenging internalised heterosexism, supporting to connect with others with similar experiences can all increase self-acceptance [74].

The importance of connecting with allies; family and friends was important throughout this review, and links with the theoretical importance of interpersonal connection to suicide [26]. Significant others may be a valuable resource for suicidal individuals, therefore working therapeutically with family and friends to support them to be accepting, supportive and caring may help, particularly as those closest to the individual are often best placed to identify when the person is in crisis [75]. Mental health services in the UK often support individuals on a 1:1 basis, however, is has been suggested that supporting the system around the individual can help to aid recovery [31]. Studies have evidenced the benefits of family interventions and involving others in all stages of recovery [76,77,78,79].

As the theme of connection to others who are part of the LGBTQ population was important for many participants, services that are open about clinicians being allies and/or part of the LGBTQ community could be advantageous. A club to provide a safe space for

LGBTQ individuals struggling with their mental health was created in the US, which was found to increase social support, reduce the probably of a psychiatric admission, and demonstrated organisational acceptance of the minority group [80].

It is important for services to be sensitive and aware of the unique needs of LGBTQ individuals [81]. This could create a sense of safety for service users and encourage help-seeking within professional services. Interventions could focus on support groups and creating connections for individuals within a community, demonstrated by Ferlatte et al. [66], where participants mentioned specifically organised groups for LGBTQ communities offering social connectedness, a sense of belonging and feelings of safety.

It is important for mental health professionals to have an awareness of when LGBTQ issues should be the focus of clinical work, as well as having an awareness of LGBTQ issues [82]. Preliminary findings within 'affirmative therapy' are promising to combat the effects of minority stress [83]. It has been found that LGBTQ-affirmative interventions using cognitive behavioural strategies can support LGBTQ individuals to develop awareness of minority stress effects and can improve wellbeing [84].

This review suggests that richer representations of LGBTQ identities in the public domain would be beneficial. Societal changes such as government policy focusing on reducing stigma is needed [85,86]. Furthermore, talking to others who were suicidal was not perceived as stigmatising, compared to professional therapeutic environments [66]. Therefore, training staff within healthcare services around how to connect with and provide support to those experiencing suicidality could support individuals from all levels and provide more opportunities to intervene.

This review highlights the need for research into experiences of recovery from suicidality in LGBTQ populations to contribute to the limited literature base. It has been

suggested that suicide research needs to move away from traditional risk factors and look towards the complexities of suicide [87]. Future research could investigate the influence of self-acceptance of sexuality, the impact of community groups, and training within healthcare professions. Future research could also explore distinct groups within LGBTQ communities, and other identities that are under-represented currently, to reveal differences between these groups.

Overall, this review highlighted that research regarding LGBTQ perspectives on recovery from suicidality is currently limited. Further exploration of experiences needs and views of this group is required. Focusing on recovery can create a better understanding of the risk factors for suicide, to help to develop services and interventions that are recovery focused [31].

Conclusion

The present meta-ethnographic review synthesised qualitative research exploring the experience of recovery from suicidality within LGBTQ populations. Overall, this review highlights micro, meso, and macro level influences on recovery from suicidality, which incorporate feelings of self-acceptance; connection to allies and communities; and a commitment to changing societal narratives. Further research can examine these processes further and may include specific groups within the LGBTQ umbrella to offer further distinctions to this group.

Declaration of Interest Statement

The authors report there are no competing interests to declare.

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Appendices

Appendix 1-A: Search Terms.

LGBTQ: lesbian*; gay*; bisexual*; pansexual*; transgender*; queer*; questioning; intersex*; asexual*; two spirit; LGB*; transsexual*; homosexual*; gender minority; gender queer; gender variant; trans gender; trans sexual; trans-gender; trans-sexual; trans*; abro; allo; aro; gender fluid; gender dysphoria; gender identity; coming out; came out; gender reassign; non binary

Suicide: suicid*; self murder; death desire; suicidal thought; suicidal attempt; suicidal feeling; suicidal act; suicidal behaviour; suicidal hope; suicidal death

Recovery: Recover*; protect*; recuperate*; convale*; overcome*; overcame; buffer; rehab*; psychotherapeutic outcomes; remission; therapeutic processes.

Appendix 1-B. Search Dates and Results.

Database	Searched date	Yielded results
PsychINFO	16th September 2022	4129
Web of Science	29th September 2022	8133
Academic Search Ultimate	16th September 2022	3786
PubMed	16th September 2022	5537
Cinahl	16th September 2022	2287
Socindex	16th September 2022	771

Appendix 1-C: Details of studies included for analysis.

Study	Country	Study Aim	Sample	Data Collection Method	Type of Qualitative Analysis Used
Fenaughty & Harré, 2003	Australia/New Zealand	To gain further insight into the factors that may buffer L/B/G youth from suicidality.	8 participants; males; gay; ages 18-23	Semi-structured interviews	Grounded Theory
Ferlatte et al. 2019	Canada	To explore perspectives on GBTSM suicide to inform targeted programs and policies to prevent suicide in their communities.	29 participants; males; gay, bisexual and two-spirit; ages 23-71	Semi-structured interviews and photovoice interviews	Thematic Analysis
Moody, Fuks, Peláez, & Smith, 2015	Canada	To provide an in-depth investigation into suicide protective factors among transgender adults.	133 participants; mixed gender, transgender; ages 18-75	Online interviews	Thematic Analysis
Gaveras, Fabbre, Gillani & Sloan, 2021	USA	To answer the following questions: How do trans older adults contextualise and ascribe meaning to their past experiences of suicidal behaviour? How do these contextualisation's and meanings enhance understanding of resilience strategies and long-term recovery?	14 participants; mixed gender; transgender; ages 50-79	Interviews	Narrative and thematic analysis

Handlovsky et al. 2022	Canada	To adopt a strengths-based approach to address the research question what are the social processes underpinning the survival of gay men living with a history of suicidality post HIV diagnosis?	22 participants; males; gay; ages 24-71	Interviews and photovoice interviews.	Grounded Theory
Creighton et al., 2019	Canada	To explore sexual minority women's experience of childhood trauma and suicidality.	11 participants; females; mixed sexualities; ages 19-37	Semi-structured interviews and photovoice interviews.	Constant comparative methods
Williams, Frey, Stage, and Cerel, 2018	Unknown	To understand the unique experiences of surviving a suicide attempt as a GSM.	25 participants; mixed gender; mixed sexualities; ages 19-59	Interviews taken from the Live Through This advocacy project.	Hermeneutical Phenomenological Approach
Salway and Gesink, 2018	Unknown	To expand the collection of narratives used to understand the health inequality of gay men.	7 participants; males; gay; ages 30-74	Interviews	Dialogical Narrative Analysis
Rivers, Gonzalez, Nodin, Peel, & Tyler, 2018	England	To understand how LGBT individuals with a history of suicide attempts narrate and make sense of their experiences in early life.	17 participants; mixed gender; mixed sexualities; ages 26-52	Semi-structured interviews	Thematic Analysis

Diamond et al., 2011	USA	To capture adolescents' own perspective regarding the factors implicated in their psychological distress. To better understand how youth conceived the causes of their depression/suicidal ideation.	10 participants; mixed gender; mixed sexualities; ages 15-19	Semi-structured interviews.	Consensual Qualitative Research Approach
Handlovsky, Bungay, Oliffe, and Johnson, 2018	Canada	To explore how middle-aged and older gay men developed resilience over the life course to promote health and wellness.	25 participants; males; gay; ages 40-76	Conversational interviews	Grounded Theory
Li, Tucker, Holroyd, Zhang and Jiang, 2017	China	To examine the psychosocial context immediately following new diagnoses of HIV among men who have sex with men.	31 participants; males; mixed sexualities; ages 18-40	Interviews	Thematic Analysis
Marlin, Lewis, & McLaren, 2022	Australia	To explore how belonging is understood and experienced within the rural context and the behaviours adopted in response.	11 participants; mixed genders; mixed sexualities; ages 19-30	Interviews	Thematic Analysis
Hunt, Morrow, & McGuire, 2020	USA; Canada; Ireland	To develop understanding around the experience of suicide in transgender youth	85 participants; mixed genders; transgender and mixed sexualities; ages 15-26	Interviews	Qualitative Content Analysis

Appendix 1-D: Questions contained within the CASP qualitative checklist.

Question (Q)
Q1: Was there a clear statement of the aims of the research?
Q2: Is a qualitative methodology appropriate?
Q3: Was the research design appropriate to address the aims of the research?
Q4: Was the recruitment strategy appropriate to the aims of the research?
Q5: Was the data collected in a way that addressed the research issue?
Q6: Has the relationship between researcher and participants been adequately considered?
Q7: Have ethical issues been taken into consideration?
Q8: Was the data analysis sufficiently rigorous?
Q9: Is there a clear statement of findings?
Q10: How valuable is the research?

Appendix 1-E. Full CASP Scores

Paper	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Fenaughty & Harré, 2003	Yes	Yes	Yes	Can't tell	Yes	No	Can't tell	No	Can't tell	Yes
Ferlatte et al. 2019	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Yes	Yes
Moody, Fuks, Peláez, & Smith, 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gaveras, Fabbre, Gillani & Sloan, 2021	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Handlovsky et al. 2022	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes
Creighton et al., 2019	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes
Williams, Frey, Stage, and Cerel, 2018	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Salway and Gesink, 2018	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Rivers, Gonzalez, Nodin, Peel, & Tyler, 2018	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes	Yes	Yes
Diamond et al., 2011	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Yes
Handlovsky, Bungay, Oliffe, and Johnson, 2018	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes

Li, Tucker, Holroyd, Zhang and Jihang, 2017	Yes	Can't tell	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Marlin, Lewis, & McLaren, 2022	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes
Hunt, Morrow, & McGuire, 2020	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	Yes	Yes

Appendix 1-F. Example of a Data Extraction Table (Fenaughty & Harré, 2003)

Themes (key concepts)	Participant quotes (first order constructs)	Primary author interpretations (second order constructs)	Third order constructs
Positive L/B/G Stereotypes and Representations	"I knew there were stable gay people out there who lead full on lifestyles, and that they could be out and happy, and live like that and not be closeted…like it provides you with an option, and, and um, a role model that you know, that there is something out there that you can live that lifestyle…"	Many L/B/G young people may also find positive role models in people that are part of their everyday lives. Tim detailed how his straight brother's friendship with an openly gay man helped reduce his own feelings of social isolation and how important it was to be shown the possibility of a gay man living a happy, fulfilling life.	Positive gay role models = show possibility of being happy and reduce feelings of isolation

Positive L/B/G Stereotypes and Representations	"Irirangi Taekiawa, he's like a really awesome, he was like the best, the bombast, um Taiaha, he was really really awesome...he's like, the man at doing Taiaha, and Patu and everything, and that he wasn't quite straight, so he was a really big role model...And because he's kind of like, he's kind of in my tribe king of thing, he definitely is a big idle of mine...especially being Maori. He's Maori, and he was queer, and he was the bomb at doing this and I really appreciate that he came-out just before he died."	Carl's testimony impresses how necessary role models of the same ethnicity can be to L/G/B youth. Such role models may provide points to identify with that are consistent with their cultural identities as well as their L/B/G identities.	Positive cultural role models as well as gay role models.
Positive Family Acceptance	"I talked to my dad once before I came-out, when I was self-labelled and he was saying stuff like, why do people make such a big deal about your [lesbian] cousin, like you know if it was my child it would be fine, and stuff like that, I'm sure he was fishing for me to come-out, but I didn't, anyway that made me feel really cool."	Even straight family members can affirm homosexuality when they convey through their own behaviour and relationships that being L/B/G is a positive valid existence. Leon's father took him to the "coming-out day parade" to support family members who were marching. Such support may increase resiliency by bolstering the self-esteem of closeted L/B/G youth	Confirming LGB is a valid existence = increases resiliency by bolstering self-esteem

Positive Family Acceptance	"my parents had a hard time dealing with you, you know, but you hear stories and see examples of people who, um, don't have any of that support, quite the opposite they're thrown out, like people with really strong religious backgrounds who are up against brick wall, whereas I had something to work with my parents, they've always been supportive even if they've been a bit difficult at times, and I can't imagine what it would be like otherwise, I mean it would just make you so much more alone, you'd have to be doing so much more by yourself"	Even if unhappy with the situation, parents who do not physically reject their children can also be crucial for resiliency. Just being financially supported at home – as opposed to being "kicked out" – circumvents the stress of having to find a means and place to live. Tim's account shows that even when parents are not comfortable with their son or daughter's L/B/G-disclosure, they may still play important roles in resiliency by maintaining their children while they initially navigate the coming-out process and (re)establish their identities.	Not being physically alone – importance of practical support

Positive Family Acceptance	"I left my Kura Kaupapa, and I went to Kaha (name changed) high school, and there they're not too full on with being Maori, and I was king of a really…I was like top of the class, and they'd throw me into everything that I didn't get the chance to do when I was a Kura Kaupapa. Like I'd do everything and they were so proud of me, and…even with Kapahaka and everything, I was, they'd always back me up and say you're so on to it, and stuff like that. It was just never an issue at this school that I was queer and I loved it…Seventh form that was really awesome, I was kind of, like a Maori role model for all of our younger kids in the school, and they all knew I was queer and they were all really awesome about it, and that's why I'm glad I didn't commit suicide because, um…I can't imagine my life being better than when I was in sixth and seventh form."	As adult caregivers usually have more influence than young people, they can often use that power to engender the necessary changes that their child alone would be unable to accomplish. For example, caregivers may be prepared to talk to educational authorities about school bullying or may be willing to relocate their child to a more supportive school. Carl's account example demonstrates that such parental support in changing schools can help bolster resiliency, turning a suicidal teen into someone who could not seem to be more satisfied with life. Carl's account demonstrated that such support during coming-out has the potential to turn alienated suicidal youths into resilient individuals, characterised by renewed confidence and high self-esteem.	Parental power can influence support, bolstering resiliency and creating satisfaction

School and Peer Support	"…the support of other gay people is really important, and supportive straight people too, because they are the people who aren't in the same boat as you, I think it was really important to tell straight people who I was and for them to accept me, I think that was really important because we live in a predominantly straight world."	Sam indicated that straight peer support, may act as a protective factor.	Importance of allies.

Appendix 1-G. Example of creating newly formed categories

Belonging/connection to community
Shared experiences – being with people who understand

- Safety; not being isolated; shared experiences

Fenaughty (2003)

- L/G/B Support network participation
    - Sense of shared experience
    - LGB friendships = find solutions, gain knowledge, normalise experiences
    - STI education

Ferlatte (2019)
De-isolation through peer support and community connection

- Exchanging stories with those who understand
- Peers with similar experiences are more trusted
- Support groups = less power differential than one:one
- Connected to GBTSM community = increased knowledge and social connectedness

Gaveras (2021)
A turning point

- Developing an expanding social network in trans community

Possible paths:
Community engagement

Creighton (2019)
Reconstruction and reclaiming resilience

- Building social networks – particularly with other sexual minority women

Williams (2018)
The social environment – general social support

- Finding social networks they could "fit in"
- Does not encourage changing who they are – acceptance
- Safety to be open and vulnerable
- Positive and affirming attitudes

Social environment – chosen family support

- Negative origin family led to finding own support
- Surrogate family

The importance of peer support

- Learn from and share with others who had similar experiences
- Value in talking about experiences

Salway (2018)
Pride narrative

- Gay support group – normalised identity

Rivers (2018)
Conflicts of 'being out'

- Realising did not have to be alone and there were others who could help

- Interacting with other LGBT people
- Sense of belonging with LGBT community – strengthening individual identity, part of a collective identity
-

Diamond (2011)
Extrafamilial support

- Advocate from LGBT youth organisation
- Peer/friend network
- Romantic partners

Handlovsky (2018)
Building and sustaining networks

- With other gay men
- Frequently involved leaving home communities
- Level of comfort and safety in an established gay community was freeing
- Building networks to advocate for their rights
- Living through HIV era
- Connecting = sense of community

Addressing mental health

- Creating dialogues – no longer felt alone in struggles
- Caring and safe relationship
- Mutual help from supportive communities

Marlin (2022)
A sense of belonging

- Safe to express selves authentically
- Importance of group of like-minded people
- Importance of community in local area
- Hiding sexuality limits authentic interactions
- Fear of disclosure

Appendix 1-H. Example of a Translation Table.

Newly formed categories	First order constructs (ppt quotes)	Second order constructs (author themes)
Connection to immediate network/allies - Including family and friends	"…the support of other gay people is really important, and supportive straight people too, because they are the people who aren't in the same boat as you, I think it was really important to tell straight people who I was and for them to accept me, I think that was really important because we live in a predominantly straight world." (Fenaughty & Harré, 2003)	L/G/B Support network participation (Fenaughty & Harré, 2003)
	"I told my family I felt I was male and was afraid I would soon kill myself if I was not given room to live appropriately. The depression in my life up to this point had been overwhelming and was coming to a head. When faced with the possibility of losing me, most of my family was very supportive and helped me move forward." (Moody, Fuks, Peláez, & Smith, 2015)	Social support (Moody, Fuks, Peláez, & Smith, 2015)
	"Part of my wisdom is like 'well, you can never really kind of forget that you're depressed.' For me it just doesn't go away but I can mitigate it, I can ameliorate it, I can deal with it and, so one of the ways is just to make sure and continue to be actively involved with my friends." (Handlovsky et al. 2022)	Connecting to key supports (Handlovsky et al. 2022)
	"My friends are really amazing. I think it took me a while to really let people into my life, and there have been people who have been waiting to be in my life, in the way that I've learned recently to let people in." (Williams, Frey, Stage, and Cerel, 2018)	The social environment (Williams, Frey, Stage, and Cerel, 2018)
	"My mom accepts me for who I am…my family 'has my back' (i.e., will defend me)." (Diamond et al., 2011)	Positive life events/strengths (Diamond et al., 2011)

Appendix 1-I. Studies contributing to each theme.

Paper	Connection to Self (9 papers)	Connection to Allies (8 papers)	Connection to Community (10 papers)	Connection to Society (11 papers)
Fenaughty & Harré, 2003	X	X	X	X
Ferlatte et al. 2019			X	X
Moody, Fuks, Peláez, & Smith, 2015	X	X		X
Gaveras, Fabbre, Gillani & Sloan, 2021	X	X	X	
Handlovsky et al. 2022		X		X
Creighton et al., 2019			X	X
Williams, Frey, Stage, and Cerel, 2018	X	X	X	X
Salway and Gesink, 2018	X		X	X
Rivers, Gonzalez, Nodin, Peel, & Tyler, 2018	X		X	X
Diamond et al., 2011	X	X	X	X
Handlovsky, Bungay, Oliffe, and Johnson, 2018			X	X

Li, Tucker, Holroyd, Zhang and Jihang, 2017		X		
Marlin, Lewis, & McLaren, 2022	X		X	X
Hunt, Morrow, & McGuire, 2020	X	X		

Appendix 1-J. Guidance for Publication in the Journal of Gay and Lesbian Mental Health

About the Journal

Journal of Gay & Lesbian Mental Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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All original research papers involving humans, animals, plants, biological material, protected or non-public datasets, collections or sites, must include a written statement in the Methods section, confirming ethical approval has been obtained from the appropriate local ethics committee or Institutional Review Board and that where relevant, informed consent has been obtained. **Please also summarize this information in a separate Ethics Statement (with its own heading) at the end of the manuscript.**

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Section Two: Research Paper

Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide.

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Prepared for: Suicide and Life-Threatening Behavior Journal

Abstract

Introduction: It is estimated that 800,000 people die by suicide every year, and attempted suicides are suggested to be twenty times this. There is currently limited qualitative research exploring factors that could lead to recovery from suicidality. This study aims to explore experiences that may represent an 'exit' from states of suicidal crisis, and to gain an understanding of the impact of recalling and processing moments of exits from such states.

Methods: The study used a qualitative methodology using interviewing. The aim of interviews was to capture natural “in-the-moment” experiences through questioning participants. Reflexive Thematic analysis (RTA) was used to analyse data gathered through semi-structured interviews. Eight participants were recruited through social media platforms.

Results: Five superordinate themes were created: ‘Recognising impact on others’; ‘Interpersonal relationships’; ‘Doing something different’; ‘Leaving no room for suicide’; and ‘Sense of self’.

Discussion: It is possible that understanding experiences of natural exits from suicidal states may help to inform risk assessments, and shape interventions to be focused upon exploring exits and increasing the chances of these exits occurring for service users.

Conclusion: Exits are embedded within, and perhaps best understood within each participant’s narrative and their attempts to find meaning from their experiences.

(200/200)

Introduction

Suicide is a worldwide problem. It is estimated that 800,000 people die by suicide every year, and reported attempted suicides are suggested to be twenty times this (WHO, 2019). Furthermore, our ability to predict suicide has not improved from 50 years ago (O'Connor & Kirtley, 2018), and is felt to remain no better than chance (Franklin et al., 2017). Theories have attempted to explain the causes of suicide, however, there has been no evidence of sustained reductions in suicide rates (WHO, 2014), which suggests that there is not a well-developed understanding of the causes of suicide and recovery from suicide. As such, it is important to look for alternative perspectives of suicide prevention, for example exploring the events that could lead to reductions in suicidal states, rather than the causes of such states.

Recovery from suicidality

Research has predominantly focused upon psychological theories to explain why someone engages in suicidal thinking and behaviour. These include a lack of social support (Gunnell, Harbord, Singleton, Jenkins, & Lewis, 2004), negative life events and feelings of hopelessness (Beck, 1986; Beck, Steer, Beck, & Newman, 1993; O'Connor & Nock, 2014), perceptions of burdensomeness and thwarted belongingness (Joiner, 2005); and feelings of defeat and entrapment (O'Connor & Kirtley, 2018).

The Integrated Motivational-Volitional (IMV) model of suicide (O'Connor & Kirtley, 2018) has presented a promising framework for understanding and preventing suicide (Souza, Sosu, Thomson, & Rasmussen, 2024). It understands suicide as a behaviour that develops through motivational and volitional phases. The model suggests suicidal thoughts develop from feelings of entrapment (triggered by defeat), and suicidal behaviour is

perceived as the prominent solution (Dhingra, Boduszek, & O'Connor, 2016). According to the IMV, volitional moderators elicit transitions from suicidal ideation to suicidal behaviour (O'Connor & Kirtley, 2018).

Whilst some research has focused upon suicide recovery factors, this has mainly been explored at a macro level, for example, from a perspective of hope and recovery which has been captured at narrative level from people deeming themselves to be recovered. Research into macro-level recovery processes has evidenced helpful factors such as feelings of belonging (Gajwani, Larkin, & Jackson, 2018), connection with others, future goal setting, reconnecting with the self and spirituality, and problem-solving and emotional regulation skills (Chan, Kirkpatrick, & Brasch, 2017; Lakeman & FitzGerald, 2008; Vatne & Nåden, 2016, 2018; Zaheer et al., 2019). However, only focusing upon general and macro level factors does not consider individual variation and phenomenology as it is more concerned with general trends, and currently there is limited qualitative research exploring moments of becoming less suicidal and how these are experienced. Therefore, exploring micro-level changes could be advantageous. By micro-level changes, this paper is referring to the specific events that occurred in people's lives, why that was meaningful for them, and how these reduced their suicidal states. These moments could range from temporary relief to wholescale changes to a person's outlook on life.

There are limited studies highlighting subjective experiences of people who have been suicidal, and the key factors in their recovery (Chi et al., 2014; Lakeman & FitzGerald, 2008). However, some qualitative studies have emphasised that recovery can be more complex than a reduction in suicidal thoughts. For some, recovery is about building a life with meaning, and taking control over their own recovery (Lakeman & FitzGerald, 2008; Reading & Bowen, 2014; Sun & Long, 2013; Zaheer et al., 2019). For others, recovery was

developing hope, thinking positively about themselves and their future, and working towards personal goals (Awenat et al., 2017; Pratt et al., 2015).

Whitley and Drake (2010) proposed five dimensions of recovery from suicidal experiences. These are Clinical Recovery; Existential Recovery; Functional Recovery; Physical Recovery; and Social Recovery. Similarly, Chi et al. (2014) supposed five stages of recovery, which were Self-Awareness; Help-seeking; Repetitiveness; Adjustment; and Acceptance. Furthermore, Bergmans, Langley, Links, and Lavery (2009) found there were three elements to recovery, which were “living to die”; ambivalence and tipping/turning points; and recovery through small steps or phases. They suggested that suicidality recovery was not a linear progression, and their suicidal ideation ebbed and flowed throughout their journey to recovery.

However, little is understood about the small steps towards recovery. To understand how people move away from suicidality, we must learn from people who have experienced this, and acknowledge them as experts in the development of useful services (Fitzpatrick & River, 2018).

Literature has suggested recovery from suicidality is an ongoing process, in which individuals can continue to engage meaningfully with life whilst also experiencing suicidal thoughts and behaviours (Chi et al., 2014; Crona, Stenmarker, Öjehagen, Hallberg, & Brådvik, 2017; Sellin, Asp, Wallsten, & Wiklund Gustin, 2017).

The integrated motivational-volitional model of suicidal behaviour (O’Connor & Kirtley, 2018) suggests that a person may experience fluctuating levels of suicidal ideation and intent, which will move a person in and out of active suicidal states. However, literature has also found that some individuals experience a ‘turning point’, in which they transition

from contemplating suicide to choosing life (Lakeman & FitzGerald, 2008). This has been suggested to come from a change in environment (Everall, Bostik, & Paulson, 2006); connecting with a supportive person (Bennett, 2005); and seeking mental health care (Cutcliffe, Stevenson, Jackson, & Smith, 2006). Despite some research, little is known about specific causal factors involved in the reduced frequency (Kleiman et al., 2017). Therefore, it would be beneficial to explore "in-the-moment'" experiences of reductions of suicidal states to add to evidence surrounding more generalised recovery. The process of suicidality is individual; therefore, knowledge of first-person experiences is vital (Fitzpatrick & River, 2018; Webb, 2010).

There are multiple definitions of recovery, which have been suggested from research exploring the lived experience of individuals with suicidal thoughts and behaviours (Davidson, 2005; Jacobson & Greenley, 2001; Whitley & Drake, 2010). The clinical model of recovery, which focuses on reductions in suicidal ideation and symptoms and improvement in function, is only one way of conceptualising this process (Trainor et al., 2004; Whitley & Drake, 2010). It has been proposed that approaching suicide recovery needs to be a holistic approach, as moves away from suicidal experiences can involve more than remission of symptoms, and include self-reflection, agency, greater self-esteem, connection with supportive others, and improved quality of life (Chi et al., 2014; Kasckow, Liu, & Phillips, 2012; Lakemand & FitzGerald, 2008; Sun & Long, 2013).

'Natural' Suicide recovery

Anecdotal evidence has suggested that people can experience natural exits from suicidal states. Natural exits have been described as events of personal significance where a qualitative shift occurs and a person can recognise a reduction in suicidal states (Tarrier et al,

2013; Kelly & Welford, In preparation). However, there is limited evidence exploring these, and therefore little information regarding how to capture these experiences. Exploring natural exits, and working towards an understanding of these moments, may lead to identification of key needs of the suicidal person and how these have been met during their everyday life. Identification of these factors may be translated into psychologically informed interventions to both prevent and treat acute states of suicidality, (Kelly et al., 2012). As there are transdiagnostic factors leading a person into a suicidal state, there may be universal factors that can reduce these states, across clinical groups.

A further reason to investigate moments of natural exits is the suggestion that bringing them to attention may be therapeutic and contribute to the prevention of suicidal states in the future (Kelly et al., 2012; Kelly & Welford, In preparation; Tarrier et al., 2013).

It is suggested that people with suicidality experience cognitive constriction (Baumeister, 1990); they are in an intolerable state and don't believe that they can escape from it, despite prior experience that such states do pass. Anecdotal evidence from Tarrier et al (2013) suggests that strengthening retrieval (Brewin, 2006) of previous exits from such states may make them easier to recall during moments of 'tunnel vision', leading to a reduction in the sense that such states are never ending, increasing capacity to cope.

Implications for healthcare

This research aims to increase sensitivity of research to include and understand experiences of momentary changes away from suicidal states, as there may be differences in factors that result in temporary brief reductions, turning points, and overall recovery.

Implications for this study include potential theoretical and intervention developments. It is possible that understanding experiences of natural exits from suicidal

states may help to inform risk assessments, and shape interventions to be focused upon exploring exits, understanding the 'story' behind suicidal experiences, and increasing the chances of these exits for service users. The importance of focusing on individuals' story has been highlighted (Cutcliffe, Stevenson, Jackson, & Smith, 2006; Sellin, Kumlin, Wallsten, & Wiklund Gustin, 2018), suggesting research focusing on the subjective experience of those who have moved away from suicidal states is valuable.

Proposed Research

Hjelmeland and Knizek (2010) have argued that qualitative research can generate knowledge, and whilst quantitative studies are beneficial to understand cause-and-effect relationships in suicidal behaviours, qualitative research can bring a broader understanding of lived experiences of people who have been suicidal. This is also true for the process of moving away from suicidal states. This need for more qualitative research has been agreed upon by multiple researchers (Kral, Links, & Bergmans, 2012; Lakeman & FitzGerald, 2008).

The primary aim of this study is to elicit and explore experiences that may represent an 'exit' from suicidal states, including thoughts, feelings, and actions. 'State' refers to mind-body subjective experiences, including thoughts, feelings, actions, and bodily states. This is important as it does not limit individuals' perceptions of their experiences to language. The term 'exit', 'transition' and 'shift' are used interchangeably. Whilst a 'turning point' has been defined as "a time of event when one took a different direction from that in which one had been travelling" Clausen, 1998, p. 189), to the author's knowledge there is not a guiding framework that brings these terminologies together or provides definitions of distinct processes.

A secondary aim of this study is to gain an understanding of the impact of recalling and processing moments of exits from such states, given that anecdotal data and clinical experience suggests that this is an inherently therapeutic activity that may increase a person's sense that crisis states are transitory.

Materials and methods

Design

The study used a qualitative methodological design using semi-structured interviews, to explore the meaning of shifts away from suicidality. Qualitative interviews allow participants to share their individual experiences (Willig, 2017). To analyse the data, reflexive thematic analysis (RTA; Braun and Clarke, 2022) was used. This was chosen as it can be used collaboratively with participants (Braun and Clarke, 2022). This is particularly relevant to the study, as collaboration is pertinent to building trusting relationships, something which is necessary when discussing sensitive and personal topics.

RTA is used to understand patterns or themes across participants. As this topic has not been heavily researched, it was deemed useful to explore what common and shared elements of momentary recovery from suicidal states are. Furthermore, as the current literature base is heavily focused on generalised exploration of recovery, it felt useful to use an approach that would present with thematic understanding across participants. For this reason, more individualised approaches such as interpretive phenomenological analysis IPA were not used. RTA also aligns with the epistemological position of critical realism.

Procedure

Participants

The study included 8 participants. This number was chosen due to the time intensive nature of conducting interviews and analysing qualitative data. Information power was considered to reach this number (Malterud, Siersma & Guassora, 2016). The aim of the study was specific; the participants held specific knowledge about the topic; there is some theoretical background; there was clear communication between researcher and participant; and the analysis strategy was thematic. The recruiting method applied inclusion and exclusion criteria related to specific characteristics required for this study (see Appendix 2-A).

Recruitment Selection

Participants were recruited through a recruitment poster and adverts (Ethics Section; Appendix 4-F) on social media. For the research, a new research Facebook account was created with no personal data held on it. The poster was advertised on closed Facebook groups relevant to the topic following gaining permission from the group administrators. Personal Twitter (now X) and LinkedIn profiles were used as they were deemed professional pages. A new research Reddit account was created, and the post was shared on sub-Reddit's relating to the topic, after gaining approval by administrators. Advertisements included brief information about the study, inclusion criteria, and the email address of the researcher. It asked potential participants to email for more information. Once potential participants emailed, they were sent the participant information sheet (Ethics Section, Appendix 4-C) and further screened for inclusion and exclusion criteria. They were sent a blank consent form to complete (Ethics Section, Appendix 4-D), and the timing of the interview was discussed.

Twenty people emailed about the study, and eight participants completed an interview. Seven people emailed their interest in the study but did not complete the consent form; four were excluded as they were not living in the UK; and one participant was excluded prior to data collection, due to concerns regarding risk/accuracy of identity and location information. This participant was discussed with the ethics committee, and it was agreed to exclude based on the information provided.

Data Collection

Data was collected through 50–60-minute interviews via Microsoft Teams, which were semi-structured. The lead researcher developed an interview schedule with broad questions and topics to guide the interviews (see Appendix 2-B).

Throughout the interview, information was checked with the participants, using techniques such as summarising and reflecting. The language, and timing of the interviews were adapted to make them person-centred and understandable. At the end of the interview, participants were asked to give feedback about the interview and how they found the interview. This feedback included checking how their mood was, any risk issues identified, and if they required any follow-up support from services. Participants were offered an email check-in from the researcher the week following their interview. Participants were also sent a debrief sheet (Ethics Section, Appendix 4-E) including information about services/resources they could access if they felt they needed further support.

Throughout the data collection process, the lead researcher reviewed interview tapes and transcripts, and discussed these within supervision. Following discussion, more specific prompts were added into the interview schedule, as it was noted that there was

variation in the ability of participants to recall detailed memories of specific events when they transitioned out of a suicidal state. During supervision, it was discussed the need to balance allowing participants to tell their story, with talking about the specific memories of transition from suicidal states.

The following demographic details of participants were collected: Age; Ethnicity; Mental health diagnosis; Details of previous suicidality; Relationship status; Identified gender.

Data Analysis

Data was analysed using RTA, which included six phases. In Phase 1, the researcher familiarised themselves with the data by rewatching and re-reading the interviews. Phase 2 included generating initial codes for each transcript (Appendix 2-C). Themes were then created and reviewed for each participant based on the initial codes (Appendix 2-D) and were then compared and collated with other participants (Appendix 2-E). In phases 3 and 4, themes for the whole data set were created, and were reviewed with the research team (Appendix 2-F). For phase 5, following these discussions, themes became clearer, for example the themes of 'recognising the impact on others' and 'interpersonal relationships' were originally one theme titled 'others'. However, it was discussed that participants were talking about two separate ways of relating to others, therefore the themes were clarified. Following review, the themes were defined and named and quotes that illustrated the same point were merged.

Epistemological Position

The data was interpreted using a critical realist position. It was assumed that suicidality exists, and fluctuations in suicidal states also exist. This is evidenced by data that

people have attempted suicide/reported suicidal thoughts, plans, and/or methods, but then reported they no longer do this (O'Connor & Kirtley, 2018). However, it was assumed the causes, mechanisms, and ways out of suicidality can be interpreted. Fluctuations and reductions in suicidal states were considered a complex phenomenon that is centred around an individuals' perception and ideas about the meaning of these exits, and therefore could not be easily standardised or objectified. The critical realist perspective observes the world as complex and supports research to acknowledge context within different phenomena (Roberts, 2014). Sociocultural context is imperative within people's lives, and thus also within understanding suicide and recovery from suicidality (Hjelmeland, 2011). As such, this stance lent itself to exploring recovery from suicidality due to its complexities and importance of context. Features of critical realism such as the mind-independent nature of reality, lends itself to the complexity of suicidality, and thus the complexity of transitions out of suicidal states, which recognises the context and mechanisms where multiple elements added together are more than the sum of the parts involved (Sturgiss & Clark, 2020).

Ethical Considerations

Ethical approval was granted by the Lancaster University Faculty of Health and Medicine Research Ethics Committee (ref: FHM-2023-0742-RECR-2). Ethical issues were considered, including potential for the researcher to identify risk information regarding the participant during the interview. To mitigate this, it was made explicit to potential participants they could not have experienced any suicidal experiences in the past 12 months, and the process of obtaining informed consent included a discussion about the focus of the interview, allowing participants to decide if they felt able to discuss their suicidal experiences. Participants at immediate risk of harm to themselves or others would have been excluded, and the distress protocol (Ethics Section, Appendix 4-G) was followed

throughout. Further actions were considered and implemented as needed (Appendix 2-G). It was not necessary to conduct a welfare check for any participant, and none indicated any risk of harm towards themselves or others. Data was protected and stored in line with ethics submission requirements. It was possible that the researcher could have experienced distress from listening to and exploring participants' experiences of risk and distress. Therefore, all supervisors were qualified clinical psychologists, who have experience working with people who are communicating risk, and in supervising people who have conducted research in similar areas. The team met regularly for supervision, and the impact of this study, including any distress caused was discussed routinely.

Methodological Considerations

The researcher had regular supervision with the research and field supervisors to discuss and identify any potential biases that may have impacted the analysis of the data. In line with the importance of reflexivity, the researcher kept a reflective log throughout the process, including reflections of personal experiences, thoughts, and feelings (Appendix 2-H). This was particularly relevant during interviews in which the researchers own emotional reactions and previous experience of working with suicidal individuals was important to consider. Interviews were recorded which allowed for revisiting the data to reassess emerging themes to remain true to accounts from the participants.

Results

Participants identified as male (*n* = 5), female (*n = 1*), non-binary (*n = 1*), and gender flexible (*n = 1)* between the ages of 22 – 77. All participants identified as White British. The time since participants' last suicidal experience ranged from 12 months to 60 years. Pseudonyms were used to maintain anonymity.

Table 1. Participant demographics and recruitment pathway

Information	Participants							
	Laura	**George**	**Jake**	**Sam**	**Richard**	**Mark**	**Liam**	**Joshua**
Gender	Female	Male	Male	Non-binary	Male	Male	Gender flexible	Male
Age	22	38	32	36	77	46	48	27
Ethnicity	White British	White British	White British	White British	White British	White British	White British	White British
Relationship Status	In a relationship	Married	Married	Married	Married	Divorced	Single	Single
Mental health diagnosis	Mixed anxiety, depression, psychosis	Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Autism	Anxiety and depression	None	Post-Traumatic Stress Disorder, Anxiety and depression, Autism	Post-Traumatic Stress Disorder, Anxiety and depression	Acquired Brain Injury	Mixed anxiety and depression, ASD, Agoraphobia, Generalised Anxiety Disorder, Emotionally Unstable Personality Disorder
Time since previous suicidal experience	4 years	17 years	12 months	10 years	60 years	6 years	2 years	1 year
Recruited from	Reddit	Reddit	Linked-In	Reddit	Twitter	Reddit	Twitter	Reddit

Data analysis of participant accounts led to 5 main themes, seen in Table 2.

Table 2. Themes, subthemes and type of change represented.

Theme	Subtheme
Recognising impact on others	
Interpersonal relationships	Shared experiences
	A different perspective
	Acceptance
	Being alongside
Doing something different	Suicidality no longer working
	Knowledge of options
	Positive internal experiences
	Taking control of experiences
Leaving no room for suicide	
Sense of self	Positive view of self and abilities
	Being true to self

Recognising impact on others

This theme suggested a broadening of awareness after certain life events, leading to gaining clarity in what the impact of their suicidality would be on others. Participants described being unable to consider others or the aftermath of their suicide whilst in crisis, however noticed their attention broadened to allow for clarity in their thinking about their suicidality. Shifts away from suicidality occurred, with some changing their suicidal behaviours, and others reducing their suicidal thoughts. More generally, participants spoke of how being physically around others impacted their suicidal behaviours and thoughts. For example, Jake was only able to keep this impact in his mind, whilst he was "*around my family*"*.* This changed his behaviours, however his suicidal thoughts and feelings remained: *"I didn't have the heart to upset my family by doing anything."*

Similarly, Liam talked about the impact on others becoming clear in his mind when he was living with family: *"I thought…last thing I'm going to think about now is killing myself because I wouldn't do it to him."* Considering his father's own wellbeing and health, his suicidal thoughts *"just sort of subsided…I think the thoughts changed within about 2 weeks of moving back home."*

More distinctly, George talked about moments following a serious suicide attempt: *"It became much more clear of the impact and the chain of events that would have happened…that changed… the way I felt."*

Interpersonal Relationships

Contrastingly, this theme highlighted the positive impact of interpersonal relationships on individuals and reducing suicidal experiences. Connecting to and accepting support from others was an important factor. The subthemes of shared experiences; a different perspective; acceptance; and being alongside, identified how others helped participants avoid suicidality.

Shared experiences

This subtheme highlighted that sharing similar thoughts, feelings, and experiences with others helped participants feel connected and understood, reducing their suicidality. The changes were small shifts, that came from others.

Being with others *"who were in a similar situation"* helped Laura feel *"understood…like I belonged there".* For Joshua, being with others who had experienced suicidality made it *"easier to deal with",* as they understood the complexity of these

experiences. Jake's friend, who *"had been through a similar sort of experience"*, was able to give the right support, meaning he was able to look after his friend, which helped him to feel less vulnerable seeking support: "*we were…comparing notes and…working through things together"*. Knowledge that other people had got through these times, provided hope that things could change: *"You identify that other people have had these dark thoughts as well, and so they've got through it." (Mark)*

Sam talked about a specific moment in a museum creating connection to others who had felt the same way; they no longer felt alone in their struggle. This created a shift from a sense of isolation to being part of something, which then reduced their suicidal feelings: *"One of these artefacts is an Obsidian mirror…I remember looking into it and thinking about…all of the pagans and occultists that had come to see this mirror…I remember…almost a sense of Vertigo at this history stretching out…I was now part of. "*

A different perspective

An alternative view helped participants gain understanding and perspective on how they felt about themselves, and their situations, which created a transformational shift. More generally, participants talked about receiving recognition from others, which helped them *"to feel proud of myself"* (Laura). This created a turning point, in which she felt validated and capable. For Jake, the differing perspective of a friend "*took away the feeling of worthlessness…the shame and the guilt."* This was internalised, in which they *"helped me pull out of that hatred of myself",* which led to less suicidal feelings as they *"didn't want to get rid of this terrible person anymore."* He reflected the way his friend *"didn't see this terrible*

person that I'd painted myself to be" allowed him to let go of his shame, and to consider staying alive.

Acceptance

Feeling accepted by others helped participants feel understood and validated. This came from specific moments in time and provided momentary shifts away from suicidality. For Mark, his suffering being recognised by a therapist created a moment of change: *"Well she [therapist] said of course you're gonna feel like that. Look at all that you've been through…I sort of sat back and just felt…relief, I guess. That what I had been through was tough, and like I was being listened to."*

Similarly, for Joshua, his momentary shift came from experiencing a sense of belonging in a group of people who understood and accepted him: *"I wasn't treated like a massive burden, and I wasn't treated like someone to be got rid of."*

Finally, for Sam, a moment walking to meet someone for the first time created a sense of belonging and acceptance from someone who shared similar beliefs: *"walking up to the pub where we'd arranged to meet…I was really going to talk to a human being and… trust someone and let someone into my life."*

Being Alongside

Participants referred to having someone who was *"completely impartial"* created a sense of being understood. For Liam, their father "*created space"* and therefore they *"wanted to reciprocate"* that kindness. Similarly, Jake talked about experiencing "*relief and…appreciation"* for his relationship, as it gave him a "*chance to feel better".* He described specific moments of shifts away from suicidal states coming from someone being alongside, specifically the physical touch with someone, which *"added an extra layer of like intimacy*

and care to it, like we both genuinely cared about each other and wanted each other to be better".

Sam also spoke of feeling *"held"*, during a pagan ritual they performed alone. This helped them to feel *"connected to the universe in a way that I'd never felt in my life. Just feeling immediately in that moment, like I was part of something."* They described "*a feeling of warmth…that cocktail of emotions you feel when you are held in the arms of someone that that cares for you."*

Doing something different

This theme involved participants being presented with naturally occurring opportunities, something they did not create themselves, and their perceptual experience of suicidal thoughts and feelings changing.

Suicidality no longer working

There was a realisation that what their suicidality had provided for them previously, was no longer effective for them. Participants described specific moments of transformational shifts away from suicidal ideation during these realisations.

George spoke about a transition from a perception of being forced to stay alive following a serious suicide attempt, with associated feelings of resentment; to thinking that suicide was no longer an option for him and a motivation to find a way to live. Part of the change was the prospect of being admitted to a psychiatric hospital. The participant reflected on the shifts in emotion, towards a motivation for change: *"I remember initially being like quite upset at the prospect of having to go into this hospital and then that kind of*

converted to actually being quite annoyed, quite angry about the whole thing. And then from that, kind of gave me a bit of drive to be like… I don't want to do this."

Similarly, Mark described being *"sat on the fence on whether I'm gonna live or die".* He indicated receiving a message from an acquaintance: *"he said no one is coming to save you, save yourself... I know it's a Buddhist thing, but it was just exactly the right thing at exactly the right time I mean that I needed to hear...that was the first crack of light."*

For Joshua, this realisation came from watching a cycling event on television. This brought about a realisation of what suicide would take away from him: *"I want more of it in the future. But if I die, I won't."*

Knowledge of Options

This subtheme focused on how gaining knowledge of alternatives to suicide created a shift for participants. For Laura, it was a transformational shift, a *"turning point"*, which came following a serious suicide attempt, when she was referred to mental health services, and *"learnt there is other help there".* Laura talked about being *"very good at hiding it [suicidality] from the people who were close to me",* and following the attempt, she could no longer hide her distress from her family.

Similarly, George's viewpoint changed from *"quite a nihilistic point of view"* to "*actually wanting to do things".* He described his shift as *"liberating…I do feel quite free to do anything really".*

On the other hand, Mark recalled the first moment he experienced a thought that suicide is not the only option: *"I ended up going to a bridge…and think about jumping off…I*

stood there for about half an hour…And then walked away and thought to myself, well there must be something else I can do." He talked about a sense of freedom coming from having options. For him, the change came from a sense that suicidality as a problem, can be fixed. He shifted from a passive recipient of his thoughts and feelings, to feeling able to solve them. He was able to keep that in mind and use the idea that his mindset is flexible when he began to experience suicidal thoughts again: *"it would get heavy and then I would have to remind myself, now you do have options…Things can change."*

Positive Internal Experiences

This subtheme described having other options available provided a positive internal experience, and as such, became a better option than suicidality. Participants talked about the *"excitement"* (Laura) becoming "*hopeful"* (Jake) at the possibility of doing something different. George reflected on a sense of freedom from reaching rock bottom: *"there's nothing, literally nothing worse that is going to happen, so, where can I go from here?"*

In terms of momentary shifts, Jake described gaining hope at the prospect of something different, that acted as a *"distraction from the dark space"* whilst bumping into an old friend in a pub, and then agreeing to carry on the conversation past this point: "*It was something new…something exciting…almost like closing the chapter on the last bit."*

Mark described the shift in his bodily feelings and emotions following a realisation that suicide is not the only option: *"So I felt very heavy and depressed. And then upon this realisation…a literal sort of lightening maybe in my head and my body."* Feelings of hope created motivation to try something different: *"I don't know exactly what I could pinpoint where that motivation came from, probably the hope, and that there was choices. All this stuff I could do…switching from I can't do anything to, well what can I do?"*

Taking control of experiences

Participants spoke about becoming aware of their internal experiences, something they learnt through their suicidality. This led to understanding and recognising when they are in distress. "*Paying attention to how things felt"* (Laura) and "*recognising the signs of it"* (Liam) allowed participants to take control of their feelings and "*avoid it in the future"* (Liam). For Liam, following a period of being connected to his family, he was able to perceive his suicidality as "*not a positive experience, but it's been a life experience that I've learned from."*

Participants described finding "*light at the end of the tunnel"* and *"wanting to find other things that gave me that same kind of enjoyment" (Laura).* Participants described building up their experience of things working to take them away from suicidality, which led them to feel free from suicidality.

Once George "*made a decision…to do something different"* he turned to figuring out what this path might be. Whilst his circumstances did not change, his approach and thought process about it did, he began caring about things he had previously tolerated: *"I was in the same job essentially so that didn't change, but I just started caring about it. And doing more to try and move that forwards."* Over time, George noticed that by doing this, his suicidal thoughts reduced: *"It was, it was still a case of being in a very uncertain place…but then once I kind of found a track that I was, at that stage, comfortable pursuing, I then was able to not think about [suicide]."*

Leaving No Room for Suicide

Many participants spoke about being in a situation in which they had less capacity for suicidal thoughts. This possibly occurred due to the perception of the location of the suicidal thoughts changing, becoming less centre stage, and therefore allowing more space for more positive things. This 'space' seemed to be freed up by naturally occurring events, rather than participants creating these for themselves.

George described avoiding his suicidality for 17 years, by *"just completely remove it from my kind of consciousness."* He felt this *"gave me that headspace to…go and do other things."* This highlights the concept of space in the mind, and how not having space for suicidal thoughts allows for more positive things to come in. Whilst this helped him to cope with his suicidality at the time, he reflected that it did not solve his core levels of distress. Opposingly, some participants talked about the idea of meaningful distraction helping to reduce suicidal thoughts: *"Some form of distraction that's meaningful and substantive is the thing that stops [suicidal] thinking…It's literally like I've no room in my diary to kill myself." (Liam)*

Sam talked about distraction in relation to a transcendental experience of a pagan ritual for the first time. Despite perceptions of suicidal thoughts remaining in the same place, and having the same strength, they no longer held the same prominence for them following this experience: *"I think those did change in that moment. While the idea of suicide certainly didn't leave the forefront of my mind, for a few years yet. I don't recall ever having a desire to take myself out of the world after that point…It's not like the strength of my suicidal thoughts diminished at that time. It's that something else was putting them in perspective."*

Sense of Self

This theme centred around participants developing a positive view of their abilities to cope with distress. Participants also spoke about living an authentic life being an important factor in the reduction of the suicidality.

Positive View of Self and Abilities

This subtheme explored the shift in how participants felt about themselves and their ability to do things. Laura experienced a *"light bulb moment"* when she began exercising, which acted as a catalyst for exploring more things in life, which in turn, reduced her suicidal feelings: *"a mentality switch...instead of just feeling like everything is crushing down on me, I felt more like I could do something about it."* She reflected that previously, her thoughts were telling her that she is not capable, and enjoyment *"felt out of reach".*

George also reflected on his perception shift: *"It was very much a case… I've got to do something… I just didn't have that before…I didn't think I could have made myself go and do something."*

Similarly, Sam talked about opening up to new experiences, in the form of a new friendship: *"I think opening myself up to that friendship is something that my thoughts would have never allowed me to do before because I would just have been overwhelmed by the idea that this person was better off not knowing me."*

Similarly, Mark found that *"building up a faith in myself"* came from reading the words of philosophers and faith leaders, which was able to instil some hope within himself, and in turn create a feeling of ability to change.

Being True to Self

The ability to live authentically created a change in participants' level of suicidality. Themes of discovering who they were and living in line with this helped participants to feel a sense of freedom of expression, which helped to address the causes of their suicidal distress. For example, Richard reflected on hiding his sexuality for most of his life. He found that being open about this, and accepted, created a sense of freedom, and thus reduced his suicidal feelings, as the world felt more tolerable: *"I survived. Here I am…happier in many ways because I can be myself."*

Mark spoke of authenticity solving the root cause for his distress: *"if you don't get to the root of the problem then other secondary causes just come back… that was what authenticity did…I was addressing the primary causes of…my suffering and therefore the secondary causes don't happen."* He talked about "*that one moment"* within therapy where he felt recognised, which enabled him to be himself and: *"let go of societal expectations."*

Liam reported his perception of himself changing in the context of connecting with his father, which reduced and finally eliminate their suicidal thoughts: *"I became the person I recognised as me again…thoughts became less and less significant over time…it never gets as bad as taking me into the suicidal stuff."*

Discussion

This study found participants were able to talk about experiences of becoming less suicidal. These ranged from autobiographical memories of specific moments to a more general narrative of how this change had occurred.

Five superordinate themes were generated from participant accounts: (1) awareness of impact; (2) interpersonal relationships; (3) doing something different; (4) leaving no room for suicide; and (5) sense of self.

Theme one centred around participants being able to clearly consider the impact their potential suicide would have on others, moving them away from considering suicide. Similarly, findings from Kirkpatrick, Brasch, Chan, and Kang (2017) suggested that realising the impact on family and friends was for some participants, a turning point. However, they found that considering the impact on others changed the action, but not the suicidal thought, whereas participants in this study described their suicidal thoughts reducing following physically being around family and considering the impact. Sun and Long (2013) reported participants spoke of struggling to consider others during their most suicidal times but following life events such as moving in with family after a serious suicide attempt, the impact of their behaviours became clear, which is consistent with participants reports from this study.

Theme two highlighted how relationships could move participants away from suicidality. The subthemes extended the characteristics or ways in which participants' relationships influenced them. These were (1) shared experiences; (2) a different perspective; (3) acceptance; (4) attunement; (5) being alongside.

Connection with others and relationships have been demonstrated across the literature as main factors in suicide recovery. These connections include family and friends (Crona et al., 2017), mental health professionals (Vatne & Nåden, 2018), and from others who have had similar experiences (Bergmans, Gordon, & Eynan, 2017), which connects with the subtheme of shared experiences. Interpersonal factors underpin the interpersonal theory of suicide (Joiner, 2005), which suggests that perceived burdensomeness and thwarted belongingness can lead to the belief that an individual's death is worthwhile to others, and therefore creates the desire to die.

It has been suggested that relationships can offer acceptance (Crona et al., 2017; Oliffe et al., 2021), which was also found within this theme. Furthermore, literature has suggested that relationships helped participants to challenge their view or perspective of themselves (Bergmans et al., 2017; Chan et al., 2017) which relates to the subtheme of offering a different perspective. Relationships have been found to help others feel understood and not alone (Bergmans et al., 2017; Vatne & Nåden, 2018), conceptualised by the subtheme being alongside. For one participant, feeling listened to, changed their view on suicidality, and can be seen through a quote from Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak (2012) which stated *"what most people need is just to have someone listen and get something off their chest and they'll take a step back from suicide."*

Theme three described participants reaching a turning point where suicidality was no longer working for them, and then taking action to make new choices that did not involve ending their lives, thereby doing something different. For participants, this was enabled through being presented with opportunities naturally, and having a positive perception of these. Hopefulness for new experiences has been seen within the literature (Hawgood,

Rimkeviciene, Gibson, McGrath, & Edwards, 2022; Tran et al., 2015), creating a realisation that life could be valuable (Hawgood et al., 2022; Oliffe et al., 2021).

One participant within this study described a physical shift in his bodily sensations after realisation that suicide is not the only option, moving from heavy to light. Similarly, Bergmans et al., (2017) suggested participants recognised alternative ways to see the world, which created a sense of control.

Theme four centred around leaving no room for suicide. Participants found they had less capacity for suicidal thoughts from being in a routine, and distraction. Again, participants mainly spoke about natural distractions or routines coming into their life having this effect rather than creating it themselves. One participant talked about unhelpful distraction, in which there was an ignoring of thoughts and feelings, which he felt helped him to cope, but did not solve his distress. This theme also speaks to the changes in perceptual experiences of suicide, which was important.

Theme five explored a change in sense of self, and the positive impact this had on suicidality. Holding a positive view of their abilities to cope with distress, and authenticity were factors that helped participants move away from suicidality. This shift came from discovering capabilities of enjoying things in life; being open to new experiences; and not comparing to others. This links with research suggesting a link between autonomy and suicidal ideation, in which low relatedness, autonomy and competence were associated with elevated thwarted belongingness and perceived burdensomeness, factors that are associated with suicidal ideation (Hill & Pettit, 2013).

Theme five also relates to self-determination theory, a commonly researched and empirically valid theory of human needs fulfilment (Mancini, 2008). It suggests three basic psychological needs: autonomy (engaging in behaviours with volition); competence

(experiencing mastery and efficacy), and relatedness (feeling connected to others meaningfully), (Deci & Ryan, 1985, 2000). Individuals' performance, well-being, and their improvement in psychotherapy have been shown to be largely influenced by whether their basic human needs are fulfilled (Deci and Ryan, 2000).

For participants in this study, suicidal thoughts decreased due to an internal sense of capability to enjoy things, try new experiences, and not compare themselves to others, which could link to a sense of autonomy and competence. Chan et al., (2017) discussed self-value being related to an awareness of one's own worth and self-acceptance, which has led to improved coping strategies, self-care, a stronger sense of agency, and an ability to face life's difficulties (Player et al., 2015; Sun & Long, 2013; Tran et al., 2015; Zaheer et al., 2019).

Strengths and Limitations

The present study is one of the first to explore first-hand experiences of natural momentary shifts away from suicidal states. A potential limitation of this study is the process in which people answered questions about their experiences. Due to the semi-structured nature of the interviews, there were variations in the way people answered questions. For example, people who had spoken about their experiences previously may have offered a 'rehearsed' perspective, compared to more raw discovery of their experiences.

Despite the aim of the study being to capture experiences of in-the-moment shifts, many participants spoke more generally about their experiences, and struggled to recall specific moments when they noticed their suicidality reduced. This may be linked to a tendency in people reporting suicidal thoughts to have an overgeneralised autobiographical memory (Pollock & Williams, 2001). Therefore, interviews which were held many years after

the experience may not have captured the full personal experience, and memories may have been distorted, biased or have become generalised and not time specific.

Limitations regarding the length of time since participants' last suicidal experience were not imposed with the exception of exceeding 12 months. Therefore, there were variations in the amount of time between suicidal experiences, ranging from 12 months to 60 years, therefore it is possible that some participants experienced 'sealing over' of their experiences of suicidality, which has been shown within the psychosis literature (Thompson, McGorry, & Harrigan, 2003). It is possible that participants sought to forget or not integrate their traumatic or distressing experiences, and therefore were not able to recall specific moments when asked about them. As such, a limitation of this study is that participants may have struggled to answer the research questions due to the amount of time that had passed since their last suicidal experience. Future research would benefit from having less time between suicidal experience and interview to mitigate this.

Furthermore, building relationships with participants is a valuable methodological aspect of qualitative research, underpinned by the concept of trust, and particularly important when researching vulnerable groups (Batlle & Carr, 2021). It is possible that within the limits of this study, there was not enough time to build a fully trusting, therapeutic alliance between researcher and participant, which may have led to the participant not feeling able to be fully open about their experiences.

During data analysis, it became clear that the complexities and nuances of each participant's story did not fit neatly into each theme. It felt important to carefully consider the context of each participant's experiences (Hjelmeland, 2011), as suicide is a conscious and purposeful act that is unique for everyone (Hjelmeland & Knizek, 2016). Therefore, exits from suicidal states cannot be fully understood without the context in which they occurred.

To honour the complexities of participant's stories, the analysis and results of this paper considered a narrative lens. This was done through incorporating contextual information about each participant in the results, to try and avoid diluting the nuances and intricacies of each person's story. Finding the balance between capturing personal and cultural contexts and meaning, whilst also applying more general level and thematic understanding is essential to advance our understanding of suicide and provide person-centred care (Kirmayer, 2022).

Clinical Implications for Practice and Future Research

Implications include potential theoretical and intervention developments. Understanding experiences of natural exits from suicidal states may inform risk assessments, and shape interventions to be focused upon exploring exits and increasing chances of these exits for service users.

Findings suggest asking about moments when an individual shifts from a suicidal state could be incorporated into clinical risk assessments. The finding that individuals may forget these moments of transition suggests memory-based interventions that can strengthen these memories may be beneficial (Kelly & Welford, In preparation). Broad Minded Affective Coping (BMAC; Tarrier, 2010) may be effective to support those experiencing suicidality, by adjusting a person's retrieval bias.

Despite decades of research into suicide prevention, there are significant gaps between research, policy, and clinical practice (Quinlivan, Littlewood, Webb, & Kapur, 2020). More qualitative research within suicide research is needed to reflect the complex processes and experiences (Hjelmeland and Knizek, 2016), particularly exploring experiences of natural exits from suicidal states to contribute to the current literature base, to support those who experience suicidality.

It would be beneficial that future research includes use of diary methods, to capture moments in real-life where there has been a natural exit from a suicidal state. It has been suggested that people who have experienced suicidality can also experience cognitive constriction (Baumeister, 1990), or 'tunnel vision'; individuals are in an intolerable state and do not believe they can escape from it, despite having prior experiences that suicidal states can pass. It has been suggested that strengthening retrieval (Brewin, 2006) of previous 'exits' from suicidal states may make them easier to recall during moments of 'tunnel vision' (Tarrier et al., 2013). Therefore, further research exploring this would be beneficial.

Conclusion

This study explored moments of natural exit from suicidal states. Five superordinate themes identified were recognising impact on others; interpersonal relationships; doing something different; leaving no room for suicide; and sense of self. Participants at times struggled to recall and discuss specific moments of transition from suicidal states, which may have been influenced by a 'sealing over' effect. This study found that 'exits' from suicidal states are accessible and important for theoretical understanding of preventing suicide and informing the development of interventions. As such, diary studies that support individuals to capture 'in-the-moment' experiences of exits from suicidal states would be beneficial.

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Appendices

Appendix 2-A. Participant Inclusion and Exclusion Criteria and Justification

Inclusion Criteria	Justification	Exclusion Criteria
Had a form of suicidal experience (thoughts, feelings, actions), but not in the past 12 months	From a risk management and recovery perspective	Currently experiencing suicidal thoughts, urges or actions or at imminent risk to themselves
Suicidal experiences could not have occurred during an acute psychotic episode, delirium, substance intoxication or withdrawal	Transdiagnostic factors linked to suicide may not apply or be recalled by individuals participating	Not able to recall recovery
Aged 18 or over	Study exploring adults	Under 18 years old
Able to communicate verbally in English	To conduct interviews	Could not communicate in English
Have access to Microsoft Teams	To conduct interviews	No access to Microsoft Teams
Living in the UK	Risk management if required a welfare check from emergency services, and signposting to services	Not living in the UK

Appendix 2-B. Interview Schedule

Interview schedule

As part of the interview, there is an aim to put participants at ease, which will include developing a trusting relationship between participant and interviewee and giving participants clear guidance regarding information sharing and the boundaries of confidentiality at the beginning of the interview.

Participants will be asked about their view of their recovery in general, and an overview of their journey away from being suicidal, with the aim to gain an understanding of what this means for them. This will give context to the experience and ease them into the interview.

Topics of the interview will include exploring the moments of natural transitions out of suicidal states, and the state people transition to, along with the details of any event associated with this transition. By state, we mean mind-body subjective experiences, including thoughts, feelings, and bodily states. Questions may include:

Can you remember a time when your experience of suicidality reduced?
What was happening around you at this time?
What was happening just before?
Did you experience a change in your body during this time?
Did your emotions change during this time?
Did your thoughts change during this time?
Was anyone around you at this time?
How long did this experience last for?

The interview will also ask questions about the impact of reflecting on these moments, exploring how the interview felt for them. The interview will finally ask for any feedback, and check-in with the participant about their thoughts, feelings and any distress caused.

Appendix 2-C. Example of Coded Extract

No, I was still very isolated in my flat then just me on my own. And yeah, I was. I was. It was a genuine sort of, umm, I was. You know that that was the choice I was making. Was I gonna continue? Or was that gonna be? Was 2016 gonna be my last year? Uh, and I had felt, and I know I'd I'd reflected on it over that year that like I said, I had said to people, I felt like I'm, I keep. I'm waiting for something.	Choice about suicide
I don't know what I'm waiting for. It's ridiculous. I just constantly feel like I'm waiting and it was, I guess maybe I'm waiting for my luck to change or something like that to happen, you know, and. And so when that message came along, I think it did give me that extra sort of push to. I guess because I've been through a lot of difficult things in my life. Just saw it as just a problem.	Motivation to change Seeing situation as a problem – fixable
Like work it out, solve it. Solve it like a puzzle, cause a bit of a puzzler solve. This like a puzzle, and if if. So I. Well, I know one thing and it's not exactly right. It's not exactly true, but it's sort of is true, is that I said to myself, well if I was gonna go and see a therapist because that was while struggling getting access to any sort of therapy and I would just be talking to him.	
So all that would be happening is that we would be talking and I would be feeling better. So it's not like I'd be given some sort of magic pill and I'd be alright. So if that was true then, maybe I can change some of my thoughts. With like talking to myself or by doing other things, does that make sense? And and and just not have a therapist there. And that did work. I would say that did work a lot. I did manage to get therapy, it was three years I was on a waiting list for therapy and and I was in a much better place when I got the therapy.	Acceptance no magic fix Autonomy Independence Able to change self
But I think there was still stuff. The therapy definitely helped. Essentially, when I had the therapy, it definitely definitely helped, but then there was also a bunch of stuff which I was able to do on my own that didn't require therapy. And yeah, that's that's how I would sort of informally sort of put it in my own words. Yeah. So if that's. Yeah.	Therapy didn't solve everything
And I noticed some emotions came up for you when you were first talking about that message. Can you remember what kind of emotions you were experiencing at the time? Was there a shift in how you were feeling before reading that message and after reading that message?	
Yes. So so hope would be the, umm, the underlying, I guess emotion that it then gave me. I was. I was generally feeling a burden. That's how I felt. So you know when people say people who commit suicide are selfish. So I'm actually very against that message.	Feeling like a burden

I think that's completely wrong because I remember when I was feeling, the reason I was gonna commit suicide was because I didn't wanna put myself on my son and my family or anybody else. So to me it was actually an unselfish act. I'm gonna end. I'm gonna kill myself. So nobody else has to deal with me. I don't want to be a problem anymore.	Suicide as an unselfish act
Umm yeah, so that's how I was feeling. And then I guess there's a combination of hope and empowerment that I could do something, that I was able to do something or you know the and and yeah, and I guess it was in having access to people that had thought about these things.	Hope Empowerment Feeling able to do something
So. So you you think to yourself all these dark things. But then you identify that other people have had these dark thoughts as well, and so they've got through it. So it's all that like I was saying again with the therapy. So OK, So what is that then? What? What happens? What do you do to change that to escape these dark thoughts? Yeah, yeah, yeah.	Other people have felt the same Seeing others ability to get through it
Interviewer: Yeah. So, definitely something about hope and empowerment and this idea that perhaps you're capable or, you know, you can. You can do it without needing other people in that moment.	
Yeah, and that's that. And the other side, it was obviously feeling very trapped like you had no options. And then it starting to see options. Do you know what I mean? That was that was I think a big a big important factor.	Having options
Interviewer: Yeah, yeah, absolutely. And it might be difficult to remember, but did you notice any change in your body or your physical sensations? You know whilst that hope and that empowerment was oming to you?	
Yeah, I would say there was something like, it's hard to I, I don't know. It's it's not something I've particularly thought or talked about, but I would say there's something about a change from being heavy to light. So I I felt very heavy and depressed. And then upon this realization that that decision to get off the fence and just live, I'm not gonna do that.	Feeling lighter Making a decision
That's not that. I'm not gonna do it. That's not the option, so I'm gonna. I'm gonna live. There was a general lightning in the way I felt. You know, I mean like like a like, a literal sort of lightning maybe in my head and my body that I wasn't. And yeah. Yeah. And and and more active.	Suicide no longer an option
Interviewer: Yeah. What do you mean by more active?	

Like. The the motivation had come back. I would say yeah, there was no motivation before. And then there was motivation. I don't know exactly what I could pinpoint where that motivation came from, probably from the hope, and that there was choices. All this stuff I could do, what could I do? Yes, more about that question of of just switching from I can't do anything to. Well, what can I do? I can't do anything. It's quite total total. There are things I can do. So what can I do and then that created a motivation, yeah.	Hope created motivation Having choices created motivation Feeling able
Interviewer: Yeah. OK. Was there anything else in that kind of moment with that message that that feels important or thinking back on it now, significant?	
I suppose, I mean I should I should say there was a a sort of a an elation of some kind as well. It's probably because I probably think, to myself, it's quite obvious, but obviously I was very down and very sad.	Elation
And then I wasn't. It was still there in the background but and. There was a there was a release of some of that and I was probably quite tearful. I'm not sure if that's a false memory, but I could imagine myself being quite tearful in that moment when I think about of of umm. I'm just making the decision that I wasn't gonna die. Yeah.	Making a decision not to die

Appendix 2-D. Example of Organising Themes for Individual Participants

2. Doing something different
- Knowing have to move on
- Deciding to try something different
- Deciding to live
- Finding a different path
- Choosing positivity
- Actioning decisions
- Feeling able to do things differently

1. Turning Point (this led to doing something different)
- Turning point was suicide attempt
- A further breaking point
- Reaching rock bottom
- Suicide no longer an option
- Nothing to lose
- Liberated
- Suicidality no longer working
- Realising suicidality isn't helping

3. Distraction (the path he chose)
- Distract from suicidal thoughts
- Leaving no room for suicidal thoughts
- Throw energy into something else
- Distracting helps but not addressing problems
- Ignoring thoughts and feelings
- Not acknowledging thoughts and feelings
- Work and alcohol

Impact on family
- Clarity of impact on others changed suicidal feelings
- Attempt forced him to think of others – reality

Self-care
- Meeting basic needs (eating) (what he did)
- Gaining energy (what this led to)
- Making a plan (how he did this)
- Small steps – achievements (how did this)
- Routine (how did this)
- One step at a time

Change in thinking
- Clarity in thinking

- Able to consider consequences
- Focus on achievements
- Remembering the suicide attempt
- Thinking about the future
- No specific memory – sealed over
- Thinking of the future, rather than past or present
- Being single minded (internal attributes)

Finding meaning

- Gaining fulfilment
- Choosing to care about things
- Doing things that are worthwhile
- Life satisfaction

Appendix 2-E. Example of Organising Themes Across Participants

PPT 1

- Small steps
- Impact / reaction of others
- Routine/ productivity
- Gaining wisdom / remembering past experiences
- Feeling able / control
- Change in thinking / feeling
- Other options
- Self-care

PPT 4

- Doing something different
- Turning point (leading to something different)
- Distraction
- Impact on family
- Self-care
- Change in thinking
- Finding meaning

PPT 6

- Not feeling alone
- Physical touch
- Something different
- Acceptance
- Gaining wisdom
- Professionals

PPT 8

- Physical changes
- Meaning/purpose/connection
- Emotional changes

PPT 12

- Finding true self / living authentic valued life
- Making decisions
- Physical changes
- Gaining wisdom

- Acceptance
- Validation / normalisation / connection

PPT 13

- Impact on others
- Gaining wisdom
- Feeling cared for
- External circumstances/routine/distraction

PPT 14

- Goals / engaging / distraction
- Possibilities
- View of self
- Reactions from others

Appendix 2-F. Example of Themes Presented to Research Team

Theme 6a – Positive view of self/abilities

Proving to self that was able (1)

"I actually had a really good time, and it only took a few weeks for me to start actually feeling that I was finding it easier. I could do more difficult things and it's that that that's what. That's what made me feel good about it. Yeah. So I I'd wanted. I kind of like it's one of the things I want it to do something. But I was like, yeah, there's no way I can like. I I just. I was like, it felt out of reach. Like I I just can't do that. I'm not that person. I can't do that. But I proved to myself that I was that person and I I could do that."

Feeling capable (1)

- "That was kind of like a that was like a light bulb moment. You know? It's like, ohh, I am capable of enjoying things, so maybe I just need to find what those things are, you know? Erm yeah, like a mentality switch. You know, instead of just feeling like everything's like crushing down on me, I felt more like I could do something about it."

Internalised pride (1)

- "Like doing little little things and feeling accomplishment and doing the little things made and having someone there to tell me you're like ohh it's really great that you did that made me feel proud of myself for doing that."

Theme 6a – Positive view of self/abilities

Realisation of ability (1)

- "And that was a big thing for me. Was realising that I could. I could say to myself I want to do this and then I could go and do it like I I wasn't just..sat there being useless, I could, I could say to myself, I wanna get up and do this and I would then get up and do that and that. That just felt really. That felt really kind of good to me, I guess."

Feeling of achievement (1)

- "Like, I felt like I'd achieved something, you know, I. Started, started feeling a bit of fulfilment from the fact that I had achieved those things."

Perception of ability to change (4)

- "It was very much a case of just like. OK. I've got to do something. And I just didn't have that before. I didn't have a I couldn't. I didn't think I could have made myself go and do something"

Opening self up (8)

- "One of the pagans I I met on Twitter, I became friends with remotely and met in person in London. And. I think opening myself up to that friendship is something that my thoughts would have never allowed me to do before because I would just have been overwhelmed by the idea that this person was better off not knowing me. And especially as you know, this was a total stranger that I've met on Twitter and I was going to London to meet but, I do remember noticing at the time that it was significant I had opened myself up to that."

Theme 6a – Positive view of self/abilities

Letting go and building faith in self (12)

- "And so that was again when I was talking about the mindfulness stuff, letting some of that go and just going with it, and seeing what was happening and building up a faith in myself."

Feeling able to do something (12)

- "Umm yeah, so that's how I was feeling. And then I guess there's a combination of hope and empowerment that I could do something, that I was able to do something or you know the and and yeah, and I guess it was in having access to people that had thought about these things."

No comparing self to others (14)

- "I had a lot of time, even though I was like doing more, I still had quite a lot of time to myself. And it was like. I sort of lost that bit of shame because I was thinking like. I can't compare myself to my mate. Or like I can I can go on Strava and I can see what they've done on their rides. But it's not like something I can compare myself to. It's useless comparing yourself to. I guess that's what I was thinking. I was like."

Theme 6b – being true to self

Authenticity (12)

- "And then there was like, although I didn't recognize it at times there was stuff that I was doing and finding useful about authenticity and letting go of expectations of myself and societal expectations that I would. Now I can now look back and say, right ok actually existentialism helped me loads but I didn't know what existentialism was."

Trusting self (12)

- "I didn't need to trust anybody else, I only needed to trust myself. And I guess then I started building up that trust, and from those little experiences of being authentic and saying if I just do what I think is right based on me, the feedback you're getting from reality I guess, is that you can trust yourself. This is working out, you know, I mean just just go with it."

Authenticity reaps genuine connection (12)

- "I think 2019 I'd gone through the thing with the therapist at a lot of evidence for myself that if I just be be more myself, I think. There was something like. Recognizing that through that authenticity. So there's a quote by someone I can't remember what it was that says the power of authenticity, is it both repels and magnetizes, so you do connect with people better because you're being more yourself and it's more of a relaxed or like this is just me and you get on with someone, but also it does mean some people won't like you and it was accepting and learning and accepting that's OK too, that's a good thing."

Theme 6b – being true to self

Authenticity solves root cause of distress (12)

"The secondary causes and you feel alright for a bit, but if you don't get to the root of the problem then other secondary causes just come back and say something that I think about addressing the primary cause. And with me, I think that was what authenticity did and letting things go did I was addressing the primary causes of of of my suffering and therefore the secondary causes don't happen."

Letting go of others' perceptions (12)

"That's how I felt like I was being perceived as just like, some crazy guy. Umm. And then that makes it really then difficult to talk to people because you're constantly worried about saying the wrong thing…So with the therapy, so in that moment, I definitely remember that that one moment clear in my head visually of just finally just letting all that part of it go. And going OK. Thank you. Uh yes, I'm knackered. I'm ******* knackered from this, having that recognised, you know, recognizing in myself and that I needed a rest."

Being present (12)

"It's letting go of things and being in the present that helps. But then that is bolstered by the existential stuff, where you're being yourself. If you can be yourself and let go of societal expectations that helps being in the present. And these are two things help each other. To me, that's where if you were gonna, if there was any sort of formula, it's in those two two sorts of things"

Becoming self again (13)

"So I became the person I recognized as me again. And so those thoughts became less and less significant over time and to the point where I don't have them very much at all now. And you know, some days I might wake up and feel negative towards my current situation, but it never gets as bad as taking me into the suicidal stuff."

Theme 6b – being true to self

Becoming self (8)

- "I'd been a military child, kind of. That was my culture up until the point when my parents got divorced and it wasn't, and I had tried and dismally failed to join the Navy. I I think that was out of the desperate desire to be part of something. And so I think that's why this being part of paganism, had such a profound effect on me. And then to solidify that and make it real by meeting a flesh and blood person in real life who shared the same beliefs, drove home the fact that I was now, I could now identify as Pagan."

Who I am in the world (8)

- "I wouldn't say it kind of miraculously, all went away overnight. It's. But those thoughts really did lose their teeth almost immediately. Because, I think because it was no longer a question of weighing up the so much utilitarian balance of, me, my existence and the net gain or loss for the world as consequence, it became the existence of paganism, of which I'm apart, and the world. If if I, through paganism was making the world a better, or even just a more interesting place. Just in that cynically rational part of my mind, it was a different equation. And my, frankly in the grand scheme of things, quite minor failings in life in hindsight, again paled in comparison to just the the enormity of this belief system and culture that I was now part of."

Able to be true self (10)

- "But you know. I survived. Here I am…talking along and happier in in in many ways because I can be myself. You know that that repression isn't there anymore."

Appendix 2-G. Further Actions to Mitigate Risk.

– Participants were reminded they could pause, take breaks, and/or terminate the interview at any point, without giving a reason.
– Participants were reminded they do not need to answer any questions they do not wish to, and do not have to give a reason.
– Participants were informed about the content and nature of the interview during the recruitment process and again before the interview commences to ensure they felt able and willing to participate.
– Participants were given an information sheet with information about services/resources before they signed up to the study, and again during the interview.
– The researcher completed a risk assessment/debrief at the end of the interview, in which they discussed how they felt during the interview, if any difficult or distressing feelings arose, and what support they would like following the interview, giving choice to the participant.
– Participants' names, address and date of birth were taken for the duration of the interview. If imminent risk was indicated, the researcher would have requested permission to contact the emergency services to conduct a welfare check. Following the interview, these details were permanently deleted.

Appendix 2-H. Example of Reflective Log.

Pre-ethical approval

We discussed the blurred lines that can appear between research and Clinical Psychologist. There was a sense of 'imposter syndrome', in which I have experience of being in a therapeutic session with clients, however limited experience with undertaking research interviews. Each supervision session is inspirational, and makes me excited about this research project, however, also goes sideways in direction as more topics and questions come to mind.

Beginning of recruitment

I have noticed that individuals are presented with different communication styles based on where they saw the advert (e.g. reddit, twitter). There is a sense of feeling 'pulled in' as people are telling me their stories over email when asking for information about the study. I need to remember and consider the role of a researcher, rather than a psychologist. It is not possible or appropriate to formulate communication styles or how and why people are sharing information with me, I am just looking at a thematic analysis of their words – not them as people.

Following first interview

I thought through the idea that most research comes in at level 1 or 2 in terms of depth of moments. From my first interview, it felt quite broad, I panicked as I didn't know what to ask or how to get to the specific moments. I discussed with my supervisor that there's a process of whittling down – from broad to general memory, to specific memory, to the internal processes and what was the reason for the change during that moment.
When I panicked during the interview, I reflected back and summarised as a way of giving myself more time, something I do within therapy, again this difficulty differentiating between researcher and psychologist came up for me. After supervision though, I felt reassured.

Incident

There was an 'incident' in which a participant seemed to be outside, and it was unclear whether they were in the country. They were not in a private space, and there were concerns around the accuracy of the information they were sharing. I felt at risk at some points. It was difficult as I felt in a vulnerable position by being online, and not being able to see who you are speaking to. However, after speaking with the ethics board, I felt reassured that I was not the only decision maker in this process, and that safety was a priority.

Following participant 12 interview

I feel like I was more free in my questioning – had supervision and felt that it was ok if we don't get what we were originally looking for, so felt that opened me up to more possibilities and asked questions with more genuine curiosity. Ppt had had therapy, so was more aligned in his thinking, ability to self-reflect, which I found made the interview more in keeping with what we were trying to find/explore.

Appendix 2-I. Guidelines for Publication in the Suicide and Life-Threatening Behavior Journal.

This journal participates in the Wiley Clinical Psychology Publishing Network. This exciting collaboration between a number of high quality journals simplifies and speeds up the publication process, helping authors find a home for their research. At the Editors' judgement, suitable papers not accepted by one journal may be recommended for referral to another journal in the network: *Clinical Psychology & Psychotherapy* and *Journal of Clinical Psychology*. Authors decide whether to accept the referral, with the option to transfer their paper with or without revisions. Once the referral is accepted, submission happens automatically, along with any previous reviewer reports, thereby relieving pressure on the peer review process. While a transfer does not guarantee acceptance, it is more likely to lead to a successful outcome for authors by helping them to find a route to publication quickly and easily.

1. Submission and Peer Review Process

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://mc.manuscriptcentral.com/sltb

For help with submissions, please contact: Thomas Joiner (joiner@psy.fsu.edu)

For help with article preparation, Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, and figure preparation.

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Section Three: Critical Appraisal

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Introduction

This critical appraisal will provide a summary and overview of the findings from both the empirical paper and the systematic literature review. Strengths and limitations of both projects will be discussed, as well as clinical implications and possible future directions. Personal reflections about the processes and different stages of the projects will also be considered, including selection of the project topic; applying for ethical approval; the emotional impact of the project; recruitment of participants; conducting interviews; and data analysis.

Summary and overview of findings

The aim of this thesis project was to explore the processes involved in experiences of recovery from suicidality. The systematic literature review focused specifically on synthesising literature exploring first-hand experiences of recovery from suicidality within LGBTQ populations. Through meta-ethnographic synthesis, four themes were identified: (1) connection to self; (2) connection to allies; (3) connection to community; and (4) connection to society. It was the first to consider experiences of recovery from an LGBTQ perspective. The systematic review highlighted the value of accepting and feeling safe to express one's own identity. It also identified that connecting to allies, and community of others who share similar experiences and beliefs helps to alleviate suicidality, as well as the importance of positive societal narratives, and having others who will advocate for their rights.

The outcome of the review suggests the need for strengthening communities, and access to these communities, as well as creating a sense of safety within therapeutic settings. It also highlights the need for more research into this area.

The aim of the empirical paper was to elicit and explore experiences that may represent an 'exit' from suicidal states, including thoughts, feelings, and actions. Eight

participants were recruited to take part in online interviews. Interviews were transcribed and analysed using Reflective Thematic Analysis (Braun & Clarke, 2022). Five main themes were identified: (1) recognising impact on others; (2) interpersonal relationships; (3) doing something different; (4) leaving no room for suicide; and (5) sense of self.

Participants discussed how there were a range of natural processes that occurred, that supported them to move away from suicidal states. Experiences such as having the ability to clearly think about the impact of their potential suicide on important others; relationships offering shared experiences, different perspectives, acceptance, attunement and 'being alongside; taking action once realising that suicide no longer provides the function it once did; creating less capacity for suicidal thoughts through routine and distraction; and having a more positive view of their abilities to cope with distress, and a space for authenticity.

The findings from the empirical paper highlight the need for individualised, nuanced and person-centred approaches to both understanding and managing suicidality. It highlights that there are natural processes that can occur to change and resolve 'core' distress, that include connection to community and the change in contextual circumstance.

The empirical paper described processes of ways people have come through their suicidality. It is important to recognise that these experiences are individual to each participant, and although clustered together through themes, each participant came with their own story, and their own way of making meaning about these stories. Furthermore, the researcher also came with their own story, and their own way of making sense of participants' stories (see Reflexivity section, page 3-7). Most themes represented the ebb and flow of moving away from suicidal states, peppered with some individual transformational moments. This can be summarised through a quote by one participant:

"It felt like if you imagine a series of dominoes. It felt like I was knocking over all these little dominoes which were like progressively helping me. And every now and then, I'll get to a big domino that I couldn't push over on my own, and I'd be stuck. Then I'd have to go and explore something and then that would knock [it over], and once I've got past that bit, it would then hit the next lot of small dominoes."

The majority of moments also occurred naturally, not initiated by participants and not done with an intention to reduce their suicidality. Due to this, it was important to honour the fragility and changeability of participants' experiences by honouring the context surrounding each individual and their moments of change.

Strengths and limitations within the research process

This thesis presents a novel understanding of recovery from suicidality, as it is the first to explore micro changes of suicidal states within the recovery process and is the first to review recovery within LGBTQ populations. However, there are some limitations within the research process. Within the empirical paper, most participants were male, therefore the generalisability of these results may be limited. However, this falls in line with the idea that suicide is a gendered phenomenon, with male deaths outnumbering female deaths around the world (Bennett et al., 2023), and accounting for three-quarters of suicide deaths in the UK (Ridge, Smith, Fixsen, Broom, & Oliffe, 2021). There is an over-representation of females in non-fatal suicidal behaviour and a preponderance of males in completed suicides (Schrijvers, Bollen, & Sabbe, 2012). Researchers have called for a more in-depth understanding of the suicide process, and particularly how males turn away from the act of suicide (Ridge et al., 2021), therefore the unexpected high proportion of males represented in this study may be of benefit.

The empirical study generated a relatively small sample size, due to the limitations and nature of a project of this scope. As such, the results should be reinforced by further qualitative data and through the use of larger sample sizes. There was the potential for self-selection bias from participants, as there may have been a bias towards people who are more reflective, or open about their experiences. As such, it is difficult to generalise insights from this study to other individuals who have been suicidal, or who may become suicidal in the future. Due to the qualitative methodology, which provides an in-depth exploration into the processes involved in recovery, it is however with a non-representative sample.

Virtual interviews

Given that I have not had much experience in carrying out research-based interviews, I worried that I might struggle to collect the level of detail needed to carry out in-depth analysis of the interviews using online interviews, especially during the initial interviews. I was aware of the sensitive nature of the interviews, and as such there was some reservation in terms of conducting interviews virtually, as I was worried that an alliance would be harder to form online. However, research has suggested that online qualitative research participants do not experience this way of conducting interviews as a disadvantage for creating a connection to the researcher (Saarijärvi & Bratt, 2021). This was certainly my experience, where I was able to feel connected to the participants and create a level of comfort when interviewing. It has also been found by Saberi (2020) that video conferencing during Covid-19 closely replicated in-person interviews.

Studies have suggested that taking part in research exploring suicide can be beneficial for participants (Biddle et al., 2013; Gibson, Boden, Benson, & Brand, 2014; Rivlin, Marzano, Hawton, & Fazel, 2012), as the opportunity to talk in-depth about sensitive topics is helpful (Dyregrov et al., 2011; Hawton, Houston, Malmbergand, & Simkin, 2003).

Despite some of the potential limitations and methodological issues throughout this project, I believe that this project provides further insights to the topic area, which requires more literature. Throughout the project, I considered the importance and significance of exploring and providing a voice to those who are often marginalised or overlooked in research. This thesis allowed me to explore in-depth experiences, and by doing so, my hope is that this contributes to a more comprehensive understanding of the processes involved in recovery from suicidality.

Clinical Implications

The importance of understanding suicide risk and prevention can be seen through the introduction of Crisis Resolution and Home Treatment Teams in England in 2000, which include 24-hour and intensive support for those experiencing a mental health crisis (NHS, 2022). However, even with these services, suicide rates have varied little since 2008 (Brown et al., 2020). Currently, most NHS mental health trusts use checklist-style approaches (NCISH, 2018) to assess risk of suicide, however it is known that individuals with experiences of suicidality can present with numerous needs, including relationship, societal, community and individual (Turecki & Brent, 2016), and as such the full complexity of the suicidal experience may be missed. Research has defined clinical recovery as a change in scores on a range of measures that look at suicidality, from a clinical to a non-clinical range (Leavey & Hawkins, 2017; Pratt et al., 2015; Tarrier, Taylor, & Gooding, 2008). However, participants in the empirical study discussed that whilst mental health services and medication helped to reduce some suicidal symptomology, it was community and naturally occurring experiences that helped to resolve their 'core' distress. As such, an approach that is individualised, nuanced, and holds the complexities of suicidal experiences, that listens to the stories of

those telling them, and that supports people to connect with their community may be effective in supporting people who are suicidal.

To date, the primary focus of psychological intervention for individuals experiencing suicidal thoughts has been to reduce ideation and behaviours (Ropaj, Haddock, & Pratt, 2023). Gaining more understanding of recovery and how people move away from suicidality, that goes beyond reductions in symptomology could be helpful for professionals, who report indecisions around how to have conversations about suicide with service users, and fear that broaching this topic could cause harm to the individual (Awenat et al., 2017). It has been suggested that a focus on clinical recovery, i.e. reduction of suicide symptomology, may provide inadequate support from those experiencing suicidality, as service users may want to develop an understanding of their suicidal experiences (Awenat et al., 2018).

Risk of suicide can fluctuate over time, and therefore may mean assessment can present challenges for healthcare practitioners (Fedoroqicz, Dempsey, Ellis, Phillips, & Gidlow, 2023). Therefore, it is imperative that the field of suicide research continues to extend its understanding and move forward from the traditional risk factors and embrace the complexity of this phenomenon (O'Connor & Portzky, 2018).

A common theme found in both the review and empirical paper was the importance of peer support through lived experience. Connecting with others who have similar experiences helped participants to feel supported, understood, safe and ultimately protected against suicidality. As such, there are clinical implications that relate to the value of lived experience, particularly within LGBTQ populations, where lived experience of both suicidal experiences and being a member of a sexual or gender minority group may help support those who are suicidal.

This project has reinforced by belief in the importance of integrating research with clinical work and has been instrumental in emphasising the critical role of evidence-based understanding in providing effective, safe, and compassionate care.

Reflexivity

Shacklock and Smyth (1998) have described reflexivity as the 'conscious revelation of the underlying beliefs and values held by the researcher in selecting and justifying their methodological approach'. It is a defining feature of qualitative research (Parker, Banister, Burman, Taylor, & Tindall, 1994). In line with the epistemological position of critical realism, it was important for the me to recognise and consider how my own context could have influenced the research. A reflective approach suggests that knowledge is constructed, and is therefore developed throughout the research process, and relies on existing beliefs, understandings, and biases (Kvale & Brinkmann, 2009).

It was important therefore, to uphold a reflexive process throughout the research, something described by Berger (2015) as "a researcher's conscious and deliberate effort to be attuned to one's own reactions to respondents and to the way in which the research account is constructed". As such, I kept a reflective log throughout the ethical procedure, literature review, empirical paper, and write-up. This included reflections and discussions had with my research supervisors, as well as documenting my person experiences, thoughts and feelings throughout (see Empirical Section; Appendix 2-H).

Personal reflections

During the process of this thesis project, I regularly reflected upon my own values and practice as a clinician and how this may have influenced my approach and focus through this piece of research. To support the separation of my own views and personal therapeutic

alignments I used a reflective journal to record my own thoughts and experiences of the research process, as a way to separate these thoughts and prevent them from overly influencing the research process.

Selection of project topic

The thesis topic was clinically relevant as the process of suicide is necessary to understand in order to prevent further suicides, of which there remains limited knowledge about (O'Connor & Kirtley, 2018). There is a clinical need for additional understanding around preventing suicide, as evidenced by the government 5 year cross-sector strategy from the Department of Health and Social Care to enhance research and understanding of suicide (DHSC, 2023). By further understanding the mechanisms and processes involved in recovering from suicidality, we can better consider how to develop interventions and support for those experiencing such.

My personal and professional interest in this topic was also relevant for me. Having had personal experiences of the impact of suicide, it felt important to further the knowledge and support available. Having worked with many individuals who are suicidal as an Assistant Psychologist prior to the doctorate, this also fed an interest and passion for this area. My hope was that this research may further our understanding, help to develop interventions to support those who are suicidal, and ultimately to prevent further deaths by suicide.

Ethics application

Ethical issues are important to consider when conducting research within clinical psychology. The nature of such involves personal, sensitive psychological information gathered from potentially vulnerable people (Rae & Sullivan, 2003). Gaining ethical approval can sometimes be considered as a 'hurdle' to get over, which may dominate over fully considering the deeper challenges, tensions and dilemmas that can occur during research

(Reid, Brown, Smith, Cope, & Jamieson, 2018). However, I found that having to complete several versions of ethics documents and thesis proposals, the ethical standpoint of the empirical paper was deeply considered and highly important to myself and the research team.

The first submission to ethics proposed asking participants who were actively suicidal within a Home-Based Treatment Team to complete diary entries for two weeks prior to the interview. Unfortunately, this proposal was not approved, which I found challenging as it felt that so much work had gone into considering the depth of this research. However, this allowed for changes to the study, including adding in the inclusion criteria of not having had any suicidal experiences for the past 12 months and reassured me in relation to risk mitigation during the study. This process allowed me to move away from the 'hurdle' of ethics to get over, and to consider the valuable importance of considering how research impacts those who take part in varied ways.

Contemplating ethical considerations is something that continues long after approval has been granted (Reid et al., 2018). As such, ethical issues were consistently thought about and discussed within the research team. During recruitment, there was an incident in which someone attended for an online interview, however, did not have their camera turned on. There were concerns about the accuracy of their comments about their physical location, and it was felt they were not in a private space. During this, there was a sense of risk, as it was difficult to ascertain who and where this individual was, and there was a sense of myself being vulnerable due to being online. This was discussed with the ethics board, and it was jointly decided that they would be excluded from the study. This was dealt with in conjunction with my supervisor and the ethics board, and I felt reassured that I was not the sole decision maker in this process.

As it was thought that psychological distress caused by discussing the topic of suicide was possible, several measures were put in place to attempt to mitigate against this. This included gaining formal consent following a clear understanding of the process and topic of the research; participants being given information on services and support available; completing a debrief at the end of the interview; and collecting name, address and date of birth for the duration of the interview to allow for information sharing to emergency services if required. A thorough distress protocol was also created and used that stipulated processes to follow if risk was identified (See Ethics Section; Appendix 4-G and 4-H).

Emotional Impact of the Project

Working with sensitive topics has the potential to expose researchers to distress, and it may mean that they may struggle to cope with their emotions (Dickson-Swift, James, Kippen, & Liamputtong, 2006; Jackson, Backett-Milburn, & Newall, 2013). Prior to data collection, I experienced losing a friend to suicide, which made it difficult to emotionally engage with the research at that time. However, with self-awareness, empathy and support I was able to reflect on the significance of this experience. It allowed for more passion and commitment to the research, alongside a willingness to be vulnerable with my research team. Having already had an interest in this area, this experience reinforced my dedication to present the voices and stories of the participants, and to honour their contribution to this research.

Providing supervision or psychological support for researchers working with sensitive topics is imperative (Dickson-Swift, James, Kippen, & Liamputtong, 2009; Johnson & Clarke, 2003; Rager, 2005). To support me, my research supervisor and two field supervisors were clinical psychologists, and were able to offer guidance, support and supervision in relation to

the research. I also had a clinical tutor who was outside of the research, and was able to offer supervision, however this was not necessary during the research.

Recruitment

During the recruitment process, I engaged with forms of social media that I had never used before (Reddit). I noted that the communication style on this forum felt different to other online media platforms I had used previously. Individuals were commenting on the advertising posts on Reddit, stating their issues with the research post, including the word 'suicide'. This was challenging, as within ethical approval it was not appropriate to reply to comments other than to encourage potential participants to email the researcher. Emotions of guilt were present for me, as care had been taken to include trigger warning titles in all posts. It reinforced the notion that suicidality is distressing. However, people also commented stating what an important topic this was, and that they were pleased research was being conducted in this area.

As potential participants were asked to contact the research via email to show an interest in the study, first communication was this method. At times, I felt 'pulled in' by individuals, who sometimes began sharing their stories over email. Whilst this was not asked for, and dealt with appropriately, regular reflection and supervision was needed to understand the role of a researcher compared to a clinician. It was important not to formulate their communication style, but rather to analyse the use of their words.

Conducting Interviews

Following the first interview, it felt that we had not reached the depth of 'momentary shifts' that we were trying to explore. The discussions were broader in nature, and I felt as though I had not asked specific enough questions to reach those true, raw concepts. However, during supervision we reflected on the process of 'whittling down', from broad and

more generalised memories to more specific memories, which would lead to internal processes and the reasons for change during those specific moments.

Throughout the interview process, I experienced a multitude of different emotions. There were some that arose due to feeling connected and attuned to a participant, which helped to reduce some of my anxieties and delve into their experiences more fully. There was also a consistent feeling of anxiety about being a “good” researcher, something that was explored within supervision.

During one interview, brief details about a previous criminal offence was disclosed. This did not create further risk, as it had been dealt with accordingly by police, however it brought about complex feelings of anger, disgust, and disconnection towards the participant. This was challenging to navigate due to the consciousness of the aim of the conversation, and a sense that I was indebted to them as they were offering their time and knowledge. The feelings experienced subsequently arose for a period following the interview and led to a delay in transcribing the interview. Delaying transcription and coding of this interview however, allowed for reflection and discussion with my research supervisor and therefore time to process, acknowledge and manage my initial emotional reactions, therefore minimising the potential influence of these emotions on the analysis.

Data Analysis

The approach used in the empirical paper was reflexive thematic analysis (Braun & Clarke, 2022) whilst conducting the analysis and writing the results, it became clear that the context surrounding participants’ stories was important to describe and share. As such, the write up incorporated a narrative lens, to incorporate contextual information about each participant.

Synthesising data from qualitative research continues to be recognised as an important means to attempt to make sense of complex phenomenon (Luong, Bearman, & MacLeod, 2023). Despite meta-ethnography being an increasingly used qualitative literature synthesis method within healthcare research, (Cahill, Robinson, Pettigrew, Galvin, & Stanley, 2018), there remains a lack of transparency regarding the description of the stages of data analysis (France et al., 2019). As such, I experienced anxieties surrounding conducting a meta-ethnography, as this was something I felt I had no expertise in. Therefore, during this process a lot of time was spent on understanding the mechanisms and processes of conducting this type of analysis.

As qualitative synthesis is subjective, it is possible that there are many other alternative interpretations that could have come from the literature reviews (Sandelowski, Voils, & Barroso, 2006), which may impact on how well represented the synthesis findings could be (Sattar, Lawton, Panagioti, & Johnson, 2021).

Conclusion

This critical appraisal has aimed to provide transparency towards my role within the research bias. The research aimed to contribute to the understanding of suicidality, it's processes and recovery from such. The research has presented a synthesis of experiences of recovery from suicidality from the perspectives of LGBTQ populations, as well as new evidence for processes of momentary shifts away from suicidal states within the general population. As a result of this thesis, clinical implications and directions for future research have been presented.

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Section Four: Ethical Section

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval Research

Exploring personal experiences of naturally occurring exists from thoughts and behaviours of suicide – Approved

Information regarding this research project

Are you conducting a research project?

Yes

Does your research only involve animals?

No

Are you undertaking this research as/you are filling this form out as:

PhD or DClinPsy student

Which faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

Will your project require NHS REC approval?

No

Do you need Health Research Authority (HRA) approval?

No

Have you got external ethical approval from another organisation? For example another University, the NHS, or an institution abroad?

No

Is this an amendment to a project previously approved by Lancaster University?

No

Will your research involve any of the following?

Human Participants

Project information

Please confirm/append the title of this project.

Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide.

Estimated Project Start Date

29/05/2023

Estimated End Date

31/08/2023

Is this a funded Project?

No

Research Site(s) Information

Will you be using Research Site(s) outside of Lancaster University?

No

Applicant Details

Are you the named Principal Investigator at Lancaster University?

Yes

First Name:

Sophie

Surname:

Thomas

Department:

Health Research

Faculty:

Faculty of Health and Medicine

Email:

s.thomas8@lancaster.ac.uk

Phone number:

Supervisor Details

First Name

James

Surname

Kelly

Department

Health Research

Faculty

Faculty of Health and Medicine

Email:

Do you need to add a second supervisor to sign off on this project?

No

Additional Team Members

Other than those already added, please select which type of team members will be working on this project:

External

Please list all external contacts here:

Lee Fitzpatrick, NHS

Peter Taylor, Manchester University

Details about the participants

As you are conducting research with Human Participants/Tissue you will need to answer the following questions before your application can be reviewed.

What’s the minimum number of participants needed for this project?

8

What’s the maximum number of expected participants?

12

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

Yes

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

Yes

Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

No

Is your research with any vulnerable groups? (Vulnerable group as defined by Lancaster University Guidelines).

No

Is your research with any adults (aged 18 or over)?

Yes

Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

No

Is your research with adult participants (aged 18 years or older) in private interactions (for example, one to one interviews, online questionnaires)?

Yes

Is your research with any young people (under 18 years old)?

No

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

Yes

Could the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life?

Yes

Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

Yes

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

No

Details about Participant relationships

Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

No

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

N/A

Will you be using a gatekeeper to access participants?

No

Will participants be subjected to any undue incentives to participate?

No

Will you ensure that there is no perceived pressure to participate?

Yes

Will you be using video recording or photography as part of your research pr publication of results?

Yes

Will you be using audio recording as part of your research?

Yes

Will you be using audio recordings in outputs (e.g. giving a presentation in a conference, using it for teaching)?

No

Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc.)?

Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data

Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)?

Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

No

Online Sources

Does your research comply with the site(s) terms and conditions?

Yes

Is there a reasonable expectation of privacy?

No

Is it practical to obtain consent?

Yes

General Queries

Does the funder or any organisations involved in the research have a vested interest in specific research outcomes that would affect the independence of the research?

No

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

No

Can the research results be freely disseminated?

Yes

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

No

Will you be gathering/working with any special category personal data?

Yes

Are there any other ethical considerations which haven't been covered?

Yes

REC Review Details

Based on the answers you have given so far you will need to complete some additional questions to allow reviewers to assess your application.

Questions for REC Review

Summarise your research protocol in lay terms (indicative maximum length 150 words).

According to the World Health Organisation report in 2019, every year 700,000 people die by suicide, and twenty times this attempt suicide globally. Evidence shows suicidal experiences can increase and decrease in strength, and some people recover from feeling suicidal. However, little is known about factors that reduce suicidal states. To our knowledge, no studies have captured the nature of experiences of exits from suicidal states.

The study aims to capture experiences of reductions in suicidal experiences in everyday life. Participants will include people who have experienced suicidal thoughts, feelings, and/or behaviours, however, are no longer experiencing these. Responses will be collected through interviews. Interviews will be analysed to identify themes. Talking about experiences of recovering from suicidal states could help people to strengthen these memories, which could help other people who might become suicidal in the future.

State the Aims and Objectives of the project in Lay persons' language.

1) What are individuals' experiences of exits from states they identity as suicidal?
2) What does it feel like when these moments are brought to attention?

Participant Information

<u>Please explain the number of participants you intend to include in your study and explain your rationale in detail (e.g. who will be recruited, how, where from; and expected availability of participants).</u>

It is aimed to recruit 8-12 participants. There will be a minimum of 8 completed interviews. The maximum number is due to the time intensive nature of conducting interviews and analysing qualitative data, and the limited time available for a thesis project. It is thought that 12 data sets will be adequate to prevent dilution of richness of individual accounts that can be an issue with larger amounts of participants. It has also been found that within interview studies, after around 12 participants, saturation begins to occur. As this study is part of a doctorate program with limits in relation to time and resources, it is thought that any more than 12 full data sets will not be feasible to analyse and report in a timely manner. As this is a novel study, it is difficult to predict potential drop-out rates for participants. However, the study will have a minimum of 8 completed interviews, to protect against any incomplete participation. The minimum and maximum number of participants does not include potential drop-out.

Once the maximum number of participants has been reached, participants will be informed once they express interest in the study that we are no longer recruiting, and all posts will be taken down from social media. Participants will be recruited from UK wide. As recruitment is taking place via social media, this offers the change to advertise across all areas of the UK and will hopefully mean each area is represented.

<u>You have selected that the research may involve personal sensitive topics that participants may not be willing to otherwise talk about. Please indicate what discomfort, inconvenience or harm could be caused to the participant and what steps you will take to mitigate or manage these situations.</u>

It will be made clear to participants before beginning the interview, that we will be discussing experiences of suicidality. As such, participants will have the choice as to whether they feel comfortable discussing these topics, before it begins. Research has found that making clear expectations that potentially uncomfortable topics will be discussed offset any distress caused (Peters et al, 2022).

Interviews will include information that could be sensitive or upsetting. However, particularly sensitive topics will not be necessary to discuss, and the participant will have freedom to decide whether they wish to answer a question or not. Participants will be reminded that they are able to pause the interview at any time, and the interviewer and participant can discuss whether they would like to meet again on another day, discontinue the interview all together, or take a break and come back on the same day. Please see the Distress Protocol for more detail.

Between accepting participants for the study and the interview (around two weeks) participants will be sent an email reminding them to look at the participant information sheet and to consider their wellbeing. The day before the interview is due to take place an email will be sent to participants offering to discuss how they are feeling and any concerns they may have. Prior to the interview, the researcher will discuss with participants how they are feeling, and whether they feel ok to complete the interview.

<u>You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.</u>

We will collect gender from participants. We will also collect participants' name, address and date of birth for the duration of the interview. This will be so that if risk is seen within the interview, the research will ask permission to contact the emergency services on their behalf and request a welfare check. This will only occur if risk is deemed to be imminent. If permission was not given for a welfare check, and the risk was deemed to be imminent, it would be explained to the participant that the researcher is duty bound to share information for their safety and the emergency services would still be contacted. If a participant had communicated any risk and left the teams call in distress, the emergency services would be contacted to complete a welfare check.

<u>Please describe how the data will be collected and stored.</u>

Participants' gender will be stored securely on the University's authorised secure network, OneDrive. This information will be stored alongside participant ID's, and will not be stored with names or email addresses.

Participants' address and date of birth will be typed onto a word document on an encrypted laptop for the duration of the interview for the purposes of giving this information to emergency services to complete a welfare check if required. Requirements for this would include the participant communicating imminent risk towards themselves. This information would be beneficial as it would give emergency services enough information to provide a

welfare check and keep the participant safe from harm. The justification for this information being collected will be shared with the participant clearly before the interview begins.
Once the interview is completed, and no imminent risk has been communicated, this document will be permanently deleted. This information is not necessary for conducting this research, and therefore maintaining this information following the interview would go against the Data Protection Act (2018). There would also be a risk that this information is identifying for the participant, and therefore it is vital this information is deleted as soon as is possible.

Please describe how long the data will be stored and who is responsible for the deletion of the data.

The participants' gender will be detailed within the write up of the study, however it will not be alongside any other identifying information. The study will detail how many participants identified with which gender, and pseudonyms used within the write up will be specific to the gender they aligned with during the time of the interview.
The participants address and date of birth will be deleted immediately once the interview has been completed. If risk is imminent, and the researcher was required to contact the emergency services, the address and date of birth will be deleted once this phone call has been terminated. The researcher conducting the interview will be responsible for deleting this data.

<u>You stated that the study could induce psychological stress or anxiety or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life. Please describe the question(s) and situation(s) that could lead to those outcomes and explain how you will mitigate this.</u>

It is possible that taking part in the study and discussing potentially traumatic suicidal experiences may cause distress or anxiety for the participant. However, individuals completing the study will have self-identified that they no longer experience any suicidality, including thoughts, urges, bodily sensations, or actions. As such, participants will have decided as to whether they feel able to contribute to the project safely. The advertisements for the study, and information sheet will both reflect that participants do not need to take part if they are concerned, they will find the study distressing and that they can exit the study at any time if desired.

Questions that may be included in the interview include:

Can you remember a time when your experience of suicidality reduced?

What was happening around you at this time?

Did you experience a change in your body during this time?

Did your emotions change during this time?

Did your thoughts change during this time?

Was anyone around you at this time?

Please see the interview schedule for more details.

Participants will be reminded they are able to pause or stop the interview at any time, and they are not required to answer any questions they feel will cause intolerable stress or anxiety. At the end of the interview, a short debrief session will take place in which it will be discussed how the participant is feeling, and if anything came up for them during the interview. They will also be given a debrief sheet, with information about services/resources they can access if they are distressed and need further support. They will also be offered the option of the researcher emailing them to check-in one week later. A distress protocol will be always followed. Please see Research Protocol for evidence showing that talking about suicide does not increase thoughts, risk, or behaviours of suicide.

It is very unlikely that participating in the research will cause humiliation for the participant.

<u>You have selected that there is a risk that the nature of the research might lead to disclosures from the participant. What kind of information might participants disclose? How will you manage that situation?</u>

It is possible that during the interview the participant may share information about their current level of risk to themselves. This is unlikely however, as it will be made clear to participants that to take part in the study, they cannot have experienced suicidality for 12 months prior, and will be expected to discuss previous suicidal experiences. If a participant discloses that they are currently experiencing suicidal thoughts or urges, the distress protocol will be followed. The interview will not continue as they will no longer meet the inclusion criteria. They will be encouraged to access crisis lines (provided to them before the interview and after the interview), call 999 or attend A&E if they feel they are at imminent risk of harm towards themselves. They will be encouraged to contact their person of contact

if they felt they would like immediate support from someone they trust. If it is deemed that the participant is in imminent risk of harm towards themselves, and do not feel they are able to contact emergency services themselves, they will be asked whether they consent to the researcher contacting the emergency services on their behalf. If they do not consent, researcher will inform participant they must break confidentiality and contact the emergency services. Please see Distress Protocol and Distress Protocol Flow Diagram for more detailed information.

Participant Data

<u>Explain what you will video or photograph as part of your project, why it is appropriate and how it will be used.</u>

The interviews will be audio and video recorded. This is so when the researcher is transcribing the data, non-verbal cues and body language can be re-examined along with the transcript to further the interpretation of content. It is appropriate due to the sensitive nature of the topics discussed, non-verbal cues and bodily movements may be pertinent to the context and meaning underlying what is being said. During the interview, participants may also be asked about their bodily sensations, and therefore pointing or showing may occur if the participant does not verbalise their response. If this is the case, video recording is necessary. However, participants will not be required to provide video recordings. They will be asked to consent, and if they do not, the researcher will leave their camera on, however the participant will turn their camera off and only audio recording will take place.

Images of participants will not be used in any outputs such as publication. The video file will be created through Microsoft Teams, which is secure. Videos will then be transferred to a folder on the University's secure drive, OneDrive. This will occur using a laptop that is password protected and encrypted. Only the researcher and the direct research team will have access to this file. Once I am not longer a student at the University the video recordings will be deleted.

How will you gain consent for the use of video/photography?

The use of video recording has been clearly stated within the participant information sheet, and participants will be asked whether they agree on the consent form. Participants will be reminded at the beginning of the interview, before recording begins, and will be asked to again consent verbally to this. At all points, participants will be reminded that their participation is voluntary, and they do not have to process if they do not wish to.

State your video/photography storage, retention and deletion plans and the reasons why.

Recordings will be stored in a secure storage cloud file on the University's server. Video recordings will be kept until I am no longer a student at the university and will then be deleted.

What would you do if a participant chose to make use of their GDPR right of "being forgotten" or "right to erasure"? Could you remove their data/video/picture from publication?

If it is within two weeks of the participant completing the interview, the video data and audio recordings would be deleted, and their data would not be used within the study. This is outlined on the participant information sheet and consent form. Following this, once the

interview has been transcribed, the video recordings will be deleted permanently if requested by the participant, however their transcripts would remain as they would have been linked with other interview transcripts.

Will you take all reasonable steps to protect the anonymity of the participants involved in this project?

Yes

Explain what steps you will take to protect anonymity.

Only the direct research team will have access to the video recording. Videos will not be shown in any part of the write-up, or published in any way. videos will not be used for any other purpose than identifying distress within the interview, and for aiding context when analysing the data. Until the transcription of the interview is complete, videos will be saved in a separate folder to the transcript and any other form of identifiable information. Following transcription, videos will be deleted.

Information about the Research

What are your dissemination plans? E.g. publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

There is a plan to publish this research in an appropriate academic journal, for example The Journal of Crisis Intervention and Suicide Prevention, or Psychology and Psychiatry Research and Practice. It may also be possible to disseminate the findings of the research on social media. More dissemination plans will be made in conjunction with the research team following completion of the study. Participants will be asked if they would like to be sent the results of the study upon completion.

Online Sources

You have stated that it is practical to obtain consent for the use of the data for this project. Please explain how you propose to obtain consent.

After a participant has had an opportunity to look at the information sheet provided, they will be asked to sign a consent form. Participants will respond to a poster on social media via email. The researcher and potential participant will then discuss the study in more detail, and the participant will be sent the information sheet and consent form over email to consider. Once the participant has had adequate time to consider the study, they will return the signed consent form to the researcher via email. Eligibility for the study will be discussed both at the introduction to the study, and at the beginning of the interview. If a participant has not signed the consent form when the interview is due to begin, a separate teams meeting will be recorded to go through the consent form verbally with the participant before the interview begins.

General Queries

You have indicated that you will be gathering/working with special category data. Please confirm here how you will comply with data protection law (GDPR) for use of special category/personal data.

Processing of this special category data (collecting information about ethnicity) is in the public interest. It is possible suicidality has a differing impact for people from different ethnic background. This meets the condition of ‘processing is necessary for the performance of a task carried out in the public interest’ of article 6(1). It also meets the condition of being

necessary for the purposes of public interest and scientific research purposes from article 9(2).

You have stated that there are other ethical considerations that have not been covered. Please explain what these other ethical considerations are, and how you would mitigate concerns regarding this research project.

There is a potential risk for the researcher to become distressed listening to individuals' experiences of suicidality. Considering this, there are three qualified clinical psychologists who will be acting as supervisors for the primary researcher. They will provide guidance and support throughout the project. All three supervisors have experience of working with individuals who are distressed and who are communicating risk. They also have experience of supervising researchers who are undertaking research in similar areas. The potential distressing impact of this research will be a continuous agenda item within meetings and supervision. There will be time and space allocated specifically to discuss this. The primary researcher has also allocated a member of Lancaster University staff who is outside of the research team, who has consented to be contacted for support and guidance related to the wellbeing of the researcher. The researcher will not be conducting interviews with anyone who is currently a risk to themselves or others.

Those who have encountered trigger warnings believe they are crucial ad essential when discussing potentially triggering subjects (Boysen et al, 2021). As a result, the study's advertisements will feature a content warning that explicitly states that the study will inquire about suicidal states, enabling prospective participants to make informed decisions.

Data Storage

How long will you retain the research data?

The research data will be stored for up to 10 years following the study end. This will be stored in a secure file on the University's network.

How long and where will you store any personal and/or sensitive data?

Personal data will be stored for less than three months following the study end. Data will be stored on the University's secure network. If participants wish to receive a summary of the findings once they are available, email address will be kept to allow to contact following the end of the study. This will be consented to and kept in a separate secure file to any other data. Once the results have been shared, these email addresses will be deleted.

Please explain when and how you will anonymise data and delete any identifiable record?

Only names, email addresses and gender will be collected as identifiable information. All identifiable information will be anonymised in the write up of the study. Only members of the direct research team will have access to the study data. Only members of the research team will have access to the participants' names and email addresses. Recordings will be transcribed by the researcher and saved onto a Microsoft Word document. Both the recordings and transcripts will be uploaded on the secure university OneDrive as soon as possible. The laptop used for this will be password protected and encrypted.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

As you are using Human Participants you must upload a copy of the Participant Information Sheet:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	Participant Information Sheet (002)	Participant Information Sheet (002).docx	03/07/2023	2	132.6 KB

As you are using Human Participants you must upload a copy of your Consent Form:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	Consent Form (002)	Consent Form (002).docx	03/04/2023	5	57.4 KB

As you are FHM you are required to upload a Research Proposal.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Research Proposal	2069 Thesis Proposal Form 06.04.23	2069 Thesis Proposal Form 06.04.23.docx	06/04/2023	4	113.5 KB

In addition to completing this form you must submit all supporting materials. Upload documents that you will use and that participants will see. Please indicate which of the following documents are appropriate for your project:

- [x] Advertising materials (posters, emails)
- [ ] Letters/emails of invitation to participate
- [ ] Consent forms
- [ ] Participant information sheet(s)
- [x] Interview question guides
- [ ] Focus group scripts
- [ ] Questionnaires, surveys, demographic sheets
- [ ] Workshop guide(s)
- [x] Debrief sheet(s)
- [ ] Transcription (confidentiality) agreement
- [x] Other
- [ ] None of the above.

Please upload the documents in the correct sections below:

Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

Please upload all advertising materials (posters, emails)

Documents

Type	Document Name	File Name	Version Date	Version	Size
Advertising materials	Advertisements	Advertisements.docx	03/07/2023	2	407.7 KB

Please upload all different Interview Question Guides.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Interview question guide	v.2 Interview schedule	v.2 Interview schedule.docx	03/07/2023	1	14.8 KB

Please upload a copy of your Debrief sheet.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Debrief sheet	Debrief Sheet	Debrief Sheet.docx	27/04/2023	2	45.9 KB

Please upload any other relevant documentation related to this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Other	v2. Research Protocol	v2. Research Protocol.docx	03/07/2023	2	792.6 KB

Declaration

Please Note

Research Services monitors projects entered into the online system, and may select projects for quality control.

All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

- [x] I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

- [x] I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

Request Signature

Signed: This form was signed by Dr James Kelly (j.a.kelly@lancaster.ac.uk) on 05/07/2023 21:04

To complete and submit this application please click "Sign" to confirm that:

- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS
- That you have completed the ISS Information Security training and passed the assessment
- That you will abide by Lancaster University's lone working policy for field work if appropriate
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission
- If anything changes in your research project you will submit an amendment

Signed: This form was signed by Miss Sophie Thomas (s.thomas8@lancaster.ac.uk) on 03/07/2023 10:02

Appendices

Appendix 4-A. Research Protocol

Title

Exploring personal experiences of naturally occurring exits from states associated with suicide.

Name of applicant/supervisors

Applicant: Sophie Thomas

Research Supervisor: James Kelly

Field Supervisors: Lee Fitzpatrick, Peter Taylor

Introduction

Suicide is a worldwide problem. It is estimated that 800,000 people die by suicide every year, and reported attempted suicides are suggested to be twenty times this (WHO, 2019). Furthermore, our ability to predict suicide has not improved from 50 years ago (O'Connor & Kirtley, 2018). Therefore, further exploration into the prevention and intervention of suicide is necessary.

As part of this, research has predominantly focused upon psychological theories to explain why someone might consider suicide. These include a lack of social support (Gunnell, Harbord, Singleton, Jenkins, & Lewis, 2004); negative life events and feelings of hopelessness (O'Connor & Nock, 2014); perceptions of burdensomeness and thwarted belongingness (Joiner, 2005); and feelings of defeat and entrapment (O'Connor & Kirtley, 2018). These factors could be defined as transdiagnostic suicide specific states, and have been found across multiple diagnostic groups including Psychosis (Girgis, 2020); bipolar disorder (Costa

et al., 2014); and Borderline Personality Disorder (Yen et al., 2021). Considering this, more evidence regarding transdiagnostic factors that may lead someone to recovery of suicide, may be useful to study.

Whilst there is some research focusing upon factors that could lead to recovery from suicidality, this has mainly been explored at a macro level, for example, from a perspective of hope and recovery which has occurred from a narrative level from people deeming themselves to be recovered. Research into macro-level recovery processes has evidenced helpful factors such as feelings of belonging (Gajwani, Larkin & Jackson, 2018) and connection with others (Lakeman & FitzGerald, 2008). However, the difficulty with only focusing upon general and macro level factors, is that it does not consider individual variation and phenomenology as it is more concerned with general trends, and currently there is limited qualitative research exploring this. Furthermore, the integrated motivational-volitional model of suicidal behaviour (O'Connor & Kirtley, 2018) suggests that a person may experience fluctuating levels of suicidal ideation and intent, which will move a person in and out of active suicidal states. Diary studies have also reported that people can experience fluctuations in suicidal thoughts in daily life, although very little is known about specific causal factors involved in the reduced frequency (Kleiman et al, 2017). Therefore, it would be beneficial to explore “in-the-moment’” experiences of reductions of suicidal states to add to evidence surrounding more generalised recovery.

Anecdotal evidence has suggested that people can experience natural exits from suicidal states. Natural exits have been described as events of personal significance where a qualitative shift occurs and a person can recognise a reduction in suicidal states, an example may be someone feeling a sense of relief when they reconnect with a loved one (Tarrier et

al, 2013). However, there is limited evidence exploring these, and as such, there is also little information regarding how to capture these experiences. By exploring these natural exits, and working towards an understanding of these moments, it may lead to identification of key needs of the suicidal person and how these have been met during their everyday life. Identification of these factors may then be translated into psychologically informed interventions to both prevent and treat acute states of suicidality, particularly for an acute risk. As there are transdiagnostic factors leading a person into a suicidal state, there may be universal factors that can reduce these states, across clinical groups. As such, this research will explore these experiences with a people from the community who identify as having recovered with no exclusion based on differing mental health.

A further reason to investigate moments of natural exits is that there is a suggestion that bringing them to people's attention may be inherently therapeutic and contribute to the prevention of suicidal states in the future. It has been suggested that people with suicidality experience cognitive constriction (Baumeister, 1990) or tunnel vision; they are in an intolerable state and don't believe that they can escape from it, despite prior experience that such states do pass. Anecdotal evidence from Tarrier et al. (2013) suggests that strengthening retrieval (Brewin, 2006) of previous exits from such states may make them easier to recall during moments of 'tunnel vision', leading to a reduction in the sense that such states are never ending, increasing the person's capacity to cope.

This study will collect data on peoples naturally occurring reductions or exits from suicidal states and the thoughts, feelings, and behaviours associated with such events. Data will be collected through qualitative semi-structured interviews.

Implications for this study include potential theoretical and intervention developments. More specifically, it is possible that understanding experiences of natural exits from suicidal states may help to inform risk assessments, and shape interventions to be focused upon exploring exits and increasing the chances of these exits for service users.

The primary aim of this study is to elicit and explore experiences that may represent an 'exit' from states of suicidal crisis. A secondary aim of this study is to gain an understanding of the impact of recalling and processing moments of exits from such states, given that anecdotal data and clinical experience suggests that this is an inherently therapeutic activity that may increase a person's sense that crisis states are transitory.

Method

1. Design

The study will use a qualitative methodological design using semi-structured interviewing. It is aimed to capture natural "in-the-moment" experiences.

2. Participants

It is aimed to recruit 8-12 participants. The minimum number is due to the time intensive nature of conducting interviews and analysing qualitative data, and the limited time available for a thesis project. It is thought that 12 data sets will be adequate to prevent dilution of richness of individual accounts that can be an issue with larger amounts of participants.

Participants will be recruited from social media. Participants will no longer be self-identified as experiencing suicidal thoughts, plans, intentions, or behaviours.

Inclusion criteria:

- Over 18 years old
- Having previously experienced a state of mental health crisis that has involved suicidal thoughts, urges or actions.
- Having not experienced a state of mental health crisis that has involved suicidal thoughts, urges or actions in the past 12 months.
- Participants will be judged as having capacity to consent to the research.
- Suicidal behaviour will not have occurred during an acute psychotic episode, delirium, substance intoxication or withdrawal.
- English speaking and an ability to communicate verbally regarding their experience of crisis
- Access to a smart phone or laptop
- Living in the UK

Exclusion criteria:

Under 18 years old; non-English speakers; Participants whose crisis occurred during an acute psychotic episode, delirium, substance intoxication or withdrawal; Participants who are currently experiencing suicidal thoughts, urges or actions; Participants who are at imminent risk of harm to themselves or others

3. <u>Materials</u>

<u>3a. Measures</u>

The following demographic details of participants will be collected: age, ethnicity, diagnosis (if appropriate), details of previous suicidality. and mental health status.

3b. The interview schedule

Topics of the interview will include exploring the moments of natural transitions out of suicidal states, and the state people transition to, along with the details of any event associated with this transition. By state, we mean mind-body subjective experiences, including thoughts, feelings, and bodily states.

As part of the interview, there is an aim to put participants at ease, which will include developing a trusting relationship between participant and interviewee and giving participants clear guidance regarding information sharing and the boundaries of confidentiality.

Feedback regarding the interview will be provided and discussed with each participant at the end of the interview. This will include completing a risk assessment. Throughout the interview the interviewer will monitor for verbal expression of risk and/or affect changes that may be indicative of risk and will follow the distress protocol in conducting a risk assessment (please see appendix).

4. Procedure

4a. Recruitment

Potential participants will be recruited using social medica platforms of Facebook, Twitter Reddit, and LinkedIn. The social media posts (See Appendix C) will encourage sharing via professional network contacts and the use of tagging influencers in the field. Recruitment

will take place following ethical approval and virtual interviews will be arranged via email communication to take place as soon as is feasible for the interview and participant.

The poster will be advertised on Facebook. For the purposes of this research, a new research Facebook page will be created with no personal data held on it. The poster will be advertised on closed groups relevant to the topic area. The researcher will ask permission from the group admin to post.

The researcher will use their personal LinkedIn and Twitter accounts as these are deemed to be professional pages. We will also request that the study be advertised on the Lancaster DClin Twitter page. The poster will be shared on the main page, however any comments related to the post will be encouraged to email the researcher directly. The researcher will only reply to comments asking the individual to email directly.

4b. Referred to the study

Once the participant has made contact via email with the researcher, and is deemed to be appropriate, taking into consideration the inclusion and exclusion criteria, the participant information sheet and consent form will be sent via email to the potential participant. The participant will then have time to consider if they would like to take part, and will be asked to complete the consent form and return it via email to the researcher.

4c. Consent procedures

After the participant has had an opportunity to look at the information sheet provided, and ask any questions, they will be asked to sign a consent form. Participants will be asked to email a completed consent form to the researcher. If participants do not send a completed consent form by the time of the interview, a separate teams meeting will be recorded

where the researcher and participant go through the consent form through screen sharing, and the participant verbally consents.

4d. Interviews

Throughout the interview, information will be regularly checked with the participant to check the meaning of discussions. This will be done through using techniques such as summarising and reflecting, which will also support engagement. The academic supervisor, who is also a trained Clinical Psychologist experienced in suicide risk assessment and management will also be available at the time of the interview, for the trainee to contact, should any risk issue arise.

Interviews will be held online via Microsoft Teams. During the interviews participants will be asked directly about their suicidal experiences. Whilst there is research evidence to suggest that this does not increase risk (Kivelä, van der Does, Riese, & Antypa, 2022), it is possible that people will experience distress. We have a full distress protocol (see Appendix A). Participants will be made aware that there is no requirement for them to answer questions if they do not wish to do so. It will be made clear to the participant that they can stop at any time during the interview. The interview questions/topic guide may be amended, based on feedback of participants, to better capture the experience of future participants.

The language, timing and form of the interview questions will be adapted, from discussions with each participant to make them more understandable and person-centred for them.

4e. Debrief with the participants

Feedback regarding the interview will be sought from the participant at the end of the session. This will include checking how they found the interview, how their mood is, any risk

issues identified, if they need any follow-up support from their mental health team. Participants will also be provided with a debrief sheet following the interview. This will include information about services/resources they can access if they feel they need for further support.

5. Proposed Data analysis

The study will use Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2022) as a method to analyse interview data collected. This will use six phases, including familiarising with the data by reading; generating initial codes; looking for themes; reviewing these themes; defining and naming the themes; and using these to produce a report. As part of the first stage, familiarising self with data, watching video recordings and listening to audio recordings is important to immerse self into the data. Codes will be derived from transcripts made from audio recordings of the interviews. There will be an initial stage of listening and watching the recordings prior to making notes, to engage in active listening, and using non-verbal cues to enhance and provide contextual information to the words being spoken. RTA has advantages as it can be used collaboratively with participants (Braun & Clarke, 2022). This is beneficial and relevant to this study, as collaboration is key to building a trusting relationship which will be necessary in producing data for this project.

Whilst using thematic analysis, the data will also be interpreted using a critical realist position. This will assume that suicidality exists within reality, however the causes and mechanisms, and ways out of suicidality can be interpreted. The critical realist perspective observes the world as complex and supports research to acknowledge context within different phenomena (Roberts, 2014). As such, this stance lends itself to exploring suicidality

due to its complexities and importance of context. Features of critical realism such as the mind-independent nature of reality, lends itself to the complexity of suicidality, which recognises the context and mechanisms where multiple elements added together are more than the sum of the parts involved (Sturgiss & Clark, 2019).

6. Data Management

The interview session will be audio and video recorded via the record function on MS Teams, the data is encrypted in transit and at rest, and the data is secured on the MS Teams secure network. The recordings will be transcribed by the researcher and saved onto a word document. Both the recordings and the transcripts will be saved onto the University's approved secure system, OneDrive, which is only accessible for the research team. The laptop used for this will be password protected and encrypted.

If participants wish to receive a copy of the study once it is completed, email addresses will be kept until the write up has been completed. These will be stored in a separate folder on OneDrive, with no other information. These will be deleted once the study has been sent out. If they do not wish to receive a copy, email addresses will be deleted once data has been collected and has begun to be analysed (two weeks following interview). A separate secure folder will contain a list of participant ID numbers and the associated names. This will allow data the researchers to identify transcripts if participants wish to withdraw from the study. This will be deleted once their data has been analysed and it is no longer possible to withdraw data from the study. Participants will be provided with a copy of the consent form and information sheet. The researcher will keep a copy of the completed consent forms in a separate electronic folder to transcript data.

The data will be stored securely on a shared space on the university server that only myself and the research team will have access to. The computer used to conduct interviews and to analyse the data will be password protected and encrypted. This complies with the university legislation, and their good practice policy.

7. Ethical considerations

There is the potential for the researcher to identify risk information regarding the participant during the interview. However, it will be made sure that participants will not have experienced suicidal experiences in the past 12 months and feel able to discuss these experiences. This will be to exclude participants who are at immediate risk of harm to themselves or others. The distress protocol will be followed at all times (please see appendix A).

There is also a potential that participating in the study could increase the participants' risk. However, it has been evidenced that assessing and discussing suicidal thoughts does not increase severity or intensity of suicidal thoughts, or risks associated with them (Coppersmith et al., 2020). Dazzi, Gribble, Wessely, and Fear (2014) conducted a review of the published literature and reported that no studies found a significant increase in suicidal ideation when asked about suicidal thoughts. They suggested that talking about suicide could reduce rather than increase suicidal ideation. A further review of both published and unpublished literature in 2018 similarly found that exposure to suicide-related content led to significant reductions in suicidal behaviours, and reduced the risk of engaging in suicidal behaviour (Blades, Stritzke, Page, & Brown, 2018). Kivelä et al. (2022) recently conducted a

systematic literature review looking at using ecological momentary assessment to explore suicidal thoughts and behaviours. No evidence of reactivity of mood or suicidal ideation was found following repeated assessments of suicidal thoughts and behaviours. They concluded that ecological momentary assessment is suitable for capturing fluctuations in suicidality over time. Finally Peters et al. (2022) conducted research exploring whether participants experienced any brief or lasting impact of taking part in research studying suicide. They found that mood either improved or did not change over the course of assessment, with more positive than negative feelings identified. Participants identified many benefits of participating, and any short- and long-term distress arising from participation was offset by the expectation and acceptance of this occurring. Together, research therefore suggests that inviting people with severe mental health difficulties to participate in research exploring suicide is not detrimental. As part of the inclusion and exclusion criteria, participants will not be able to take part in the study if they have experienced any suicidal thoughts, urges or actions in the past 12 months.

Furthermore to mitigate against the possibility of this, the following actions will take place.

- A distress protocol will be followed at all times during the interview (please see Appendix A and B for full protocols)
- Participants will be reminded they are able to pause, take breaks, and/or terminate the interview at any point, without giving a reason.
- Participant will be reminded they do not need to answer any questions they do not wish to, and do not have to give a reason.

- Participants will be informed about the content and nature of the interview during the recruitment process and again before the interview commences to ensure they feel able and willing to participate.
- Participants will be given an information sheet with information about services/resources before they sign up to the study, and again during the interview.
- Participants will be offered the option of identifying a designated person that is contactable at the time of the interview, with whom they can speak and seek support if they feel they need to.
- The researcher will complete a risk assessment/debrief at the end of the interview, in which they will discuss how they felt during the interview, if any difficult or distressing feelings arose, and what support they would like following this, giving choice to the participant.
- Participants' names, address and date of birth will be taken for the duration of the interview. If imminent risk is indicated, the researcher will request permission to contact the emergency services to conduct a welfare check. Following the interview, these details will be permanently deleted.

It is possible that the researcher may experience distress from listening to and exploring participants' experiences of risk and distress. Considering this, all supervisors are qualified clinical psychologists, who have experience working with people who are communicating risk. They are also experienced in supervising people who have conducted research in similar areas. Furthermore, the team will meet regularly for supervision, and the impact of this study, including any distress caused will be discussed routinely. The researcher has also

identified support if needed from a clinical psychologist who is not involved in the research project.

8. Methodological considerations

It is possible that issues around validity will be present during the research. These issues include the researcher not recognising their own personal bias and assumptions when conducting the interviews or analysing the data. As such, there is potential for the analysis of the data to not accurately reflect the participants' accounts and experiences. To aid in the reduction of these possibilities, several actions will be taken. The researcher will keep a reflective journal throughout the study, to support them to recognise their personal biases. They will also be having regular supervision and reflection sessions with the research and field supervisors to discuss and identify any potential biases that may impact the analysis of the data.

Furthermore, the interviews will be recorded, and as such this allows for revisiting the data to reassess emerging themes to remain true to accounts from the participants. The study will also include verbatim extracts of the interview to support the reader to make their own judgements regarding the final themes, and the accuracy of them to the original accounts. There will also be a need to create audit trails to evidence where the themes have emerged from. This will be incorporated into the analysis and will go alongside the reflective diary.

9. Possible benefits of participating

Participants may benefit from taking part in the study by having the opportunity to discuss their experiences, and by contributing to research that may inform interventions for people who are suicidal in the future. Participants may have an increased opportunity to connect with shifts to positive emotion, which may help to support personal resources (Fredrickson & Joiner, 2002). Participating in the study may also increase participants' opportunity to pay attention to their strengths, which many crisis models have identified as a central component to recovery. Participation may also encourage links to the current crisis intervention participants are engaging with.

Timescale

Ethics: April – July 2023

Recruitment: July 2023 – August 2023

Data collection: August– September 2023

Analysis: October 2023 – November 2023

Write up: October 2023 – November 2023

Possible difficulties in recruitment may mean that data collection will need to be extended. The results will be fed back to participants who have asked for feedback once the study has been completed and written up.

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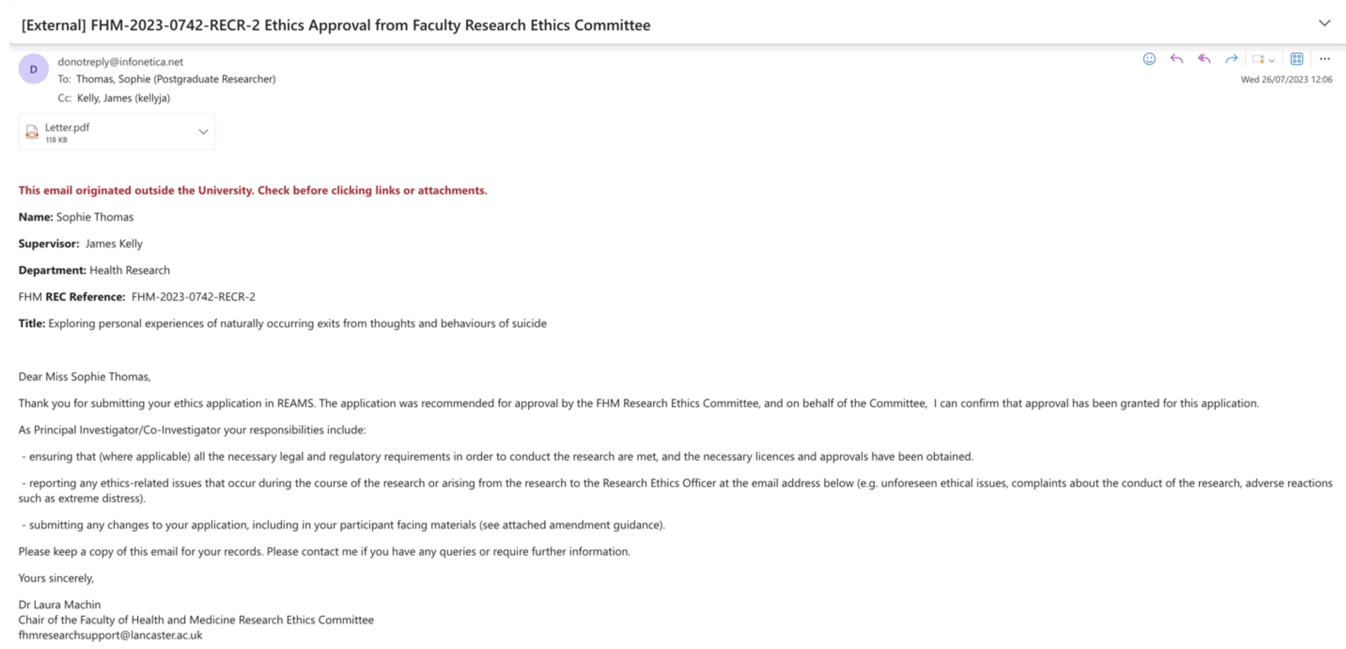
Appendix 4-B. Email of Ethical Approval



[External] FHM-2023-0742-RECR-2 Ethics Approval from Faculty Research Ethics Committee

donotreply@infonetica.net
To: Thomas, Sophie (Postgraduate Researcher)
Cc: Kelly, James (kellyja)

Wed 26/07/2023 12:06

Letter.pdf
118 KB

This email originated outside the University. Check before clicking links or attachments.

Name: Sophie Thomas

Supervisor: James Kelly

Department: Health Research

FHM **REC Reference:** FHM-2023-0742-RECR-2

Title: Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide

Dear Miss Sophie Thomas,

Thank you for submitting your ethics application in REAMS. The application was recommended for approval by the FHM Research Ethics Committee, and on behalf of the Committee, I can confirm that approval has been granted for this application.

As Principal Investigator/Co-Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licences and approvals have been obtained.

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).

- submitting any changes to your application, including in your participant facing materials (see attached amendment guidance).

Please keep a copy of this email for your records. Please contact me if you have any queries or require further information.

Yours sincerely,

Dr Laura Machin
Chair of the Faculty of Health and Medicine Research Ethics Committee
fhmresearchsupport@lancaster.ac.uk

Appendix 4-C. Participant Information Sheet

Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide.

Participant Information Sheet

You are being invited to take part in a research study which is being conducted as part of a Doctorate in Clinical Psychology. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

The research will be conducted by Sophie Thomas, a Clinical Psychology trainee at Lancaster University. It is being conducted as part of a Clinical Psychology Doctorate programme (DClinPsy) at Lancaster University. The researcher conducting the study has undergone a satisfactory DBS check. The research is supervised by three qualified Clinical Psychologists, Dr James Kelly, Dr Lee Fitzpatrick, and Dr Peter Taylor. This study is sponsored by Lancaster University. Within this document, any reference to 'we' refers to the sponsor, and not the local site.

What is the purpose of the research?

Suicide is a global problem, and there is not a lot of information to explain what might help people to feel less suicidal throughout their daily life.

The purpose of this research is to understand people's experiences of reductions in suicidal states, and what has helped to facilitate these reductions.

Why have I been chosen to take part?

You have been invited to take part because you are over 18 years of age, have previously experienced suicidal thoughts, urges or actions, and are no longer experiencing these. We aim to recruit 12 participants to the study.

What would taking part involve?

If you are interested in taking part, you will email the researcher to find out more information. The researcher will then discuss the study and inclusion and exclusion criteria with you over email. If you are eligible to take part in the study, you will then be asked to attend an appointment for an interview on Microsoft Teams. It is estimated that the appointment will take 1 hour altogether.

Once we have discussed the study and you feel you would like to take part, we will arrange the interview for around 2 weeks following this. You will be able to ask questions at any time via email, including before and during the interview. We would recommend that you look over this information sheet again before the interview. You also might want to refer to the NHS self-assessment website so you can check on your wellbeing and take the necessary steps for care if required. https://assets.nhs.uk/tools/self-assessments/index.mob.html?cookie_consent=true&variant=44

During the interview, you will be asked some questions about your experiences of reductions in suicidal states. The interview will be audio and video recorded through Microsoft Teams. This is to help the researcher review the interviews. After the interview has taken place, the researcher will re-watch the interviews and will make a transcript of the words spoken and will look for non-verbal cues from your body language to make sure we have understood what you were saying. This will help us to identify themes and patterns from your interview. The recordings will be stored securely on the University's server, and only the research team will have access to this. The recordings will only be used to analyse the data, once this has happened, they will be deleted. The videos will never be made public for any purposes.

What are the disadvantages or risks of taking part?

It is possible that you may find some of the questions uncomfortable or upsetting to answer. It is also possible that thinking and talking about your experiences of thoughts and feelings of suicide could be upsetting. You are free to have a break or end the appointment at any time should you feel upset or distressed. If there are any questions you do not wish to answer you can leave them unanswered. It is also possible that you may experience some fatigue due to the length of the interview and the effort required to attend. You will be able to take breaks during the interview if you wish to. You will have the right to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised and data analysis has begun. As such, you will have up to two weeks after the interview to withdraw your data. This does not affect your data protection rights.

What are the possible benefits of taking part?

There is no direct benefit to taking part, however, some people enjoy taking part in research that can help inform future treatments, and benefit from having the opportunity to talk to somebody about their experiences. It is possible that you may find talking about reductions in your suicidal states helpful. It may also benefit you to contribute to research that might help people who feel suicidal in the future.

How will we use information about you?

We will collect demographic information about you for this research project. This information will include:

- Age
- Ethnicity
- Relationship status
- Mental health (including if you have ever been diagnosed with a mental health problem and if you are taking medication)
- Gender you identify with

We will keep all information about you safe and secure. We will also ask for your name and contact details (email address), so we can contact you to take part in the study. When you complete the consent form, we will also ask if you would like us to retain your name and contact details, so that you can receive a copy of the study once it is completed. We will only keep this information if you would like a copy. Any information we hold about you will be kept safe and will be deleted once it is no longer needed.

For the interview, we will also ask you to provide you date of birth, and your address. This will only be used if it feels during the interview, you are in imminent danger, to contact the emergency services to complete a welfare check. One the interview is finished we will delete this information immediately.

Once we have finished the study, we will keep some of the anonymised data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. Direct quotations from the interview may be written up in publications to illustrate participant experiences. All quotations will be fully anonymised and will only be used if you have given consent at the start of the research.

Only the research team will have access to this information. We are collecting and storing this personal information in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act (2018) which legislate to protect your personal information. The legal basis upon which we are using your personal information is “public interest task” and “for research purposes” if sensitive information is collected.

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.
Your personal information will be entered into a password protected database stored on the Lancaster University servers. This database can only be accessed by the research team. As soon as you have consented to take part in the project, you will be given a unique participant identifier (a number). All other data that you provide during the project will be anonymised using your participant identifier. Your consent form will be stored in a separate secure file to other data.
In line with Lancaster University guidelines on research data management, the data will be retained for a period of either 10 years after study completion, or 5 years after the last publication from the study, whichever is greater.
If you wish to contact us about your data protection rights, please email: compliance@lancaster.ac.uk or write to Mike Abbots, Lancaster University, Bailrigg, Lancaster, LA1 4YW.

Will my participation in the study be confidential?

Any information you give to the researcher will not be shared outside of the research team without your consent. Individuals from Lancaster University, NHS Trust or regulatory authorities may need to look at the data collected for this study to make sure the research is being carried out as planned. This may involve looking at identifiable data but all individuals involved in auditing and monitoring the study, will have a strict duty of confidentiality to you as a research participant.
All study data will be linked via a unique participant ID known only to the research team. In addition, all reporting of the data in publications will be completely anonymous.

Will my data be used for future research?

When you agree to take part in a research study, anonymised data from the study may be provided to researchers running other research studies in this organisation. The future research should not be incompatible with this research project and will concern exploring reductions in suicidal states. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research and cannot be used to contact you

regarding any other matter or to affect your care. It will not be used to make decisions about future services available to you.

What happens if I do not want to take part or if I change my mind?

You can stop being part of the study at any time, without giving a reason. It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised and data analysis has begun. As such, you will have up to two weeks after the interview to withdraw your data. This does not affect your data protection rights.

What if something goes wrong or I want to make a complaint?

If you have a concern about any aspect of the study or a minor complaint, the first point of contact is the researchers who you can get in touch with using the email addresses provided at the end of this information sheet. They will do their best to answer any questions you may have.

If you wish to make a formal complaint to someone independent of the research team or if you are not satisfied with the response you have gained from the researchers in the first instance, then please contact:

Ian Smith (Research Director, Faculty of Health Research)
Email: i.smith@lancaster.ac.uk
Telephone: +44 1524 592282
Lancaster University, Lancaster, LA1 4YW

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

Dr Laura Machin (Chair, Faculty of Health and Medicine Research Ethics Committee)
Email: l.machin@lancaster.ac.uk
Telephone: 01524 594973
Lancaster Medical School
Lancaster University

Will I be paid for participating in the research?

Unfortunately, we are unable to provide monetary compensation for taking part.

What is the duration of the research?

In total, we estimate that taking part in the study will involve a time commitment of approximately 1 hour for the appointment with the researcher to complete an interview.

Where will the research be conducted?

The research will be conducted online. Interviews will be completed via Microsoft Teams.

Will the outcomes of the research be published?

The data will be analysed by Sophie Thomas as part of her doctoral thesis, under the supervision of qualified Clinical Psychologists. The findings will be written up for publication and hopefully published in a scientific journal and presented at conferences. All information will remain anonymous, and you will not be identifiable in any reports or publications.

If you wish to receive a summary of the results once they are available, you can provide an email or postal address that will allow us to contact you in the future. This personal information will be kept separate from your other data and will be stored electronically, which will be secure by being password protected and encrypted.

Who has reviewed the study?

This study has been reviewed and approved by FHMREC, and supervisors (James Kelly, Lee Fitzpatrick and Peter Taylor).

Contact Details

If you have any queries about the study or if you are interested in taking part then please contact the lead researcher, Sophie Thomas by email (listed below). Alternatively, with your consent, your care team can contact the researcher on your behalf.

Sophie Thomas, Trainee Clinical Psychologist
Email: s.thomas8@lancaster.ac.uk

THANK YOU VERY MUCH FOR READING THIS INFORMATION SHEET

2- What if I need to speak with someone?

If you are experiencing suicidal urges and feel you cannot keep yourself safe, please attend your nearest A&E.
NHS 111 is available to provide urgent care, advice and mental health support, day or night.
Phone: 111, every day, 24 hours a day

You can also find local crisis helpline numbers through the NHS website:
https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline
You can also see advice and support from one of the services listed below:
Shout Crisis Text Line is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope, anywhere, anytime.
Text “SHOUT” to 85258
Website: www.giveusashout.org

Samaritans is a voluntary organisation that offers support for anyone in distress. Phone: 116 123, every day, 24 hours a day
Website: https://www.samaritans.org
Phone Number: 116123

Mind offers a helpline available. Their website also offers resources, support and guidance.
Website: https://www.mind.org.uk
Phone Number: 0300 123 3393

CALM offers support for anyone in distress. Their helpline and webchat are open everyday of the year. Helplines are open from 5pm to midnight.
Website: https://www.thecalmzone.net/help/get-help/
Phone number: 0800 585 858

For young people in crisis:

The Mix is an information and support service for young people (25 years and younger). It operates via an online community, on social, through a free, confidential helpline or a counselling service.
Phone: 0808 808 4994, every day, 3pm to midnight
Crisis messenger text service: text 85258, every day, 24 hours a day
Website: www.themix.org.uk

PAPYRUS is a national charity dedicated to the prevention of young suicide. It operates **HOPELINEUK**, which offers support and advice to young people (under 35 years) at risk of suicide.
Phone: 0800 068 41 41, every day, 9am to midnight
Text: 0786 0039967

For older adults in crisis

Silver Line is a free confidential helpline providing information and advice to older people.
Phone: 0800 4 70 80 90, every day, 24 hours a day
Website: www.thesilverline.org.uk

Appendix 4-D. Participant Consent Form

Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide.

Consent Form

We are asking if you would like to take part in a research project, which is exploring people's personal experiences of natural exits from suicidal thoughts and behaviours.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Sophie Thomas.

You will keep a copy of this consent form and the researcher will also keep a copy which will be stored securely on the University's server.

Statement	Initials
1. I confirm that I have read the information sheet 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 interview will be audio and video recorded and then made into an anonymised written transcript	☐
4. I understand that audio and video recordings will be kept until the study has been examined.	☐
5. I understand that my participation is voluntary and that I am free to withdraw my participation at any time without giving any reason, without my care or legal rights being affected	☐
6. I understand that once my data has been anonymised and incorporated into themes it might not be possible for it to be withdrawn. I understand I will have two weeks following the interview to withdraw my data.	☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised, and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project	☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events	☐
9. I understand that the researcher will discuss data with their supervisor as needed	☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will share this information with their field supervisor and research supervisor.	☐
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished	☐
12. I consent to my email address being stored securely if I wish to recieve a copy of the results once the study is completed	Yes ☐ (if yes, your email will be stored securely until a summary has been emailed out to you. At which point, it will be deleted.) No ☐ (If no, your email will be deleted as soon as your participation has ended)

13. I understand the researcher will require my date of birth and address for the purposes of safety during the interview, which will be deleted immediately following the interview.	☐
14. I consent to take part in the above study.	☐

Name of participant: Signature: Date:

Name of Researcher: Signature: Date:

Appendix 4-E. Participant Debrief Sheet

Debrief Sheet
Naturally occurring exits from states associated with suicide

Thank you very much for taking part in our study. The data you contributed will help us complete our research project which is exploring naturally occurring exits from states associated with suicide.

3- What happens now?

A transcript of our interview will be typed up in the weeks following our meeting. In the two weeks following interview, you may still choose to withdraw from the study if you no longer wish your data to be used. If this is the case, please contact Sophie Thomas via email (s.thomas8@lancaster.ac.uk). After this two-week period, the transcript will be analysed and collated together with other interview transcripts, and we will be unable to extract and delete your individual data.
If you would like to receive a one-page summary of the results of our study, we would be happy to send this to you upon the study's completion. Please let us know if you do require this summary so we can make a note of your email and ensure that we send it to you.

4- What if I need to speak with someone following interview?

I hope you found the interview to be a positive experience. If, however, the experience has brought up difficult feelings, or left you feeling distressed, I would encourage you to contact your GP for advice.
If you are experiencing suicidal urges and feel you cannot keep yourself safe, please attend your nearest A&E.
NHS 111 is available to provide urgent care, advice and mental health support, day or night.
Phone: 111, every day, 24 hours a day

You can also find local crisis helpline numbers through the NHS website:
https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

You can also see advice and support from one of the services listed below:
Shout Crisis Text Line is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope, anywhere, anytime.
Text "SHOUT" to 85258
Website: www.giveusashout.org

Samaritans is a voluntary organisation that offers support for anyone in distress. Phone: 116 123, every day, 24 hours a day
Website: https://www.samaritans.org
Phone Number: 116123

Mind offers a helpline available. Their website also offers resources, support and guidance.
Website: https://www.mind.org.uk
Phone Number: 0300 123 3393

CALM offers support for anyone in distress. Their helpline and webchat are open everyday of the year. Helplines are open from 5pm to midnight.
Website: https://www.thecalmzone.net/help/get-help/
Phone number: 0800 585 858

For young people in crisis:

The Mix is an information and support service for young people (25 years and younger). It operates via an online community, on social, through a free, confidential helpline or a counselling service.
Phone: 0808 808 4994, every day, 3pm to midnight
Crisis messenger text service: text 85258, every day, 24 hours a day
Website: www.themix.org.uk

PAPYRUS is a national charity dedicated to the prevention of young suicide. It operates **HOPELINEUK**, which offers support and advice to young people (under 35 years) at risk of suicide.
Phone: 0800 068 41 41, every day, 9am to midnight
Text: 0786 0039967

For older adults in crisis

Silver Line is a free confidential helpline providing information and advice to older people.
Phone: 0800 4 70 80 90, every day, 24 hours a day
Website: www.thesilverline.org.uk
Finally, if you have any further questions, or want an update on the research, please feel free to contact me on s.thomas8@lancaster.ac.uk.

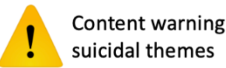
Thank you again for taking part.

Appendix 4-F. Advertisements

Advertisements

A poster/shareable image has been designed as below:

Research Study: Learning from individuals who experience reductions in suicidal experiences



What is the study?	Who can take part?	What would I do?	Why is this important?	How do I take part?
My name is Sophie Thomas and I am conducting this research as a Trainee Clinical Psychologist on the Doctorate in Clinical Psychology at Lancaster University, United Kingdom. This study asks about moments when suicidal states have reduced naturally.	Aged 18 or over Live in the UK Have previously experienced suicidal thoughts, urges or actions Have not experienced any form of suicidality in the past 12 months	You will take part in an interview over Microsoft Teams, which will last about an hour. The interview will be with Sophie Thomas. Participation is voluntary. You will be talking about your experiences of moving away from suicidal states. You can withdraw from taking part in the study at any time.	In 2021, 5,583 suicide deaths were recorded in the UK. Participating in this research could help to inform support for other people who are suicidal in the future, to help prevent people from ending their own lives.	Please email Sophie Thomas at s.thomas8@lancaster.ac.uk

This research is part of a Doctorate in Clinical Psychology thesis project at Lancaster University. It has gained ethical approval.

Twitter:
Twitter will be used to tweet out to organisations and using hashtags to invite sharing of the study and to recruit participants.
Examples of tweets which will be used are as below (the above poster will also be attached to tweets):

- "Content warning: Suicide content:
  Have you previously experienced suicidal thoughts or feelings? Do you identify as no longer experiencing these? Want to help research understand how people feel less suicidal? Email s.thomas8@lancaster.ac.uk for further info! #suiciderecovery #suicideresearch #mentalhealth @(twitter account) pls RT"
- "Content warning: Suicide content:
  If you are interested in helping us to understand what helps people to recover from suicide, please read more about our research study in the attached image."

Reddit:
Reddit will also be used to post in relevant forums with a summary of the research study aims and criteria to invite people to find out more information, an example of this is as below:

- "Content warning: Suicide:
  Suicide is a worldwide problem. We are interested in finding out what helps people to feel less suicidal, which may help to support those who are experiencing this. We are looking for people aged 18 or over, live in the UK, have previously experienced

any form of suicidality, but not in the past 12 months. If you are interested in taking part or finding out more information, please email s.thomas8@lancaster.ac.uk. "

Facebook:
A dedicated Facebook account has been created for the project: Facebook groups may also be identified to share the above advertisement poster in addition to the below text:

- "Content warning: Suicide:
  We are interested in finding out more about what helps people to feel less suicidal. We are looking for people who are over 18, live in the UK, and have previously had suicidal experiences but not in the past 12 months. If you are interested, email s.thomas8@lancaster.ac.uk to find out more.

LinkedIn
I will use my own personal LinkedIn account as this is a professional social media platform and has no personal information on it. The poster will be advertised on my own page, and can be shared on others' pages too.

Appendix 4-G. Distress Protocol

Exploring personal experiences of naturally occurring exits from thoughts and behaviours of suicide.

Introduction and Aims

This protocol has been developed in collaboration between Sophie Thomas (Main Researcher/Trainee Clinical Psychologist), Dr James Kelly (Chief Investigator/Academic Supervisor; Clinical Psychologist and Lecturer in Research Methods), Dr Peter Taylor (Academic Supervisor/Clinical lecturer and Clinical psychologist) and Dr Lee Fitzpatrick (Field Supervisor/Consultant Clinical Psychologist and Psychology Lead at Bolton HBT).

The aim of this document is to provide a protocol for the main researcher to follow to ensure:

- Assessment of risk
- Management of immediate risk by main researcher under supervision of the field superviser

General principles

A realistic and genuine discussion should be had with all participants (prior to consent being taken) about the possibility of distress/risk during the study, and what might be a helpful response if this were to happen for them.

Another goal of this discussion is to explain the limits of confidentiality and discuss how to manage this should issues arise. Furthermore, during this discussion it should be agreed what actions will be taken by both participant and researcher if risk becomes apparent, with the emphasis (except in extremis) upon the researcher and participant building understanding and trust. Just as the researcher can be trusted to follow ethical and research standards, the participant should also be 'trusted' to know how to manage their emotions and feelings.

The researcher should also explain to the participant that the researcher will not be available outside of meetings and email contact, and it will also be sensitively explained to participants that the researcher cannot act as a crisis or clinical service. However, it is possible that participants may become distressed while in contact with the researcher during the interview session. Therefore, the distress protocol will be used at all times.

Procedures to be followed throughout the study:-

To be enacted if a participant and the researcher is concerned about the participant's current and subsequent welfare, for example if a participant:

- Reports or displays notable distress
- Reports current plans or actions of suicide
- Reports current urges to harm themselves

If participant reports or shows signs of low or moderate distress:

- Pause the meeting/interview (with the participant's agreement) and allow time to talk about other topics including how the participant feels, and then carefully observe levels of distress.
- If distress seems to have lessened, discuss with participant whether they wish to continue with the meeting/interview.
- If distress remains prominent or worsens, follow steps below.

If participants report more severe distress or thoughts/feelings related to current urge to self-harm or suicidal ideation:

- Halt or pause the meeting/interview.
- Try to assess what the participant needs at that point in time - active listening alone, validation, acknowledgement, normalisation.
- Allow the participant an appropriate amount of time to say more about how they are feeling and allow time to listen to them, be non-judgmental and empathic.
- Ask specifically about any thoughts of active suicide, if not already mentioned.
- Where these are present, assess level of immediate risk (this should be done as part of a calm, collaborative conversation, avoiding appearing panicked). The researcher should ask about intent, planning/access to means, and how hard it feels to resist this for both suicide and NSSI. A Likert scale could be used to assist this discussion and quantify risk.
- Ask the participant: Do you feel that taking part in this interview is affecting how you feel? If so, in what way? / Is participation making you feel more like self-injuring or suicidal?
- If so, explain that the researcher has a duty of care and refer to current risk management (previously discussed) or previously agreed plan of action.
- Risk management should be a collaborative process, taking into account the wishes of the participant; however the limits of confidentiality should be reiterated.
- In judging the level of risk associated with urges to self-harm/attempt suicide it is important to involve the participant themselves in discussing this. In doing this the researcher can check with the participant about the usual severity of their self-harm and aftercare (including any aftercare they provide themselves such as wound

- cleaning and also any health services they routinely attend), and also their degree of suicidal ideation.

Where taking part in the study is having an adverse effect on the participant the study should be immediately halted.

If the researcher considers the risk level to have returned to low to moderate, and the participant is euthymic, lucid and appears to have capacity, the participant will be asked if they wish to continue with the interview, and be reminded of their right to withdraw at any point without adverse consequences for their psychological and health care.

If the participant does not feel able to continue the interview, but is eager to remain involved in the research, this could be discussed with them, once they have had a break from the study, and once the issue has been reviewed by the study supervisors.

The participant would be judged as high risk of intentional or accidental suicide if

Current suicidal ideation present, and suicidal intent rated moderate to high, but no plan or access to lethal means.

Clinical judgement should be employed in making this judgement and a cautious approach should generally be adopted where uncertain. The participant should be involved in this discussion where possible.

If high level of risk is identified, **then the researcher should follow the procedure below:**

- Encourage participant to immediately contact support(s) and clinician(s)/emergency services to inform of risk.
- If the participant does not feel able to do so, the researcher will seek permission from the participant to contact these people for them (contact support(s)/emergency services) to inform them of level of risk and enlist their assistance in getting participant to a clinician.
- If participant does not agree to contacting supports/emergency services, then the researcher should inform the participant that they must break confidentiality and contact identified support(s)/emergency services to inform them of level of risk and enlist their assistance in supporting participant by conducting a welfare check*
- Discuss with field supervisor immediately after contact
- Record adverse event

* Where researcher is required to contact and inform others of risk this should be first discussed with the participant where possible. It can be emphasised this action is about keeping the participant safe. It can also be discussed if the participant has preferences regarding who you contact or how you share this information. Where possible (and not conflicting with duty of care or other requirements of the researcher) participants’ preferences should be taken into account.

The participant would be judged as being at imminent risk of intentional or accidental suicide if:

- Current suicidal ideation present, and suicidal intent rated moderate to high, with plan and access to lethal means. moderate to high
- Plan to self-harm in a way that could result in severe injury, long-term disability or death (e.g. planned overdose or hanging), and access to means

If imminent level of risk is identified **then the researcher should follow the procedure below:**

- ❒ Speak to Supervisor
- ❒ If consent can be gained for the steps below then this is preferable, if not the researcher must break confidentiality.
- ❒ If Participant refuses to do the above: call 999 and inform of subject's location and risk level.
- ❒ Inform research supervisor and field supervisor, who will follow trust policy

Personal Safety and Boundaries

In responding to the above situations it is important that the researcher balances these actions against their own personal safety, and should avoid situations where their personal safety feels compromised. However, physical risk to the researcher is low due to the interviews being held on Microsoft Teams.

In addition, where any of the above incidents take place the researcher should inform their supervisor(s) and arrange a time to debrief with regards to the situation, including a focus on how they have personally been affected.

If this protocol is used due to an adverse event or serious adverse event, this will be dealt with immediately by the Chief Investigator, and Lancaster University Sponsorship will be informed.

Appendix 4-H. Distress Protocol Flow Diagram