School of Psychology
Ysgol Seicoleg

Extending our understanding of male suicide: Qualitative investigations into the factors associated with men's suicide attempts

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Preface

Close to 800,000 people die by suicide every year. There are various risk factors which increase suicidal risk, including having a mental health condition, physical illness, debt and unemployment. It is a global trend that men are at a greater risk of death by suicide. However, risk factors alone do not help us to understand why people die by suicide. Psychological models have attempted to conceptualise these risk factors into theories which help us to understand suicidal behaviour. However, they do not account for men's elevated risk of death by suicide. It appears that the factors associated with male suicide are complex and warrants further research attention. This Large-Scale Research Project (LSRP) adds to the limited literature in this area. It is made up of two qualitative papers which aim to provide an in-depth exploration of the factors associated with male suicide. A prior suicide attempt is the biggest risk factor for a future death by suicide. Therefore, both papers present the findings of research using samples of men with lived experience of having attempted suicide.

Paper one reports a systematic review of the qualitative literature which aimed to better understand the factors associated with men's suicide attempts and to integrate these findings into a theoretical understanding of male suicide. Eleven studies were included in the review which were assessed for their quality and contribution to the literature. The findings from these studies were synthesised using a meta-ethnography approach. The synthesis identified that the men's suicide attempts were experienced in the context of feeling disconnected from themselves, others and the world. Many interconnecting factors accounted for this disconnection, including feelings of loneliness, early adversities, substance use, psychological pain, feeling different, experiencing rejection

and factors related to masculine gender norms. Feeling disconnected led to experiences of hopelessness. It was from this position that the men viewed suicide to be a solution to their distress. The synthesis identified how reconnection with the self and others provided turning points towards a more hopeful future.

Paper two reports a grounded theory analysis examining the role of self-directed disgust in male suicide. Self-disgust, whereby aspects of the self are perceived as "revolting" or "contaminated", has been associated with some mental health difficulties. To date, qualitative research has not examined self-disgust in males, nor in suicidality. This was the aim of paper two. Nine men who had attempted suicide took part in an interview which explored self-disgust and their suicidality. The interview data was analysed using constructivist grounded theory. This approach acknowledges the role of the researcher in the analysis process and fits with the researcher's position on the social construction of knowledge and understanding. What emerged out of the analysis, was that self-disgust did not explain the participant's suicide attempts in their entirety; instead, self-disgust interacted with other endured emotional experiences and feelings of worthlessness. The combination of this endured distress provided a context for the participants to perceive themselves as unable to cope and experience feelings of disconnection and hopelessness. It was from this position that suicide was seen as a solution to their psychological pain. During this process, many disgust-related properties (such as seeing oneself as repellent or fearing exposure of one's "disgustingness") increased the men's suicide risk. Self-disgust appeared more pervasive in the lives, and suicidality, of men with a history of multiple traumas.

The findings of this LSRP support current theoretical accounts of suicide (e.g. hopelessness, suicide as a solution to psychological pain), whilst also providing novel insights into male suicidality. What emerged out of both analyses was how the experience of being disconnected worsened men's distress and exacerbated suicide risk. Paper two builds on our understanding of suicidal men's disconnection and psychological pain by highlighting the prominence of self-disgust within these factors, particularly in those with a history of childhood abuse. The analyses provide some support for the theory that masculine gender rules and norms may increase men's suicide risk (for example, leading men to conceal distress). However, it should be noted that men who conceal their distress may be unlikely to participate in research. Additional limitations are discussed in each paper. Despite this, there are methodological strengths to this LSRP, including methods to increased trustworthiness and quality. Furthermore, both papers used analytic methods which are grounded in their respective data sources.

This LSRP has implications for clinical psychology and the wider healthcare context. This includes risk assessment and the benefits of exploring disconnection and fostering reconnection. Future research could explore the current findings and the effectiveness of intervening with high levels of self-disgust. Evaluating these interventions will further advance our understanding of working clinically with men at risk of suicide. By disseminating this LSRP, it is hopeful that the findings (and the voices and bravery of the research participants) will prompt further clinical and research exploration of male suicide.

Preface Word Count – 800 words

Paper 1
The factors associated with attempted suicide in males: A meta-ethnography

Prepared in accordance with the author guidelines for *Archives of Suicide Research*[1] (Appendix A)

Word count excluding tables, figures and references: 8,071*
* (7,994 words in original thesis submission prior to corrected amendments)

[1] To ease readability for thesis submission, this paper has been written in British English, with tables and figures inserted in their precise location. This will be adapted when submitting the paper to *Archives of Suicide Research,* which stipulates that papers be written in American English and that tables and figures are submitted in an additional file.

The factors associated with attempted suicide in males: A meta-ethnography

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The factors associated with attempted suicide in males: A meta-ethnography

Abstract

Objective: Men are at an elevated risk of death by suicide. Whilst current theoretical accounts of suicidality help us to conceptualise certain risk factors, they fail to aid our understanding of the increased risk in males. Although a traditional form of masculinity has been hypothesised to factor in male suicide, it may not account for the entirety of male suicidality. The aim of this review and synthesis was to better understand the factors associated with attempted suicide in males by systematically reviewing and synthesising the qualitative literature. **Method**: Eleven qualitative studies exploring the factors associated with attempted suicide in males were examined using a meta-ethnography approach to develop a line of argument synthesis. **Results**: The synthesis revealed an overarching concept which captured men's experiences of *disconnection from the self and others*. This concept was comprised of seven core themes: (1) using substances; (2) alone; (3) early adversities and trauma; (4) "the pain"; (5) feeling different; (6) masculinity; and (7) rejection. Experiencing disconnection led to feelings of hopelessness and, ultimately, to the men viewing suicide as a solution to their distress. Reconnection with the self and others moved men on a trajectory away from suicide. **Conclusion**: Men who attempt suicide experience a complex interweave of factors which leads to intrapersonal and interpersonal disconnection. The implications of this are discussed, along with suggestions for suicide prevention. The limitations of this review and recommendations for future research are considered.

Keywords: systematic review; meta-ethnography, meta-synthesis, qualitative, suicide, male.

Highlights:

- Men's suicide risk is exacerbated by experiences of disconnection.
- Disconnection is a result of a complex interweave of multiple factors.
- Facilitating reconnection can move men on a trajectory towards recovery.

Introduction

Suicide is described as a global public health issue (World Health Organisation; WHO, 2014), with close to 800,000 people dying from suicide each year. In 2018, just over 6,500 people died from suicide in the UK (WHO, 2019). Simms et al. (2019) notes that it is an established trend that males are three times more likely to die by suicide. Furthermore, an increase in male suicide has driven a recent surge in deaths from suicide in the UK, after a five-year decline.

Psychological theories of suicide

The causes of suicidality are complex, multifactorial and not fully understood (O'Connor & Nock, 2014). Having a mental health condition is the biggest risk factor for death by suicide, particularly with comorbid substance use (Cavanagh et al., 2003). Mental health difficulties (especially depression), moments of crisis, chronic pain and illness, conflict, disaster, violence, abuse, loss, being a refugee, migrant, indigenous person, prisoner, or sexual minority are considered risk factors for death by suicide (WHO, 2019). A prior suicide attempt is regularly cited as the biggest predictor of future death by suicide (Franklin et al., 2017). Hunt et al. (2017) noted a gender

difference in risk factors, with men showing increased withdrawal, apathy, anger and risk taking. However, risk factors alone have little predictive power and fail to aid our understanding of why some people die by suicide and others do not (O'Connor & Nock, 2014).

Psychological theories have attempted to understand the complex interplay of risk factors and how these may increase suicidality (for a review, see Barzilay & Apter, 2014; O'Connor & Nock, 2014). Earlier perspectives viewed suicide as an attempt to escape from psychological pain (e.g. Baumeister, 1990; Shneidman, 1993), whereas feelings of hopelessness and problem solving difficulties are central to cognitive-behavioural accounts of suicidality (e.g. Beck et al., 1990; Wenzel & Beck, 2008). The arrested flight models of suicide (e.g. Williams, 1997; Williams & Pollock, 2000) posit that defeat and entrapment further exacerbate psychological pain and hopelessness which increase suicidality. Stress-diathesis models (e.g. Mann et al., 1999; Schotte & Clum, 1987) propose that predisposing biopsychosocial factors can be triggered by stressors to increase suicidal risk. However, early models only explain the process of a small number of risk factors (e.g. hopelessness) and fail to account for the diverse factors which suicidal individuals often present (Van Orden et al., 2010). They also limit our understanding of the variability of suicide risk within high risk groups. For example, a mental health diagnosis is significantly predictive of a future death by suicide (Cavanagh et al., 2003), yet the majority of individuals with a mental health condition will not attempt or die by suicide (O'Connor & Nock, 2014). Early suicide models have also been criticised for failing to account for the processes which delineate suicidal ideation from action, which is clinically significant for predicting suicidal risk (O'Connor & Nock, 2014).

The interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) seeks to address these limitations. The authors posit that suicidal behaviour occurs in the presence of both the desire and the capability to die, with the desire created by the combination of a thwarted belongingness and a perceived burdensomeness. The capability to die (e.g. impulsivity) is needed to move individuals from suicidal ideation to action. This model has received significant empirical support (see Chu et al., 2017), although has also been criticised for failing to account for the role of mental health difficulties (Barzilay & Apter, 2014). By integrating multiple theoretical perspectives, the integrated motivational-volitional model of suicide (IMV; O'Connor, 2011) addresses many previous limitations. It proposes a dynamic process in the aetiology of suicide and positions various risk factors as increasing feelings of defeat and entrapment and is supported in the literature (e.g. Dhingra et al., 2016). However, O'Connor and Nock (2014) recommend that all models undergo further cross-cultural empirical scrutiny and criticise models for failing to account for the heterogeneity in suicide across demographics, such as gender.

The gender paradox in suicide

Canetto and Sakinofsky (1998) designated the gender paradox in suicide to represent men's increased risk of death by suicide, despite the increased prevalence of depression and non-fatal suicide in females (Nolen-Hoeksema, 2001; O'Loughlin & Sherwood, 2005). Biological processes have been hypothesised to account for the gender paradox (Kraemer, 2000; Rutz & Rihmer, 2007; Steiner et al., 1997). Moreover, the social construction of masculinity has been theorised to account for men's increased anger

responses, reduced recognition of distress, reluctance to seek help and increased substance use (Möller-Leimkühler, 2003). These can potentially exacerbate men's vulnerability to mental health difficulties and suicide. Connell (1995) described the term hegemonic masculinity to explain a socially desired form of traditional masculinity. Payne et al. (2008) argued that this social construction of gender drives men to suicidal behaviours through limiting their emotional expressions, dismissing symptoms of distress, increased risk taking and the use of more lethal methods of suicide. According to these authors, these factors suggest that gender differences in depression may be due to females being more willing to seek help, whilst males are more likely to turn to maladaptive ways to cope, such as using substances (e.g. alcohol). Payne et al. also argue that gender roles influence contextual risk factors, such as relationship separation, unemployment and low socio-economic status. This hypothesis has received some empirical support (e.g. Adinkrah, 2012; Denning et al., 2000; Hunt et al., 2017). However, Denning et al. (2000) found no gender differences in suicidal individuals' intention to die, despite men's use of more violent methods. Whilst demonstrating the impact of hegemonic masculinity, research has been criticised for placing an emphasis on the negative aspects of gender norms (Krumm et al., 2017; Seager, 2019). Furthermore, a gender constructivist account for male suicide has been criticised for failing to acknowledge diversity in male populations (e.g. sexuality). As highlighted by Paul et al. (2002), male sexual minorities are at an increased risk of suicide.

Qualitative insights

Qualitative approaches can provide new understandings and explanations of suicidality by exploring how suicidal individuals engage with, experience and interpret their world

(Hjelmeland & Knizek, 2010). A qualitative review by Lakeman and Fitzgerald (2008) identified five themes of how people live with or recover from suicidality, which were: *Suffering/psychache*, describing participants' endured and overwhelming emotional pain, hopelessness and suffering; *Struggle*, which related to the struggle between wanting to live, versus the desire for death and struggles between more nuanced dialectics (e.g. stoicism versus support); *Connection*, and significantly how disconnection and detachment increased suicidal risk, whilst interpersonal relationships aided recovery; *Turning Points*, which described events steering the individual on a pathway to recovery; and *Suicide and Coping*, denoting how individuals used suicidality as coping strategies. Lakeman and Fitzgerald's review is limited as they studied suicidality as a homogenous group (i.e. ideation and attempts), which may limit conclusions as not all those who think about suicide will attempt suicide (Nock et al., 2008). Further insight into those who die by suicide may be gained by solely recruiting those who have attempted suicide as they have been described as "overlapping populations" (Beautrais, 2001, p.845; Hawton, 2002). In a review sampling those who attempted suicide, Berglund et al. (2016) identified an overarching theme of *struggling to maintain hope when life became too difficult*. Within this theme were descriptions of psychological pain, rejection, isolation and worthlessness which were perpetuated by a loss of control and a lack of understanding. A sense of hope was obtained by reconnecting with others and discussing suicide, however this focussed on relationships with nursing staff. Both reviews highlight the role of psychological pain, entrapment, difficulties in coping and disconnection which can be conceptualised within the previously discussed models, particularly the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) and the IMV model of suicide (O'Connor, 2011). However, their findings cannot be generalised outside of an inpatient setting and their

usage of mixed gendered designs limits our understanding of any potential nuance in male suicide.

Whilst a qualitative review of male suicidality is missing from the literature, two recent qualitative meta-syntheses have explored male mental health. McKenzie at al. (2016) conducted a review on men's perspectives on mental health difficulties and identified five themes: triggers and causes; being aware of emotional pain; managing the problem; seeking help and support; and to disclose or not to disclose. Views around masculinity were central to many of these themes, including the need to be strong and in control and how seeking help was opposed to masculine norms, leading to concealing distress. Men's difficulties were found to be accumulating in nature and with increased anger and substance use. Interestingly, there were some descriptions of masculine norms being a protective factor. Similar findings were reported in Krumm et al.'s (2017) synthesis of men's experience of depression, which was often seen as contravening masculine norms, leading men to feel vulnerable, out of control and weak. Similarly to McKenzie et al. (2016), men's depression was associated with increased agitation and aggression and distress concealment. Although mainly focussing on depression, both reviews support theoretical accounts of the impact of hegemonic masculinity on male mental health difficulties. Yet, it is unclear whether these findings translate to male suicide, as not all individuals with mental health difficulties are suicidal (O'Connor & Nock, 2014).

The current review

As described above, previous qualitative reviews support extant accounts of suicidality (Berglund et al., 2016; Lakeman & Fitzgerald, 2008). However, they do not delineate the experience of males. This paper builds on these reviews, and the syntheses on male mental health (Krumm et al., 2017; McKenzie et al., 2016), by focussing on male attempted suicide and aims to better understand what perceived factors are linked to suicide attempts in men. Due to men's increased risk of death by suicide, it seems pertinent to understand the factors specifically affecting suicidal males, which lends itself to a qualitative evaluation. This paper utilises a meta-ethnography approach which is considered a useful method for synthesising qualitative research (Atkins et al., 2008) and goes beyond a solely narrative review of the extant literature (Britten et al., 2002).

This paper has two aims:

(1) To systematically review the qualitative literature exploring the lived experience of men who have attempted suicide.
(2) To synthesise this literature to provide a deeper understanding of the perceived factors underpinning suicidality within males.

For the purposes of this review, the term male denotes cisgender male. The term cisgender describes an individual whose gender identity corresponds to their designated sex at birth. Transgender individuals are at an elevated risk of suicidality which has been explored in a recent systematic review (McNeil et al., 2017).

Method

Systematic literature search

Search strategy

The following databases were systematically searched in November 2019 (repeated in May 2020): PsycInfo, MEDLINE, PubMed, CINALH and EMBASE. The databases were searched for English studies reporting on the factors associated with attempted suicide in males. Three categories of search terms – suicide, male and qualitative research – were combined using Boolean operators, with search terms shown in Table 1. No date restrictions were applied. In order to be comprehensive, reference lists (and cited by lists) of included and relevant articles were manually searched, as were six specific journals pertinent to the research topic (*Archives of Suicide Research*, *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *Death Studies*, *Suicide and Life-Threatening Behavior*, *Suicidology Online* and *Qualitative Health Research*). The combined search strategy yielded 13,479 articles.

Category	**Subject heading** (If available in database)	**Key words** (title, abstract and key word)
Suicide	Suicide Attempted Suicide	suicid* Attempted suicid*
Men	Human males Masculinity	Male Men Masculin* Mach*
Qualitative research	Qualitative measures Qualitative methods Grounded theory Narrative analysis Discourse analysis Interpretive phenomenological analysis Thematic analysis Ethnography Interview	Qualitative* Grounded theory Narrative analysis Discourse analysis Interpretive phenomenological analysis IPA Ethnograph* Thematic analysis *The relative search terms for qualitative research for the specific database*

Table 1. Search terms

Inclusion and exclusion criteria

Inclusion and exclusion criteria were applied to the articles identified in the literature search (see Table 2). Examples of this process in Appendix B.

Considerations	Inclusion criteria	Exclusion criteria
Sample	Males. No age restriction.	Female only. Mixed gendered designs without separate male data analysis and reporting.
Suicide attempt	Previous suicide attempt (no criteria around measurement of intent/lethality).	Combined samples without separate suicide attempt data, analysis and reporting. This may include studies using suicidal ideation, self-harm, professionals, family etc.
	Studies focussing on the factors associated with men's suicide attempts (for example, process, perceived causes, triggers)	Studies focussing on the process of an attempted assisted suicide. Studies which have not focussed on the factors associated with a suicide attempt (e.g. suicidal men's utilisation of health services; Strike et al., 2006) Studies whose main focus has not been suicide (e.g. depression).
Study type	Research using standard and established qualitative methods. (using Barker et al.'s, 2016, four categories: Thematic; narrative; language-based; and ethnographic approaches)	Quantitative research. Studies which do not use established qualitative methods. Studies which do not report the analysis methods employed.
	Mixed methods design with separate qualitative reporting.	
	Peer reviewed research and able to access full text.	"Grey" literature
Language	Studies written or translated into English	

Table 2. Inclusion and exclusion criteria applied to each study

Results of search strategy

The search strategy used the preferred reporting items for systematic reviews and meta-analyses (PRISMA; Moher et al., 2009), shown in Figure 1. The author reviewed all titles, abstracts and read full text (if applicable). Initially, 12 articles met the inclusion criteria which were screened by the research supervisor. A discrepancy was found in

one of the articles and this was resolved via discussion and resulted in the exclusion of this paper due to not using an established qualitative method (i.e. McAndrew & Warne, 2010). Of the 11 included studies, three were selected and reviewed by an independent qualitative researcher to assess their adherence to inclusion and exclusion criteria. No discrepancies were found during this process.

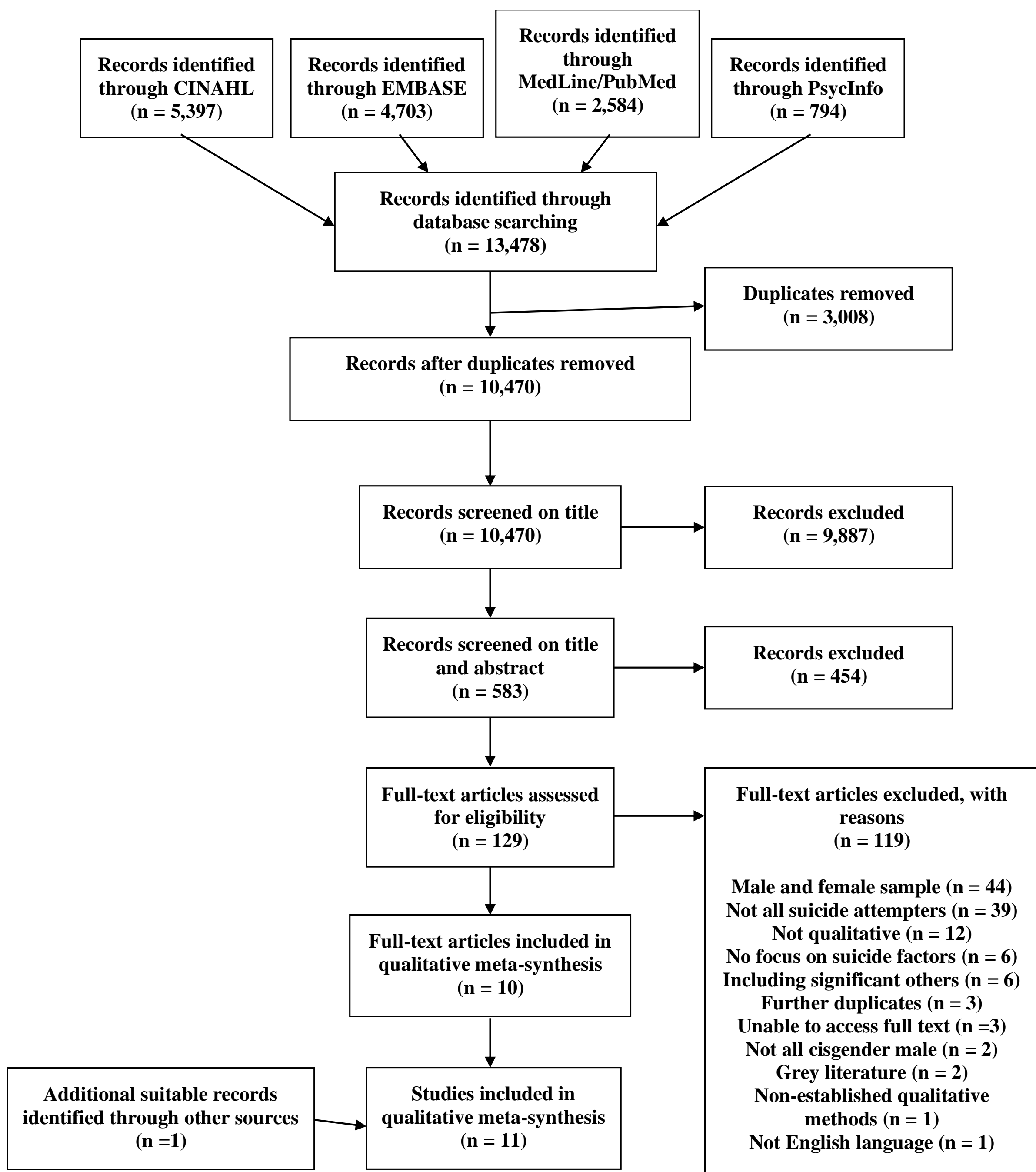

Figure 1. PRISMA diagram of search process and selection

Quality assessment

The Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist was used to assess the quality and rigour of the included studies (examples in Appendix C), whilst following additional guidance in quality assessment by Walsh and Downe (2006). The CASP framework comprises of 10 items relating to methodological, analytical and reporting aspects of the research. The CASP framework has been used in other qualitative reviews in adolescent suicidality (Gilmour et al., 2019) and men's mental health (McKenzie et al., 2016) and is a well-established quality assessment tool in the qualitative literature (Dixon-Woods et al., 2007). The first nine items are scored (1 if the criteria are met, 0.5 if partially met and 0 if not met) giving a total score out of 9. Studies were then given an overall quality rating applying an adapted A, B or C rating system used in previous meta-syntheses (e.g. Fox et al., 2017; Graham et al., 2020). Papers with a CASP rating 7.5 or above were considered to be of high quality and applied an A rating. Papers with a CASP rating between 4 and 7 were considered to be of moderate quality and were applied a B rating. CASP ratings of below 4 were considered lower quality and rated C. The final CASP item allows a qualitative description of the value the research adds to the extant literature. In keeping with recent developments in synthesising qualitative research, assessing quality was not used to exclude studies (Carroll & Booth, 2015). Instead, the quality ratings were utilised to provide an insight into the standard of the research used in the synthesis.

Meta-synthesis

Meta-syntheses go beyond the standard narrative review by interpreting research findings and identifying emerging theoretical constructs. Using Schüctz' (1962) notion of first and second order constructs (described in Toye et al., 2014), qualitative synthesisers analyse the first-order constructs (the participant's understanding of their experience), and second-order constructs (the researcher's understanding of the participant's interpretation of their experience), and develop third-order constructs (the reviewer's synthesis of these into a theoretical understanding). Although multiple methods for meta-syntheses exist, Noblit and Hare's (1988) meta-ethnography approach is the most extensively used within the extant literature (Bondas & Hall, 2007). Meta-ethnography is an inductive method which identifies more nuanced understandings which may be obscured from individual studies (Walsh & Downe, 2005). As the qualitative literature on male suicide has not been synthesised, an inductive and interpretative approach was preferred over other methods of synthesis. Following expanded guidance from France et al. (2019) and Walsh and Downe (2005), Noblit and Hare's (1988) seven phases of meta-ethnography were employed in this synthesis and detailed in Table 3. Keeping a research journal and peer review with the research supervisor and an independent qualitative researcher was used throughout this process to increase reflexivity and credibility.

Phase	Description	Process in current review
1	*Getting started*	Defining the research topic and research question around male attempted suicide.
2	*Deciding what is relevant to the initial interest*	Developing the search strategy, establishing the inclusion and exclusion criteria and identifying relevant studies. (Table 1, Table 2, Figure 1 & Appendix B)
3	*Reading the studies*	Reading the included articles several times and extracting relevant study information (e.g. sample details). Beginning to identify core concepts in studies.
4	*Determining how the studies are related*	The first and second order concepts from each study were tabulated (Appendix D1). These concepts were then extracted using Nvivo Software (QSR International, 2018). Concepts were then compared to see how they were related, discordant or provided a novel insight. Constant comparison ensured concepts were grounded in the original articles. Concept maps were used to determine relationships (example of this stage in Appendix D2).
5	*Translating the studies into each other*	Comparing and translating first and second order concepts across studies to identify and explain *reciprocal translations* (similar concepts) and *refutational translations* (contradictory concepts). This was completed in chronological order to explore any emergent processes over time (i.e. Toye et al., 2014). The findings of this review identified no refutational translations, therefore reciprocal translations were used in the synthesis (examples of the translation process in Appendix E).
6	*Synthesising translations*	Developing a conceptual model to integrate the translations into a line of argument. Using constant comparative methods to ensure the emerging line of argument is grounded in the original articles. (Figure 2 and Appendix F).
7	*Expressing the synthesis*	The findings of the synthesis were expressed in written form, using illustrative models and first order exemplars to portray conceptual arguments.

Table 3. Process of meta-ethnography (Noblit & Hare, 1988)

Results

Study characteristics

Nine of the reviewed articles were primary qualitative studies. Cleary (2012) completed secondary analysis of data from a study excluded as it did not report the method of analysis (Cleary, 2005). One paper (Biong et al., 2008) completed a secondary analysis of data from an included study (Biong & Ravndall, 2007). The authors provided a nuanced examination of this data (different aim and data analysis) and therefore, the study was included. All of the reviewed articles focussed on the lived-experience of participant's suicide attempts, with some papers focussing on a particular population, such as men with addictions (Biong & Ravndall, 2007, 2009; Biong et al., 2008; Ribeiro et al., 2016), men with a first-episode psychosis (Gajwani et al., 2018) and male prisoners (Rivlin et al., 2013). All studies completed individual interviews. The authors mainly used phenomenological, grounded theory and thematic analysis methods. Interviews were completed in prisons, community, and inpatients services and at the participant's home. The length of time between the individual's suicide attempt and the research interview ranged from 72-hours to over four years; however, not all papers reported this data. There was variation in the reporting of participant's suicidality, for example, intention to die and number of prior attempts. If reported, a variety of methods of suicide were used, including intentional vehicle crashes, intentional drug overdoses, hanging and stabbing (amongst others). Included studies were undertaken in Brazil, Ghana, Ireland, Norway, Nicaragua, South Africa and the United Kingdom. A total sample of 183 men were recruited across the 11 studies with an age range of 15-76. Eight papers used a sample age range of between 15-41 with five of these specifically aiming to explore the suicidal experiences of young men. Table 4 provides the details of the included studies.

Study No.	Authors	Aim	Participants	Sampling	Suicidality Information	Country	Data Collection	Analysis	CASP Rating
1	Biong and Ravndal (2007)	Exploring the lived experience of suicidal young Norwegian men with long-term substance use. *Research Question* - *What are the lived experiences of some young men who have attempted suicide?* - *How is meaning constructed in the narratives of suicidal behaviour?*	N=4 Age: 32-40 Historic substance use. 2 received formal education.	Purposeful	Intent reported. First attempt age range – 17-29. Last suicide attempt; one month – four years ago.	Norway	Unstructured interviews – Conversation with prompts. Duration: 1-2 hours. Tape recorded and transcribed verbatim.	A phenomenological hermeneutic approach, inspired by the philosophy of Ricoeur.	8.0 (A)
2	Biong et al. (2008)	Exploring sense of self in young suicidal Norwegian men with long-term substance use. (Secondary analysis of Biong & Ravndal, 2007). *Research Question* - *How was meaning and sense of self constructed by the metaphors?* - *How can knowledge about clients' sense of self be identified and used in recovery?*	N=4 Age: 32-40 Historic substance use. 2 received formal education.	Purposeful	Intent reported. First attempt age range – 17-29. Last suicide attempt; one month – four years ago.	Norway	Unstructured interviews – Conversation with prompts. Duration: 1-2 hours. Tape recorded and transcribed verbatim.	Steger's anthropological method for analysing metaphors.	6.0 (B)

Study No.	Authors	Aim	Participants	Sampling	Suicidality Information	Country	Data Collection	Analysis	CASP Rating
3	Biong and Ravndal. (2009)	To explore the experiences of emigration, substance use and suicidal behaviour in non-western men. *Research Questions:* - *How is meaning constructed in the narratives?* - *What impact do these experiences have on health, wellbeing and coping?*	N=4 Age: 30-40 North African, middle east, South Asian. Migrated between ages of 14-17. Historic substance use.	Purposeful	Reported past suicidal behaviour. Suicidal behaviour onset between 20-35. Last suicide attempt 1-4 years ago.	Scandinavia	In-depth unstructured interviews with prompts. Not permitted (by ethics) to ask questions on suicide. Duration: 1.5-2 hours. Audio recorded and transcribed verbatim.	Lindseth and Norberg's phenomenological hermeneutic approach, inspired by the philosophy of Ricoeur.	8.5 (A)
4	Cleary (2012)	To explore how masculinity is implicated in male suicide. *Research Question:* - *What are the subjective experiences of masculinities in male suicide stories?*	N=52 Age: 18-30	Consecutive sample	All had intent to die. Suicide method reported (majority overdose).	Ireland – 3 hospitals in Dublin (2 A&E, one psychiatric).	Unstructured interview. Audio recorded.	A modified version of grounded theory (Strauss and Corbin, 2008) and guided by Douglas' methodological approach.	7.5 (A)
5	Gajwani et al. (2018)	To examine meaning in suicide attempts of young men with first episode psychosis. Exploring the relationship between emergence of psychosis and suicide attempts.	N=7 Age: 18-35 Ethnicity, employment and education reported.	Purposeful	Mean two years since previous attempt. Attempt prior to psychosis emerging (n=1). More than one attempt (n=4).	United Kingdom Early intervention service for psychosis.	Semi-structured interview with interview schedule. Audio recorded and transcribed verbatim. Duration: 45-60 minutes.	Interpretative phenomenological analysis (IPA).	8.0 (A)
6	Knizek and Hjelmelan d (2018)	To investigate what men who have attempted suicide perceive as crucial for this decision.	N=15 Age: 20-76 Ethnicity, employment and education reported.	Opportunity sample	Intentional overdose n=13 Swallowed dilutant n=1 Hanging n=1 Alcohol involved n=5 Drugs involved n=2	Norway	Semi-structured interview. Audio recorded and transcribed verbatim.	Qualitative content analysis.	7.0 (B)

Study No.	Authors	Aim	Participants	Sampling	Suicidality Information	Country	Data Collection	Analysis	CASP Rating
7	Medina et al. (2011)	To explore and understand the pathways leading to an attempted suicide among young men in Nicaragua. Investigating triggers and interplay between structural conditions and coping strategies.	N=12 Age: 15-24	Opportunity sample	Triggering events reported. Attempts defined as impulsive (n=7) or planned (n=5) Lifetime suicide attempts reported. Warning signs, medical input, family/friends and protective factors all noted.	Nicaragua (Leon Region)	In-depth interviews. Interview completed 72 hours after suicide attempt.	Grounded theory (Bryant & Charmaz, 2007).	8.5 (A)
8	Meissner and Bantjes (2016)	Examining the attempted suicide process in young South African men. To explore recovery experiences.	N=4 Age: 20-25 Undergraduate Ethnicity, language, religion, sexuality reported.	Opportunity Self-selecting sample.	Suicide method: Car accident (n=2) Hanging (n=2)	South Africa	Semi-structured interview. Audio recorded and transcribed verbatim.	IPA	7.5 (A)
9	Osafo et al. (2015)	To understand the experiences of suicidal people in Ghana. To examine the aftermath experiences of suicidal people.	N=10 Age: 30-41 All identified as Christian.	Engagement with population through community elders. Engaged in educational programme and then a self-selecting opportunity sample.	Methods reported as poisoning, hanging and abdominal stabbing.	Ghana. Small village in the Eastern region. Farming community.	Interview.	Thematic analysis.	3.5 (C)

Study No.	Authors	Aim	Participants	Sampling	Suicidality Information	Country	Data Collection	Analysis	CASP Rating
10	Ribeiro et al. (2016)	To understand experiences of attempted suicide and substance use. *Research Question:* - *What are the reasons behind suicide attempts among men who use alcohol and other drugs?*	N=11 Demographics not provided (inclusion age rage was 19-59).	Purposeful	Limited suicide information provided.	Brazil State of Rio Grande Do Sul.	Individual phenomenological interview.	Phenomenological sociology of Alfred Schütz.	6.0 (B)
11	Rivlin et al. (2013)	To identify the psychological problems and processes leading up to, and following, suicide attempts in male prisoners. To identify key opportunities for prevention.	N=60 Age: 18-57 Ethnicity, offending and sentencing information provided.	Purposeful. Recruited across 19 prisons (multiple categories).	All near-lethal attempts. Various suicide information provided including: Triggers to act. Time between idea and act. Precautions against discovery. Plans and arrangements for death. Communication before act. Imagery before act. Location and timing. Method used and reasons for this. Consequences of attempt.	United Kingdom (England and Wales)	Individual semi-structured interviews. Interview schedule with additional prompts.	Thematic analysis.	8.0 (A)

Table 4. Study characteristics

Findings of quality assessment

The quality assessment scores for each paper are shown in Table 5. Three of the included studies were reviewed by an independent researcher to provide reliability to the quality assessment process. Individually, there was 82% agreement between the two ratings. 100% consensus was achieved when discussing discrepancies, which included comparing CASP assessment with original data and referring to checklist criteria and additional guidance (i.e. Walsh & Downe, 2006). Examples of the quality assessment consensus process is shown in Appendix G. Seven of the included papers were assessed as high quality whereas three were of moderate quality. Osafo et al. (2015) was the only paper to receive a low-quality assessment. The mean quality rating score was 7.1. Papers mainly lost points for lack of reflexivity, lack of rationale for methodological approach and for lack of analysis rigour.

The final CASP question considers the study's contribution to the extant literature. Individual paper's strengths and limitations were tabulated (Appendix H). All papers contributed to the existing literature, often by providing a greater understanding of male suicide in a distinct population (e.g. prisoners, Rivlin et al., 2013). Occasionally, papers also commented on their contribution to clinical practice or policy, such as risk assessment (e.g. Osafo et al., 2015). Eight of the included papers provided details of future research direction, such as further explorations around relationships and connectedness (Meissner & Bantjes, 2016). The lack of transferability onto other populations was often hampered by small sample sizes or specific populations. However, generalisability is not the goal of qualitative research, which instead aims to provide an in-depth understanding of the phenomenon under study.

CASP Criteria	Biong and Ravndal (2007)	Biong et al. (2008)	Biong and Ravndal (2009)	Cleary (2012)	Gajwani et al. (2018)	Knizek and Hjelmeland (2018)	Medina et al. (2011)	Meissner and Bantjes (2016)	Osafo et al. (2015)	Ribeiro et al. (2016)	Rivlin et al. (2013)
1) Was there a clear statement of the aims of the research?	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)
2) Is a qualitative methodology appropriate?	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)
3) Was the research design appropriate to address the aims of the research?	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)
4) Was the recruitment strategy appropriate to the aims of the research?	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	No (0)	Unclear (0.5)	Unclear (0.5)	Yes (1)
5) Was the data collected in a way that addressed the research issue?	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Unclear (0.5)	Unclear (0.5)	Yes (1)
6) Has the relationship between researcher and participant been adequately considered?	No (0)	No (0)	Unclear (0.5)	No (0)	No (0)	No (0)	Unclear (0.5)	Unclear (0.5)	No (0)	No (0)	No (0)
7) Have ethical issues been taken into consideration?	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	No (0)	Yes (1)	Yes (1)
8) Was the data analysis sufficiently rigorous?	Yes (1)	Unclear (0.5)	Yes (1)	Unclear (0.5)	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)	No (0)	Unclear (0.5)	Yes (1)
9) Is there a clear statement of findings?	Yes (1)	Unclear (0.5)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Unclear (0.5)	Unclear (0.5)	Yes (1)
10) How valuable is the research?											
i) Contribution to existing knowledge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ii) Identification of future research direction	✓	X	✓	X	✓	✓	✓	✓	X	✓	✓
iii) Generalisability of the findings	X	X	X	X	X	X	X	X	X	X	X
iv) Implications discussed	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
CASP total on first 9 questions (out of 9)	8.0	6.0	8.5	7.5	8.0	7.0	8.5	7.5	3.5	6.0	8.0
CASP Rating	A	B	A	A	A	B	A	A	C	B	A

Table 5. CASP quality assessment ratings for the included studies

Meta-ethnography findings

Following Noblit and Hare (1988), the line of argument synthesis of the first, second and third order constructs exploring the lived experience of males who have attempted suicide identified an overarching theme of *'disconnection from the self and others'*. Within this overarching theme, seven core themes emerged: *'Early adversities and trauma'*; "*The pain*"; *'Feeling different'*; *'Rejection'*; *'Alone'*; *'Masculinity'*; and *'Using substances'*. Rather than working in isolation, these themes often interlinked, giving rise to increased feelings of disconnection to oneself, other people and the word. The perceived hopelessness of this position led men to identify *'suicide as a solution'* on the trajectory towards their attempt. The theme of *'after the attempt'* described men's reflections on suicide and views towards the future. *'Hope through reconnection'* moved the men away from suicidality, whereas *'an ambivalent future'* was associated with dejection and continued suicidality. There was significant overlap in the endorsement of the themes across the included studies, shown in Table 6. This consistency of the synthesised themes suggests that papers with poorer quality ratings did not adversely influence the results.

Translated Concepts and themes.	Number of papers endorsing theme	Biong and Ravndal (2007)	Biong et al. (2008)	Biong and Ravndal (2009)	Cleary (2012)	Gajwani et al. (2018)	Knizek and Hjelmeland (2018)	Medina et al. (2011)	Meissner and Bantjes (2016)	Osafo et al. (2015)	Ribeiro et al. (2016)	Rivlin et al. (2013)
Quality Rating		A	B	A	A	A	B	A	A	C	B	A
Overarching concept: Disconnection from the self and others	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trauma & adversities	8	✓	✓	✓	✓	✓		✓	✓			✓
"The pain"	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Concealing distress	5	✓			✓			✓	✓			✓
Using substances	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rejection	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rejecting	8	✓	✓	✓	✓	✓			✓	✓	✓	
Rejected	9	✓	✓	✓	✓	✓	✓		✓	✓		✓
Feeling different	8		✓	✓	✓	✓	✓		✓		✓	✓
Alone	10	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Masculinity	8	✓	✓		✓		✓	✓	✓	✓	✓	
Suicide as a solution to hopelessness	10	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Inability to cope	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hopelessness	10	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Suicide as a solution	10	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
After the act	10	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
An ambivalent future	6		✓		✓	✓	✓			✓		✓
Hope through reconnection	9	✓	✓	✓		✓	✓	✓	✓	✓		✓

Key: **Bold Type –** Overarching and main concepts; Standard Type – Core Themes; *Italic Type* – Sub-themes

Table 6. Overlap in pertinent theme across the included studies

A conceptual model of the line of argument synthesis is show in Figure 2. This model proposes that men who attempt suicide have multiple complex and interconnecting difficulties in which suicide is identified as a potential solution. Each core theme can interconnect, highlighting their potential to interweave and increase an experience of disconnection. Experiencing disconnection appeared to exacerbate suicidal risk. The process after the attempt highlights how reconnection provides a potential exit from suicidality. Using constant comparison methods, the model was explored across each individual paper to ensure that the third-order model is grounded in the first and second order interpretations. Firstly, each of the seven core themes will be presented followed by a discussion of the overarching disconnection theme.

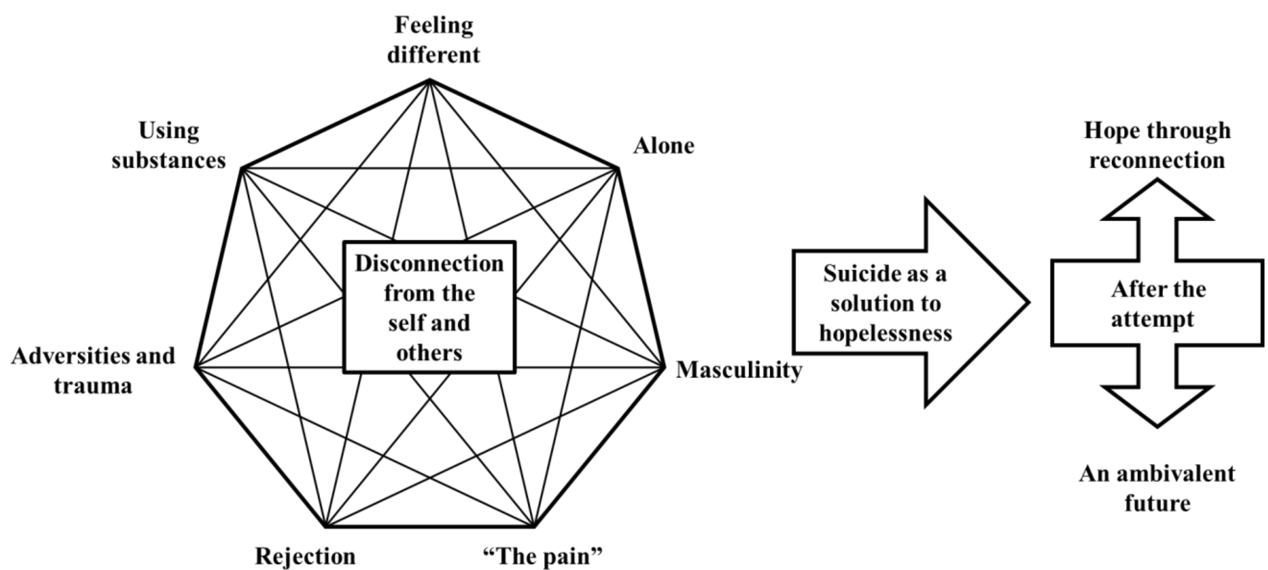

Figure 2. Model to illustrate the factors leading to attempted suicide in males

Trauma and adversities

Early adversities and traumas played a crucial role in the origins of participant's difficulties. Eight studies endorsed this theme, which was often associated with early familial

experiences, including domestic violence, parental separation, sibling conflict and poverty. These adversities could provide a direct link to the theme of *'suicide as a solution'*, often due to feelings of hopelessness.

> *It was very difficult when my mom left us… sometimes we ate, sometimes we didn't… if we didn't [have] anything [to eat], we used to wait to see if my grandmother would bring a bowl of soup… that's why I did what I did* [attempted suicide].
> (Medina et al., 2011, p.21).

The father-son dyad as a source of trauma and adversity was described in six papers. These relationships were portrayed as either violent and abusive or as absent (through death or separation). These traumas often led to endured distress, conveyed in *"the pain"* theme and maladaptive coping strategies, such as those described in *'using substances'*.

> *The loss* [of] *my father* (age thirteen)… *I think not having a role model around the house, it affected me quite badly… school grades started going down quite badly and I started cannabis. I don't think my dad would have let me consume…*
> (Gajwani et al., 2018, p.1122).

Participants across three studies identified the negative impact of bullying and how this connected to further core themes, such as *"the pain"*.

> *You can see little bits of it throughout your life basically when you look at your mental illness, you can see parts of your life which have been leading up to it, contributing towards it, like bullying… teasing basically, that can get you very angry, almost horribly angry.*
> (Gajwani et al., 2018, p.1123).

"The pain"

One participant described his emotional "pain" (Cleary, 2012, p.501) which is synonymous with the endured psychological suffering and intense emotional experiences described across all studies. The men's pain comprised of prolonged and intense feelings of anger, panic, sadness, depression and shame. Men's pain was often interconnected with the other core themes, often arising out of *'early adversities'*. The exert below describes how one man's pain arose out of feelings of *'rejection'*, although the pain of this rejection appeared intensified due to feelings of shame around manliness, connecting with the *'masculinity'* theme.

> *That feeling of a girl leaving you like that. It is a feeling of you don't feel good enough, you don't feel sufficient, or you are not man enough and suddenly once again you feel ashamed of yourself. You are disappointed in yourself, why can't you just hold onto a girl?*
>
> (Meissner & Bantjes, 2016, p.8).

Men attempted to manage their pain by concealing distress, a sub-theme endorsed in five studies. This often related to factors described in the *'masculinity'* theme, such as worries that revealing their pain may lead to emasculation or appearing weak.

> *I thought of it but I didn't do it. You're telling someone you failed. I feel like I failed, that's why I did that* [attempted suicide]. *They* [men] *don't tell anyone about their problems. Men feel they have to be strong, that you have to be able to manage when you are a man.*
>
> (Cleary, 2012, p.501).

Using substances

Substance use was commonplace in the lives of the men across the included studies and was often used to manage *"the pain"*. This included regular accounts of self-medication for emotional management and to facilitate disconnection.

> *The use of opiates was like folding up my body, putting it in a drawer, and getting rid of the burden of carrying it around.*
>
> (Biong & Ravndal, 2009, p.10).

Paradoxically, the complexities and consequences of substance use often worsened the men's *"pain"* and exacerbated their suicidal risk. Furthermore, substance use increased feelings of disconnection by causing relational difficulties, thereby risking *'rejection'*, leading to feeling *'alone'*. The reciprocal nature of substance use, rejection and loneliness further intensified disconnection.

> *Amphetamines came into my life when I experienced one of the most empty periods in my life. I had broken my ties with my family, like being without any past or future.... I was in a vacuum and felt extremely empty, never felt so empty in my life. The drug got me on my feet on a daily basis but brought me ultimately to the edge of madness…I knew I was reaching the point of no return. I intoxicated myself to escape from suicidal thoughts.*
>
> (Biong et al., 2008, p.39).

Rejection

This theme was pertinent across all studies and describes experiences of rejection in interpersonal and societal relationships. Participants experienced the reciprocal nature of this role, described in the sub-themes below.

Within the *rejected* sub-theme were participant's experiences of being rejected by close relationships, health services and society. This was endorsed by nine of the included studies. Individuals described feeling rejected by current relationships, including separation and partner infidelity, from family members associated with *'trauma and adversities'* or from feeling unwanted in society.

> *I have had a painful issue between me and my wife. She was seeing another man although we were legally married. I caught her red-handed, but she was still denying it. Later she left the marriage and made away with my hard-earned money.*
> (Osafo et al., 2015, p.277).

Rejection from society was often linked to the *'feeling different'* theme. Sexual minority participants also felt rejected by society due to their incongruence with *'masculinity'* norms. Both accounts below highlight the relationship between rejection*, 'feeling different'* and participant's *"pain"*, particularly shame and how this exacerbated suicide risk.

> *You just get shunned if you're different. That's being a fag. When you're growing up there's a lot of pressure not to be gay… If you're gay you get an awful time… Gay and feminine is the same.*
> (Cleary, 2012, p.502).

> *My culture gives me quite specific obligations. I cannot live up to any of these expectations. I became a shame to my family. I have become useless. I hate myself so much. I could do my family a favour by getting rid of myself.*
>
> (Biong & Ravndal, 2009, p.10).

When positioning themselves in the rejecting role, participants described disconnecting from others and society, and this was endorsed by eight papers. Distancing themselves from others, either physically or through *'substance use'* was described as a strategy to manage *"pain"*. However, the consequences of this led participants to feel *'alone'* and further disconnected.

> *My family slowly abandoned me, or rather, I abandoned them and ended up alone.*
>
> (Ribeiro et al., 2016, p.4).

Feeling different

Within this theme were individuals' sense of insecurity due to feeling dissimilar to significant others, or a sense of incongruence to societal norms. This was endorsed across eight studies. Some men attributed their mental health difficulties or sexuality to feeling different. However, in the absence of an identifiable *reason* for their difference, participants described an unclear identity and a lack of belonging. Feeling different was linked to perceptions of *'rejection'* from others which exacerbated *"pain"* and disconnection as their suicide risk increased.

> *I hate myself, you know, cos what is this! Not even God will accept me…many churches are obviously against homosexuality and it's like, I'm standing here and everyone is going crazy for God and there is a person with pain in the middle, who wants to commit suicide. You know, and nobody even sees that.*
>
> (Meissner & Bantjes, 2016, p.8).

> *We are Norwegians, but are not accepted, not in Norway, and not in our country of origin.*
>
> (Biong & Ravndal, 2009, p.12).

Alone

The theme of alone covers individuals' descriptions of being isolated, alone or lonely and was endorsed by ten of the included studies. The consequences of the *'rejection'*, *'using substances'* and '*feeling different'* themes often led the men to feel alone. Feelings of loneliness appeared to exacerbate the men's *"pain"* and disconnection and move individuals closer towards suicidality.

> *I was spending a lot of time alone, smoking a lot of cannabis. I generally felt quite cut off from the rest of the world… because of my feelings of loneliness… I felt that …life was just very difficult… and so I thought of various ways of committing suicide.*
>
> (Gajwani et al., 2018, p.1123).

Masculinity

The theme of masculinity was identified across eight of the included papers. Participants described a set of cultures, beliefs, rules and scripts about how men should behave, think and feel. Within these discourses were rules about how men should deal with and communicate distress and the potential risks of disclosing difficulties. These rules could lead men to *'conceal distress'* for fear of it being weaponised by others. As previously noted, diverging from masculinity norms could be inferred as being *'different'*, risking *'rejection'*.

> *I come from a home where you have your gender roles, men don't cry and my dad didn't show that he is sad, my brothers as well. You can see it in them, so obviously I adopted those ways of doing things.*
>
> (Meissner & Bantjes, 2016, p.9).

> *Lads can't turn around and talk to their friends. If you turned around and gave a sign of being weak and stuff like that, you'd be ridiculed. There's no way you could show your emotions like that.*
>
> (Cleary, 2012, p.502)

Overarching concept – Disconnection from the self and others

This overarching concept was endorsed across all the included studies and describes participant's experiences of intrapersonal and interpersonal disconnection. Interpersonal disconnection encompassed feelings of detachment, depersonalisation and dehumanisation… *"That made me feel low and something different, not human"* (Gajwani et al., 2018, p.1124). Disconnection was also experienced relationally with feelings of isolation, detachment and withdrawal experienced within close relationships and with society… *"I don't like the world we live in today… I don't feel at home in the world"* (Knizek & Hjelmeland, 2018, p.5). Feeling disconnected was regularly cited as a contributing factor on the pathway towards suicide.

> *I couldn't eat anything. I couldn't really talk. I wouldn't ring my family. I couldn't speak to the staff. I wouldn't come out of my cell. I just got so depressed, so I just decided to end my life.*
>
> (Rivlin et al., 2013, p.313).

Disconnection was multifactorial and often interweaved with many of the seven themes previously discussed. This experience of disconnection appeared to worsen distress and increase suicide risk. The account below describes the interplay between *'using substances'*, *'alone'*, '*feeling different'* and *'rejection'* in the participant's experience of disconnection and suicide.

> *With heroin I got more and more distanced from society. You have no relationship to society anymore. I could sit and observe people around me, everything appeared so meaningless. You even become an observer towards yourself as well. You are not part of reality anymore, you are an observer. It is like being an un-soul, and then the wish for death develops. This existence is as close to death as it is possible to come. Death is just one step ahead.*
>
> (Biong & Ravndal, 2009, p.10).

Suicide as a solution to hopelessness

The experience of disconnection, which resulted from the interconnecting core themes, generated a sense of hopelessness in the men (endorsed across ten studies). Participants described enduring dejection at their current situation and perceived no relief. They felt pointless and were unable to see a positive future.

> *It's as if my life isn't worth anything... I didn't feel I was worth anything, unemployed, on the streets.*
>
> (Ribeiro et al., 2016, p.5).

Hopelessness was exacerbated by individuals perceiving an inability to cope with their distress, a sub-theme endorsed across all the studies. This was associated with limited choices

and feelings of entrapment. Feeling unable to cope in this position of hopelessness led to metaphors of dwindling options, such as 'being at rock bottom'.

> *I couldn't cope with it. I didn't want to live anymore. I just felt I had no choice. I'm not functioning normally. I don't want to spend every day in hell.*
>
> (Cleary, 2012, p. 503).

It was from this position of hopelessness, disconnection and an inability to cope that the men identified suicide as a solution – a sub-theme endorsed by ten of the included studies. This often occurred after an accumulation of the aforementioned difficulties. However, a smaller number of studies noted how a significant 'trigger' could potentially situate men in this position.

> *You don't have many options and something like that is your best option, your best choice and you've got the choices but the only good one you have or the best one of them all is to end it for yourself, end all your troubles, end all your worries and you'll never have to worry about it again.*
>
> (Cleary, 2012, p.503).

After the attempt

Ten of the included studies described the men's perceptions of their lives after attempting suicide. This theme contained general reflections on their attempt(s) and participant's views on the future, which are described in the sub-themes *an ambivalent future* or *hope through reconnection*. Participants reflected on the intention of their actions and where they placed responsibility for their suicide attempt. Some individuals acknowledged their intention to die, whereas others used emotional disconnection as a coping strategy to distance themselves from the event.

I have sleeping problems during night… Thus, I got sleeping pills from my doctor… and… I took all of them at once. Ninety pills. And that was after a large consumption of alcohol, so… I don't think I knew that I took them.

(Knizek & Hjelmeland, 2018, p5).

The sub-theme of an ambivalent future (described across six studies) conveys participant's uncertainty around their future. This ambivalence resulted in continued distress and dejection. Some individuals were explicit in their plans for future suicidality, whereas some experienced disregard as to whether they lived or died and indicated continued feelings of disconnection.

The way I see it is that if you are going to live, you must have something to live for or at least something to look forward to, and that I have never had and will never get. So, I see no reason why I should stay here then.

(Knizek & Hjelmeland, 2018, p5).

Hope through reconnection was more prevalent across the studies (described in nine papers) and conveyed a sense of positivity around the future. Some individuals experienced a turning point which led them on a course away from suicidality. The men reported seeing life as purposeful with an existential understanding that their survival was for a reason. At the core of individual's hope was a feeling of reconnection with themselves, others and healthcare support. Within this sense of hope appeared a connection to a positive sense of self.

I'm alive for a reason, I tried to end my life enough times, enough times and I've lost count of the amount of times so it's like I'm alive for a reason. Hopefully I think I'm on the way to recovery.

(Gajwani et al., 2018, p.1124).

Discussion

This is the first systematic review exploring the factors which underpin suicidality in males. Findings from 11 studies of variable quality, sampling 183 men across seven countries, were synthesised to identify an overarching concept of *disconnection from the self and others*. What emerged from the analysis was that disconnection worsened distress and increased the men's suicidal risk. Seven factors contributed to this state of disconnection: early adversities and trauma; substance use; feeling alone; rejection; masculinity; feeling different; and psychological "pain". These interweaving factors served to worsen distress and disconnection, ultimately leading to a sense of hopelessness and an inability to cope. Within this position, suicide was perceived as a solution. Surviving a suicide attempt presented individuals with a continuum between an ambivalent and a hopeful future. Ambivalence was associated with hopelessness and continued suicidality, whereas hope signified a turning point towards recovery. There are parallels between these findings and previous qualitative reviews into suicidality. Lakeman and Fitzgerald's (2008) review found disconnection to worsen distress and exacerbate an individual's suicidality, and how reconnection with others fostered recovery. Furthermore, their theme of "suffering" draws connections to "the pain" and hopelessness identified in the current review. The current analysis also echoes with the review of Berglund et al. (2016), who found descriptions of psychological pain, rejection and isolation. Similarly, they identified how reconnection facilitated recovery. The previous qualitative literature has mainly used an inpatient, mixed-gendered sample. The current findings further this knowledge by highlighting the nuanced role of the seven factors, including substance use and masculinity, in male suicide and how these factors interweave to intensify experiences of disconnection.

The seven interlinking factors increased men's suicide risk and are supported within the wider risk literature. Men who have experienced adverse childhood events are three times more likely to attempt suicide (Afifi et al. 2008). Substance use was prevalent across the included studies and is well documented as a factor in suicidality (Cavanagh et al., 2003; Yuodelis-Flores & Ries, 2015). Relationship difficulties are known to increase suicide risk, including familial rejection (Campos & Holden, 2015) and divorce (Kposowa, 2000), which both contributed to the men's suicidality across the meta-ethnography. Furthermore, loneliness has been associated with increased suicidal ideation (Oliffe et al., 2019; Stravynski & Boyer, 2001). In the current study, feeling different due to minority status (e.g. nationality, sexuality or society ostracism) factored in the men's suicide risk. Feeling different has been hypothesised to increase suicide risk (Rüsch et al., 2014). Furthermore, men in minority groups are at a greater risk of suicide, including male sexual minorities and male immigrants (Hottes et al., 2015; Kposowa et al., 2008).

The findings of this review support extant conceptualisations of suicide. *"The pain"* theme conveys the men's endured emotional distress. Many theoretical accounts see suicide as an escape from this pain (e.g. Baumeister, 1990; Williams, 1999). Hunt et al. (2017) identified how anger is more prevalent in suicidal men's psychological pain, which is supported by this meta-ethnography. The synthesis identified how the men viewed suicide as a solution to their feelings of hopelessness, which is central to many extant theoretical accounts of suicide (e.g. Beck et al., 1990; Schotte & Clum, 1987; Williams, 1997). The current findings can be best conceptualised within the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) and the IMV model of suicide (O'Connor, 2011). Feeling disconnected from oneself and others, and each of the individual core themes, may lead individuals to experience a thwarted belongingness and perceived burdensomeness. Both models also situate the role of

early adversities which were identified in the current review. The men's ensuing hopelessness may result in feelings of entrapment, which are central to the IVM model. These models posit that the capability for suicide is needed to move from suicidal ideation to behaviour. This meta-ethnography found that disconnection and substance use play a key role in creating a capability for suicide in men, which is missing from current conceptualisations. Whilst substance use could be inferred as increasing impulsivity (and therefore capability), theories of suicide would benefit from explicitly acknowledging the prominence of substance use and disconnection across their conceptualisations.

This review found masculine gender norms, particularly hegemonic masculinity, to be a risk factor for male suicide. Gender scripts around the appropriateness of emotional expressiveness resulted in men concealing their distress, perceiving it to show weakness. The presence of anger and hostility described across some of the studies may be related to the cultural acceptability of these emotions in males (Möller-Leimkühler, 2003). These findings are similar to previous meta-syntheses exploring male mental health difficulties (Krumm et al., 2017; McKenzie et al., 2016). The current findings support the wider literature of how the social construction of gender may account for the increased prevalence of male suicide deaths (e.g. Möller-Leimkühler, 2003; Payne et al., 2008). This review demonstrates the nuanced relationship between discordance from gender norms and experiences of disconnection. However, this review identified how masculine gender scrips do not explain male suicide in its entirety.

Implications for suicide prevention

Acknowledging and assessing suicide risk factors and warning signs is vital to prevent death by suicide. Disconnection should be considered during any assessment of risk. These findings suggest that disconnection may present itself in typical conceptualisations, such as being isolated and alone, and more atypical presentations such as feeling disconnected from oneself or from societal norms. Practitioners need to be aware of the potential nuances in how disconnection may be exhibited. Despite the similarities in men and women's experiences of suicidality, men present with additional risk factors, including anger, agitation and substance use. This review highlights the prominence of these risk factors in suicidal men.

The current findings add to the literature suggesting that reconnection with oneself and others can foster recovery from suicidality. Clinical approaches which encourage connectedness may be useful for suicidal men. For mental health services this may include therapeutic interventions, such as Dialectical Behavioural Therapy (DBT), which focus on intrapersonal and interpersonal connectedness. DBT has been demonstrated to reduce suicidality in women (Linehan et al., 2006), although its efficacy in men is unclear (Goodman et al., 2016). The benefits of connection are further demonstrated by Heisel et al. (2016) who found that focussing on reasons for living and meaning in life significantly reduced suicidal ideation. Peer support may also foster connectedness and is becoming more commonplace in mental health services (Pitt et al., 2013). These implications are supported by a recent scoping review exploring strategies to prevent male suicide (Struszczyk et al., 2019). The authors identified reconnection, emotional regulation techniques and reframing masculinity scripts around help seeking as potentially useful in reducing suicide risk. However, future research is needed to explore the effectiveness of clinical interventions for suicidal men.

A significant number of suicidal men may not approach services. The needs of suicidal men are reflected in UK guidance which proposes a holistic framework for reducing male suicide, such as targeting alcohol use and community outreach programmes (Department of Health, 2012; NICE, 2018; Welsh Government, 2015). The literature and current findings suggest that gender norms reduce help seeking and have a detrimental impact on male health (Payne et al., 2008). Further research could examine whether there is an interplay between gender scripts and strategies which are designed to increase male emotional expressiveness.

Limitations

By focussing on those who have attempted suicide it is unclear whether these findings can be generalised across the suicidality spectrum. Further research is needed to explore the transferability of these results. Excluding non-published material may have led to publication bias (Petticrew et al., 2008). The studies retrieved may limit the generalisability of the findings across sub-populations of males. UK suicide rates are highest in the 45-49 age range (Simms et al., 2019), however only three papers sampled men over 40. Similarly, heterosexuality dominated the sample, which may have been a consequence of the inclusion criteria as two papers focussing on sexual minorities were excluded for additional reasons. Future research is needed to explore diverse sub-groups in more detail. The propensity of studies in higher GDP countries may place a cultural bias on the findings. Each study varied on their reporting of the suicide intent of their sample. Therefore, the findings cannot be compared based on the perceived lethality and intent of the men's attempts. Similarly, situating the findings within particular mental health diagnoses is limited due to the lack of reporting of participant's mental health histories. It is recommended that future research

provides sufficient demographic and suicidal information in order to situate their samples and ensure that samples are diverse. This is in addition to improving reporting of reflexivity and methodological rigour which was identified during the quality assessment. It is important to note that individuals may be dissuaded from taking part in qualitative suicide research. This may be more prominent for men who conceal their distress or have difficulties with emotional expressiveness. Affleck et al. (2012) suggest that this limitation may be addressed by using methodological approaches which do not require verbal expressions of emotions (e.g. photographic methods).

There are methodological strengths to the current review. These include using rigorous inclusion and exclusion criteria, quality assessment and independent credibility checks. Furthermore, the inductive and interpretative nature of meta-ethnography befitted the aims of the review. However, meta-ethnography has been criticised for loss of context due to synthesising findings from across different qualitative paradigms (Atkins et al., 2008; Sandelowski et al., 1997). Given that the researcher is male, with clinical experience in working with suicidality and with a family history of suicide, it is possible that the findings may have been interpreted through the lens of personal experience. Although qualitative researchers are unable to ensure complete objectivity (Spencer & Richie, 2012), working collaboratively with the research supervisor, an independent qualitative researcher and keeping a research journal ensured reflexivity and transparency throughout the research process.

Future research

Qualitative researchers do not imply causal connections. Future quantitative research using linear regression modelling could explore whether particular factors are more predictive of disconnection. Research could explore the significance of factors within sub-populations of men, for example loneliness (akin to the *alone* theme) has been associated with increased depression in older men (Alpass & Neville, 2003). Future research could also explore the usefulness of this model in other populations. For example, family rejection was found to be a significant predictor of substance use and suicidal ideation in transgender and gender nonconforming individuals (Klein & Golub, 2016). Rüsch et al. (2014) suggest that the stigma around mental health difficulties can results in feeling different, alone and rejected, hypothesising that the associated shame can factor in suicidality. They propose a link between stigma and suicide which would benefit from further research to explore their hypotheses. This may be further pertinent for individuals surviving a suicide attempt, which in itself can be stigmatising (Rimkeviciene et al., 2015). Future research could explore the pertinent question of how to turn an ambivalent future into a hopeful one and what interventions are useful to aid reconnection at different locations in the suicidal journey. Future research should evaluate the efficacy of community psychological and public health strategies on male suicide, such as challenging hegemonic masculinity and community interventions to enable reconnection.

Conclusion

This is the first qualitative review of suicidality in males. The synthesis identified the multifactorial aetiology of disconnection and how this increased men's suicidal risk. A theoretical conceptualisation was developed to explain the factors associated with male suicide. Clinicians and policy makers can use this model to consider the individual factors which contribute to disconnection. By facilitating interventions which foster reconnection, clinicians can support men to embark on a trajectory away from suicidality. This model presents opportunities for further research scrutiny to explore its emerging properties and potential implications.

Declaration of interest statement

The author declared no potential conflicts of interest with respect to the research.

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Paper 2

"The last thing you feel is the self-disgust". The role of self-directed disgust in men who have attempted suicide: A grounded theory study

Prepared in accordance with the author guidelines for *Archives of Suicide Research*[2] (Appendix A)

Word count excluding tables, figures and references: 8434*
* (7,996 words in original thesis submission prior to corrected amendments)

[2] To ease readability for thesis submission, this paper has been written in British English, with tables and figures inserted in their precise location. This will be adapted when submitting the paper to *Archives of Suicide Research,* which stipulates that papers be written in American English and that tables and figures are submitted in an additional file.

"The last thing you feel is the self-disgust". The role of self-directed disgust in men who have attempted suicide: A grounded theory study

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"The last thing you feel is the self-disgust". The role of self-directed disgust in men who have attempted suicide: A grounded theory study

Abstract

Objective: Globally, suicide affects more men than women. Emotional pain underpins many theoretical accounts of suicidality, yet little is known about the role of disgust in suicide. Self-directed disgust, whereby aspects of the self serve as an object of disgust, has been hypothesised to factor in suicide. This research aimed to explore the processes which link self-disgust to attempted suicide in males. **Method:** Nine men who had attempted suicide completed semi-structured interviews. The interview data was analysed using a constructivist grounded theory methodology. **Results:** Three concepts emerged out of the analysis: (1) self-disgust; (2) worthlessness; and (3) the endured emotional distress of "the abyss" – these concepts interweaved, leading the men to experience hopelessness, disconnection and an inability to cope, leading ultimately to their suicide attempt. Throughout this journey, various disgust-related processes worsened men's distress and increased their suicidal risk. Historic adversities prevailed across the data, as did the men's difficulties in understanding their emotions. **Conclusion:** Self-disgust was an important emotion in the men's experiences of suicide and shaped their views of themselves and their lives. The distancing and repellent properties of self-disgust, in addition to the fear of having their "disgustingness" exposed, increased suicidal risk. Self-disgust appeared more pervasive in the suicidality of men with a history of multiple childhood adversities. The limitations of this research are discussed as are implications for clinical practice and directions for future research.

Keywords: attempted suicide; emotion; grounded theory; male; self-disgust; qualitative

Highlights:

- Self-disgust is a pervasive emotion in men's experience of attempted suicide.
- Self-disgust appears marked in men with a history of multiple early adversities.
- Suicide risk is exacerbated with a potential exposing of one's "disgustingness".

Introduction

It is estimated that over 800,000 people die from suicide each year (World Health Organisation; WHO, 2014). In 2018, the UK recorded just over 6,500 deaths by suicide (Simms et al., 2019). There are well established gender differences in suicidality, with men at a three times greater risk of death by suicide (WHO, 2014).

Multiple psychological, social and cultural factors contribute to suicide risk, with the biggest risk factor being a previous suicide attempt (WHO, 2019). Cavanagh et al. (2003) noted that 90% of people who died by suicide had a mental health condition. Being male, aged 35-49, having a mental health condition (particularly depression), physical illness, disability or chronic pain, substance use and stressful life events (e.g. debt, unemployment) are all factors which increase suicide risk (Department of Health, 2012). However, risk factors alone have little power in predicting future suicidality (Franklin et al., 2017). For example, the majority of individuals with mental health conditions are not suicidal (O'Connor & Nock, 2014).

Conceptualising suicide

Psychological models have attempted to conceptualise the multifactorial nature of suicide risk (for a review, see Barzilay & Apter, 2014). Suicide as an escape from enduring psychological pain is central to many theoretical accounts of suicidality (e.g. Baumeister, 1990; Shneidman, 1993; Williams, 1997). Further factors have been theorised to exacerbate suicidal risk, including the role of stressors and cognitive vulnerabilities (e.g. Schotte & Clum, 1987; Williams,1997), problem solving deficits (e.g. O'Connor, 2011; Schotte & Clum, 1987), hopelessness (e.g. Beck et al., 1990; Rudd, 2006; Van Orden et al., 2010) and entrapment (e.g. O'Connor, 2011; Williams, 1997). The above conceptualisations have tended to view risk as static, but recent work has started to look at more dynamic variables that link suicidal ideation to attempts (e.g. Joiner, 2005; O'Connor, 2011; Van Orden et al., 2010). The interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) posits that passive suicidal ideation is created by the co-occurrence of a thwarted belongingness (e.g. feeling alone and isolated) and a perceived burdensomeness (e.g. illness, unemployment). Active suicidality arises when belongingness and burdensomeness are perceived as unchangeable. The progression to suicide attempts occurs in the presence of a capability for suicide (e.g. reduced fear of death, impulsivity). The Integrated Motivational-Volitional model of suicide (IMV; O'Connor, 2011) builds on this and earlier models by conceptualising a more dynamic process of suicide and highlighting how suicidal behaviour is perceived as a solution to feelings of defeat, humiliation and entrapment.

The above theoretical accounts are limited in their ability to explain men's increased risk of death by suicide. Perceived gender norms (e.g. hegemonic masculinity, Connell, 1995) are considered to increase men's vulnerability to psychological difficulties and suicide

(Möller-Leimkühler, 2003; Payne et al., 2008; Seidler et al., 2016). These include gender scripts around reduced emotional expressiveness and help-seeking, increased substance use, and difficulties recognising psychological distress. This hypothesis has drawn some empirical support, including Cleary's (2005; 2012) qualitative work with men who have attempted suicide. She identified that hegemonic masculinity factored in men's reduced help seeking, distress concealment and usage of maladaptive coping strategies. Similarly, the negative influence of masculine gender norms has been linked to male mental health difficulties (e.g. Krumm et al., 2017; McKenzie et al., 2016). However, Krumm et al. identified that traditional masculine rules can aid recovery, for example, reframing accessing support as 'regaining control'. Furthermore, critics have warned that by pathologising masculinity, men may perceive support to be judgemental, which further limits help-seeking (Seager, 2019).

Emotions and suicide

Psychological pain and hopelessness are common across many conceptualisations of suicide and are synonymous with emotional pain (e.g. Williams, 1997). This pain has been defined as meta-emotional experiences of sadness, anxiety, fear, weakness, rejection, loneliness, emptiness, worthlessness and shame (Berglund et al., 2016; Lakeman & Fitzgerald, 2008; Lester, 1997). Higher levels of anger, guilt, self-directed hostility and shame have been found to increase suicide risk (Rogers et al., 2017; Seidlitz et al., 2001). Gender differences in emotional expressiveness are well documented (see Ashfield & Gouws, 2019; Brody & Hall, 2008). As discussed above, being male is an increased risk factor for suicide and this may be due to increased anger and hostility (Brownhill et al., 2005; Hunt et al., 2017). It is apparent that there are specific emotional processes within suicidal individuals' psychological pain. The role of shame and guilt in suicide suggest the involvement of disgust, as they can both be

considered as complex secondary emotions derived from the basic emotion of disgust (Power & Dalgleish, 2016). To date, the empirical literature has neglected the role of disgust in suicide. Yet, it has been hypothesised to factor in mental health conditions with a high risk of suicide, including depression (Phillips et al., 1998) and eating disorders (Fox & Power, 2009; Olatunji & McKay, 2009).

Disgust's adaptive role helps to avoid physical and moral contamination and is defined by a physical response to push away substances which are perceived as noxious or repugnant (Olatunji & McKay, 2009; Rozin & Fallon, 1987). Self-disgust describes the maladaptive internalisation of the disgust response. Here, the disgust eliciting object is seen as oneself and one's behaviours and results in a negative disgust-based self-evaluation (Powell et al., 2015a). Self-Disgust is conceptualised as a distinct emotional schema (i.e. Izard, 2007; 2009) and is differentiated from other subjective emotional states such as self-hatred, embarrassment, guilt and shame (Powell et al., 2015a). There are similarities between shame and self-disgust, as they both increase avoidance behaviour and negative self-criticism (Alanazi et al., 2015; Gilbert, 2015; Terrizzi & Shook, 2020). Despite being closely related, self-disgust and shame are considered separate constructs. What delineates self-disgust is feelings around contamination and repulsion, visceral physiological experiences of nausea and specific disgust-based cognitions such as "I'm revolting" (Powell et al., 2015a). Further differentiation is present in disgust's behavioural responses, including attempts to avoid contamination and "extreme attempts to cleanse or remove the disgusting self" (Clarke et al., 2019, p.111).

Self-disgust and suicide

Chu et al. (2013) situate self-disgust within the interpersonal theory of suicide. They propose that self-disgust can increase suicidality by generating feelings of inadequacy, thereby creating a sense of burdensomeness. Furthermore, they posit that disgust directed towards others and the world leads to a perception of the world as contaminated, resulting in distancing, isolation and a thwarted belongingness. The authors' model has not been subject to empirical testing, which is needed before making claims around the role of self-disgust in suicide. However, as described above, self-disgust's behavioural response involves removing aspects of the "disgusting self". Therefore, hypothetically, it follows that self-disgust may factor in suicide as an extreme attempt to eliminate a contaminated sense of self. Empirical support for this proposition comes from self-disgust's location in mental health difficulties (Clarke et al., 2019; Powell et al., 2015b), including conditions associated with high suicide risk, such as eating disorders (Chu et al., 2015; Fox, 2009; Fox & Power, 2009), post-traumatic stress disorder (PTSD; Brake et al. 2017) and depression (Overton et al., 2008; Powell et al., 2013; 2014; Simpson et al., 2010). Psychological conceptualisations of emotions, such as the Schematic Propositional Analogical and Associative Representation Systems (SPAARS; Power & Dalgleish 1997; 2016) model, propose that emotions may become coupled and this may underpin various painful emotional states, such as depression. It remains an empirical question whether disgust is the pivotal emotion that may link these mental health difficulties to suicide (e.g. Power & Dalgleish, 2016), however, answers to this question are emerging. In eating disorders, Chu et al. (2015) found self-disgust to be associated with greater suicide risk when controlling for anxiety and depression. Brake et al. (2017) found that self-disgust significantly moderated the effect between PTSD symptoms and suicidal ideation. Whilst supporting the potential link between self-disgust and suicide,

both studies are limited by their use of non-clinical samples and for using quantitative measures of suicidal intent, as these may lack validity in predicting future suicidality (Freedenthal, 2008). Both studies did not sample individuals who had attempted suicide and caution is needed when generalising research findings across suicidal behaviours, as only 29% of individuals experiencing suicidal ideation will attempt in the future (Nock et al., 2008).

The current study

Power and Dalgleish (2016) describe self-disgust as a "major component [of suicide] that has failed to be investigated" (p.323). This study aims to bridge this gap by exploring the process of self-disgust in men who have attempted suicide. An inductive qualitative methodology is well suited to explore this research aim and qualitative approaches have been welcomed in suicide research (Hjelmeland & Knizek, 2010). Grounded theory is one such method which provides a framework to identify categories of data and to integrate them into theory describing emergent processes (Willig, 2013). Qualitative research has situated self-disgust in females (Powell et al., 2014), however, it has yet to be investigated in a male only sample. Furthermore, quantitative research on self-disgust often reports a majority female sample (e.g. Brake et al., 2017; Chu et al., 2015; Overton et al., 2008; Powell et al., 2013; Simpson et al., 2010). As described above, men may have different emotional experiences to women and due to their increased risk of death by suicide, it seems pertinent to explore self-disgust within a male only population. The study presented here has two aims.

(1) To see whether men perceive self-disgust to be an important emotion within their suicidality.

(2) To understand the processes that link self-disgust to suicidality for males.

Method

Recruitment of participants

Ethical and risk issues were considered paramount (see Thompson & Russo, 2012). Participating in suicide research is not thought to increase suicidal risk (Cukrowicz et al., 2010) and a comprehensive risk management procedure was developed to ensure the safety of participants throughout the research process (Appendix I). Participants were recruited from NHS secondary care community mental health teams (CMHT). Healthcare professionals identified suitable participants, introduced them to the research and (if consenting) linked them to the researcher for further telephone screening. Additionally, participants were recruited through five third sector organisations. Here, interested individuals were directed to an online survey (using Qualtrics XM Software, 2019; Qualtrics, Provo, UT; Appendix J) which further assessed inclusion suitability and motivation to participate. Potential, suitable and consenting participants were contacted by the researcher for further telephone screening. The inclusion and exclusion criteria are described in Table 1. There was a requirement of six-months between participant's last suicide attempt and the interview date. This was to provide time for suicidality to decrease.

Inclusion criteria	Exclusion criteria
• Male • Eighteen and over • Fluent in English • Had made a previous suicide attempt over six-months ago. • Currently open to a CMHT with a named health care professional (CMHT recruitment only). • Consenting to provide contact details, including GP, in order to manage any potential risk.	• Any current suicidality (i.e. suicidal ideation, thoughts, ideas or plans). • Any current self-harm behaviour or ideation. • Currently open to crisis/home treatment teams. • Individuals with organic brain disorders. • Individuals whose suicide attempt was in the context of a psychotic episode. • Individuals (and healthcare professionals) who believed that taking part may increase suicidality or self-harm risk.

Table 1. Study inclusion and exclusion criteria

Twenty people self-selected to participate (11 from CMHTs and 9 from the third sector). Eleven individuals were excluded from the study. These were because they declined to provide address and GP details (n=3), did not respond to research correspondence (n=3), experienced a deterioration in their mental health (n=2), were concerned an interview would increase risk (n=1), did not have an allocated healthcare professional (n=1) or attributed their suicide attempts to a psychotic episode (n=1). The remaining nine participants (seven from CMHTs and two from third sector) met the inclusion criteria and consented to take part in the study.

Participants

Participants were resident in the UK and were aged between 24 and 54 (mean 39.89, standard deviation = 10.25). All identified as white-British. The majority of participants were heterosexual (n=7), with the remainder identifying as homosexual (n=1) or not disclosed (n=1). Seven of the men had accessed psychological support, whereas two had never accessed mental health services. The sample characteristics are shown in Table 2.

Name (pseudonym)	Age	Relationship status	Mental health diagnoses	Duration since last attempt	Most recent attempt method	Number of prior attempts	Self-Disgust Scale – Revised (SDS-R; Powell et al., 2015c)		
							Physical	Behaviour	Total
Huw	39	Divorced/ Separated	EUPD Depression Anxiety	10 years ago	Overdose	3	22	23	70
Ian	39	Single	EUPD	2 years ago	Overdose/Self-harm	Over 4	31	22	71
Jack	52	Married	Paranoia	4 years ago	Deliberate vehicle crash	2	18	17	57
Jacob	48	Divorced/ Separated	EUPD	2 years ago	Overdose	1	27	26	75
Lewis	24	Single	EUPD Depression Anxiety	18-24 months ago	Attempted drowning	1	29	14	67
Luke	54	Married	PTSD	12-18 months ago	Attempted jumping	3	35	19	85
Rhys	39	Single	BPAD Depression	6-12 months ago	Overdose	3	21	14	45
Richard	37	Divorced/ Separated	Anxiety Depression Mania	6-12 months ago	Hanging	3	30	20	76
Tom	27	Married	None	6-12 months ago	Hanging	0	21	17	52

Key: BPAD, Bi-polar affective disorder; EUPD, Emotionally unstable personality disorder; PTSD, Post-traumatic stress disorder

Table 2. Overview of participants

Data collection and procedure

Measures

Demographic questionnaire (Appendix K) – This questionnaire recorded basic demographic data, such as age, ethnicity, sexuality, relationship status and mental health diagnoses.

Suicide questionnaire (Appendix K) – This questionnaire recorded data around participant's suicidal behaviours, including details of current and historic suicide attempts.

Self-Disgust Scale Revised (SDS-R; Powell et al., 2015c) (Appendix L) – The SDS-R is a validated, 22-item measure of self-disgust scored on a seven-point Likert scale. Participants rate their agreement with a statement about the self, ranging from 1 (strongly disagree) to 7 (strongly agree). It provides a physical and a behavioural self-disgust score ranging from 5 to 35 and a total self-disgust score ranging from 15 to 105. Higher scores indicate higher levels of self-disgust. The scale contains high internal consistency (physical self-disgust $\alpha = .86$; behavioural self-disgust $\alpha = .78$; total self-disgust $\alpha = .92$; Powell et al., 2015c).

Data collection

Data was collected by semi-structured in-depth interviews which provide flexibility and allow for follow-up prompts (Barker et al., 2016). Face-to-face interviews were preferred over other methods due to the study's emotive nature. Interviews took place at the individual's CMHT or Cardiff University. Participants were provided with a verbal and written explanation of the research project (Appendix M). Participants provided informed consent (Appendix N) and then completed the above measures (results shown in Table 2).

Interviews were commenced and lasted between 60 to 90 minutes. A participant debrief took place after the interview to allow reflection on the research process and to assess risk. Participants were provided with a take home debrief sheet (Appendix O), containing emergency support information. The interviews were audio recorded and transcribed verbatim.

Interview schedule

A semi-structured interview scheduled was developed based on Charmaz (2014). The interview schedule covered the participant's suicidality, their understanding of self-disgust, and their experiences of self-disgust during their suicidality. The interview schedule was developed by the research team (with expertise in clinical psychology and qualitative research), and in consultation with researchers who had expertise in suicide, and self-disgust. This process aimed to develop a schedule which explored the development and context of individual's suicidality and the psychological processes present within their suicide attempts. Service-user input was provided into the project design, including the interview schedule. Questions sought to explore participant's meta-emotional experiences during suicidality, focussing on self-disgust as a distinct cognitive-affective state (e.g. Powell et al., 2015a), which can be experienced independent of cognitive appraisals (e.g. Power & Dalgleish, 2016). The interviewer was mindful throughout the process to not ask direct questions.

Ethical approval

Ethical approval was obtained from a local research ethics committee, Health Care Research Wales and from individual NHS organisations (Approvals in Appendix P).

Data analysis

Interview data was analysed using the principles of grounded theory (Glaser & Strauss, 1967) and using Nvivo Software (QSR International, Version 12). A constructivist approach of grounded theory was used (Charmaz, 2014), which views any findings as a construction of the researcher's understanding of the phenomenon of interest (Willig, 2013). Data collection and analysis run in parallel with each other. This process allows for emerging ideas to inform further data collection, allowing for theoretical sampling and theoretical saturation in order to develop a substantive grounded theory (Sbaraini et al., 2011). The process of data analysis involved coding, categorisation and theory development, with memo writing used throughout to explore analytical ideas whilst remaining grounded in the data (Charmaz, 2014).

Coding

Each transcript was initially coded line-by-line for the action, experience, process and meaning being conveyed by the participant. This was followed by focused coding (examples of coding in appendix Q) which involved raising the most pertinent initial codes that make the most analytic sense of the whole data (Sbaraini et al., 2011). Focused codes which help to explain the processes occurring in data can then be raised (or merged) into conceptual categories and descriptive concepts which are used to explain the whole data (Birks & Mills, 2011; Willig, 2013). Theoretical coding was used to explain relationships between categories, codes and concepts. Constant comparison methods were used throughout the data analysis. A worked example of the coding process can be seen in Table 3.

Raw Data (Huw)	Initial Coding	Focused Coding	Category	Concept
And so I was really mean to him	Being Mean	Disgusting ways	Experience of a	"I'm disgusting
and told him that no, I wasn't,	Asserting self		disgusting self.	and wrong"
he was disgusting, get out of my	Calling partner disgusting	Disgusted by others		
house. And then a period of	Rejecting partner		Disconnection	
time went by and I just-, well, I	Having temporal distance			
don't know whether I was	Being unsure	Lacking		
disgusted by how I treated him,	Feeling disgust by own	understanding		
disgusted with myself, but, yeah,	actions/Being disgusted	Disgusting self	Experience of a	"I'm disgusting
that's why I went to mum's	by self		disgusting self.	and wrong"
tablet cupboard and just took	Obtaining pills	Describing the		
the lot. So there you go. That's	Accounting for suicide	attempt	Reaching a	
why.	attempt		suicidal point.	

Table 3. Examples of coding process

Memo-writing and theoretical sampling

Memo writing was used throughout the research process (examples in Appendix R). By incorporating data, memos provided a link from theoretical constructs to their constituent codes. This allowed for constant comparison to ensure higher level analysis was grounded in the interviewees' accounts.

The early analysis identified commonalities and gaps in the data. This allowed for a process of theoretical sampling to guide future data collection. In keeping with a grounded theory methodology, the interview schedule was adapted multiple times as ideas and concepts emerged during the early data analysis. This allowed for constant comparisons with subsequent data to identify key processes and other analytic ideas emerging out of the data. To achieve this, four interview schedules were developed (details in Appendix S). Examples of this process are described in Table 4.

Commonalities or gap identified in early data collection	How gap/ commonality was identified	Potential gaps in future interview	Change in interview schedule to allow for future constant comparison	Outcome
Participants had difficulties in identifying, naming and differentiating their emotional experiences.	*Initial Codes.* *Focused Code:* "struggling to understand self" *Memo:* Early interviews. "Struggling to understand". "Delineating self-disgust".	Potential alexithymia in sample which has not be explored.	Questions were added to interview schedule 3 and expanded in interview schedule 4 to explore individual's ability to understand emotional experiences.	This identified difficulties in emotional literacy across many participants.
First three interviews described a history of early traumas and adversities	*Initial Codes.* *Focused Code:* "Describing a history of childhood trauma". *Memo:* Early interviews. "Developing a 'disgusting' self".	Participants may not report historic trauma without prompting.	Questions were added to interview schedule 4 which explored historic traumas, whilst not pressing for details and reminding of right to decline to answer.	This identified the key process of early traumas across the data.

Table 4. Examples of constant comparison to guide future data collection

Methods to enhance quality and reflexivity

Multiple methods were used to enhance quality, credibility, ethics and reflexivity throughout the research project. These are summarised in Table 5 (based on Elliot et al., 1999).

Area for consideration (Elliot et al., 1999)	Methods used to ensure credibility, ethics and reflexivity
Owning one's perspective (examples in Appendix T1)	The researcher's own positioning and assumptions (see below) had the potential to be imposed on the data. Field notes and a research diary were used throughout the research process in order to document the researcher's perspective and potential assumptions placed onto the data (Charmaz, 2014). Research supervision and peer supervision with an independent qualitative researcher identified times when the researcher's perspective was placed on the data. These processes allowed for reflexivity to be documented and, where possible, bracketed out (Crotty, 1996) following techniques proposed by Ahern (1999).

Situating the sample (examples in Appendix T2)	Characteristics of the sample were provided (age, sexuality, suicide information, self-disgust outcomes). Data was provided to situate the sample; however sufficient data is removed to ensure anonymity. Reflecting on the recruitment process, including the limitations of self-selecting samples. This included the role of the field supervisors and healthcare professionals in identifying participants and the potential limitations of this on the data analysis. Using supervision and research journal to explore these ideas.
Grounding in examples (examples in Appendix T3)	Providing direct interview quotations so readers can explore the fit between the researcher's interpretation and the raw data. Ensuring that quotations do not risk unintentionally identifying participants and removing quotations that could be retraumatising for the participant. Using pseudonyms to ensure anonymity. Using memos, research supervision, independent peer review and own reflective practice to explore usage of quotations in the analysis and to consider why these were chosen over others.
Providing credibility checks (examples in Appendix T4)	Supervision and peer supervision were regularly used to explore the coding process and category development. The analysis process was audited by an independent qualitative researcher who cross checked a sample of initial and focused codes and memos. Initial checks agreed in 79% of cases and after discussion and clarification this improved to 100%. In keeping with a constructivist approach, both researchers were reflexive as to how they understood and interpreted the data. Field notes and a research diary were used throughout which allowed for transparency in the data collection and analysis process and provided audit trails for emerging themes and categories. Memo writing documented the researcher's ideas and analysis. This helped to provide an audit trail to ensure that the analysis was grounded in the data. These also provided a space for personal and epistemological reflexivity (i.e. Thompson & Harper, 2012).

Table 5. Methods used to ensure credibility, ethics and reflexivity

A constructivist paradigm views the researcher's role as "actively constructing" theory, rather than solely capturing it (Willig, 2013, p.80). The researcher in this study is a 36-year-old homosexual male. He is a mental health professional with a history of working with suicidal men. He also has a family history of suicide. His interest in male suicide is born out of these personal and professional experiences. Furthermore, based on demographics, he is at a greater risk of suicide. These factors may have compelled the researcher's desire to identify

emergent theory, and whilst total objectivity is not possible (Ahern, 1999), reflexivity was important throughout the project in order to develop a grounded theory.

Results

Self-disgust was an important emotion within men's suicidality and was linked to their attempts. Self-disgust as a distinct cognitive-affective construct did not explain the men's attempts in their entirety, instead it interweaved with other factors to increase suicide risk. Participant's journey to suicide began at an early age, with all participants describing a history of early *trauma and adversity*. These early experiences provided a context for distress, encompassing participant's sense of self as "*disgusting and wrong", "worthless"* and in an endured emotional "*abyss".* Various disgust processes (e.g. distancing) within these concepts worsened distress and increased suicidality. A risk of having one's "disgustingness" *exposed* was a key process in exacerbating suicide risk. The men situated their distress within a history of being *confused by emotions* which had the potential to intensify their pain. This position left the men feeling *unable to cope, disconnected* and *hopeless*, which ultimately led them to *reach a suicidal point.* From here, suicide was perceived as a solution to their distress and led to their attempt. The intensity and positioning of self-disgust varied for the men at different points during this journey and appeared more pervasive for participants with a history of multiple adversities. Through constant comparison methods, a representation of this journey, which is grounded in the participants' accounts, is shown in Figure 1. Each category and concept are described below with illustrative quotes. Quotations were chosen for their comprehensiveness, whilst also safeguarding anonymity. Pseudonyms are used throughout.

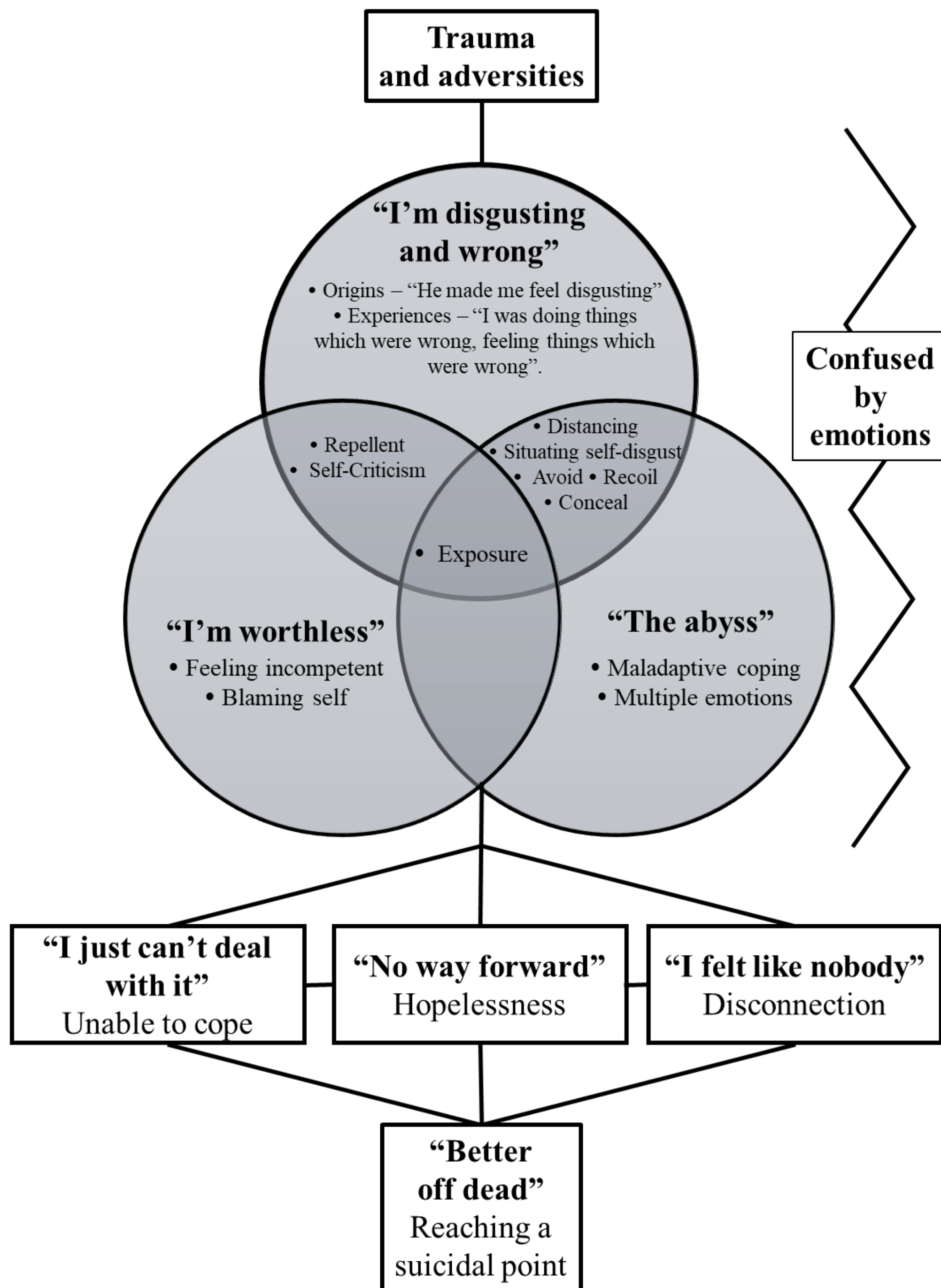

Figure 1. Grounded theory representation of men's journey to attempted suicide

Trauma and adversities

Early traumas were reported by participants, including childhood physical, sexual and emotional abuse, neglect and bullying. The majority of participants had experienced multiple early adversities. All participants highlighted the distress of these early experiences and how

it attributed to them feeling "*disgusting and wrong", "worthless",* in an endured emotional "*abyss"* and *confused by emotions*.

> *Those situations in my childhood has affected my view on life and led me to feel this way*. (Tom)

"I'm disgusting and wrong" (Ian)

All participants described a lived experience of self-disgust which punctuated their lives at different points and with diverse consequences. This concept comprises of two categories which relate to the origins and experience of the "disgusting" self.

Origins: "He [father] made me feel disgusting" (Jacob)

The majority of participants recalled experiencing self-disgust from an early age. Many participants perceived their "disgustingness" to originate from either their *trauma and adversities* or from an awareness that their identity was incongruent with social norms, therefore risking stigmatisation. For one individual this related to his identity as a sexual minority. Participants scoring higher on the SDS-R appeared more able to identify the *traumas* and stigmas that generated the "disgusting self", suggesting a link between early adversities and higher levels of self-disgust.

> *A lot of my problems are definitely programmed by my parents' attitude towards me, in the sense that I'm a bad person and therefore I'm disgusting and wrong, you know, which they instilled in me*. (Ian)

> *They said it* [homosexuality] *wasn't normal back then, you know. It was only something weird people did… I think as a child if your parent says something or a teacher says something or a policeman says something… you think they're right. You think that they know better, because they do, generally… and so, if it was a disgusting thing to do, and a teacher told me… I'm sure that that's why I think that way.* (Huw)

Subjective experience: "I was doing things which were wrong, feeling things which were wrong." (Huw)

Whist some participants experienced self-disgust as a reactionary emotional state, most men commented on its endured properties. Participants with more childhood adversities commented on self-disgust's consuming qualities, with childhood abuse appearing linked to a pervasive sense of the self being "disgusting".

> *I think, sometimes, if you've got that level of disgust with myself like I have, it's always in the back of your mind, it never goes away... That's a lot to carry round with you.* (Luke)

Self-disgust was experienced in various ways. This included feeling disgusted about their appearance, suicidal thought processes, mental health difficulties and their behaviours, including their achievements and treatment of themselves and others. Those with a greater number of adversities appeared to position disgust on more aspects of the self. Those who had been bullied tended to direct disgust more towards their image.

> *The disgust I feel now though, is that I will never-, I will never be able to have a relationship, because other than the, the fact that, like I said, I'm big and ugly, I, I've lived so long-, I've been told things are wrong.* (Huw)

One participant provided a nuanced experience of self-disgust related to childhood sexual abuse. He felt polluted by his experiences, feeling unclean and malodourous and feared the *exposure* of this, leading to avoidance. He describes *disconnection* from his younger abused self, which may be a strategy to manage the distress of this profound level of self-disgust.

> *I constantly think I smell. I constantly think [pause and exhale] I'm dirty, disgusting [pause 7 seconds]... It makes me feel physically sick, when I think about him* [younger abused self]… *I hate him.* (Luke)

There were further links between the processes of *exposure, disconnection* and participant's disgust, often involving mirrors. A number of participants experienced self-disgust when exposed to their reflected self. Feeling disconnected from this reflection was a common experience, with some participants describing their reflection as "abnormal" and "inhuman" whilst experiencing visceral disgust responses. As stated above, this may have aided managing high initial levels of distress; however, it further perpetuated self-disgust and worsened overall distress.

> *Sometimes I look in the mirror… when I'm in a really low point and I think 'what is this thing looking back at me?' I almost feel sick to the point, because it's just, that's my low state of mind at that point, when I'm feeling really low, I'm feeling depressed, you feel that cramp in your stomach and it feels like I'm about to throw up or something.* (Lewis).

Worsening emotional distress – "The abyss" (Tom)

The "abyss" was synonymous with participant's descriptions of their worsening and enduring distress. The abyss was permeated by the coexistence of multiple affect experiences including anger, sadness, fear, shame, embarrassment, guilt, self-hatred and feeling weak and vulnerable. These perpetuated the abyss, as did multiple accumulating triggers, including relational difficulties and a perceived lack of support. The consequence of the abyss appeared to move men closer to *hopelessness* and ultimately to a *suicidal point.*

> *It just went from one thing to another. Erm, I, you know, it went from feeling sad, to feeling angry, to feeling frustrated, to feeling worthless to feeling, just that there wasn't any point in me being there. It, it, each day was getting worse and worse and worse and it progressively got worse until that very night.* (Lewis)

All participants navigated the abyss using maladaptive coping strategies. These included self-medication with substance use, using food to regulate mood and self-harm. The men's coping strategies perpetuated their distress, with some direct feedback loops which maintained self-disgust.

> *I hate the way that I look and I know that part of the way that I look is due to the unhealthy stuff that I eat, and just eat something and then feel disgusting about what I'm eating, but before I know it I've got a chocolate bar in my hand, trying to make, pick myself up.* (Richard)

Interactive processes between the abyss and "I'm disgusting and wrong"

Participant's attempts to cope with feelings of self-disgust often interacted to worsen the abyss and exacerbate feelings of *disconnection*. Participants avoided, recoiled, concealed or distanced themselves from situations which may *expose* a distressing self-disgust experience. Mirrors and other people were commonly avoided. Concealment was a further strategy to avoid *exposure*. However, two participants noted that rules around masculinity also caused them to conceal distress. Participants attempted to distance themselves from disgust by cleaning or changing parts of the self which were felt to be "disgusting". This appeared to be more pertinent for those with a history of multiple traumas.

> *It's* [self-disgust] *horrible. That's what makes you lock yourself away. You don't want to be seen.* (Rhys)

Situating self-disgust in the abyss

All participants situated self-disgust within their meta-emotional experiences of the abyss. Self-disgust appeared to work on a continuum and for some participants it was positioned closer towards *a suicidal point*. For some men, this was exacerbated by *exposure*.

> *When you get to that point of looking in the mirror. It's like, that's like the last thing you feel is the self-disgust, is like when you've already gone, you've had like months of going down. And you hit, like you hit the bottom and then you start having them feelings.* (Rhys)

There was a general difficulty in differentiating self-disgust from often coexisting emotional experiences such as self-hatred, shame and embarrassment. Despite the difficulties in

differentiating these emotions, it does highlight the salience of self-disgust within the abyss. Participants who felt more able to delineate their meta-emotional experiences differentiated self-disgust by its the visceral properties, particularly nausea. Self-disgust, shame and self-hatred were situated closer than any other subjective experiences, particularly self-disgust and self-hatred. Some men highlighted disgust's repellent properties and intensity of dislike when differentiating self-disgust from self-hatred. This was noticeable in the lived experience of the interview, in which agitation arose when exploring self-disgust. After a break, the participant reported his agitation to have decreased and wished to continue.

> *I'm finding that I'm getting agitated, cos I'm incredibly uncomfortable… about that… and it is, it's not just hatred, it is, yeah, it is disgust.* (Jacob)

"I'm worthless" (Lewis)

All participants resonated with the subjective experience of worthlessness, although these were more pronounced in participants with a history of bullying and childhood physical abuse. Judgements of worthlessness permeated the men's view of themselves, their relationships and their worth in society. Common to this were experiences that their suicide would be "better for others". This moved the men towards *hopelessness* and experiencing *disconnection,* thereby increasing suicidal risk. Worthlessness was perpetuated by feelings of incompetence and self-blame, leading the men to a sense of self as being "pathetic" or a "failure". This was more marked in individuals with a history of being bullied.

> *Yeah, I think I just felt like a bad father and a bad kind of husband and like a bad friend and a bad housemate and it just, like, just this worthless feeling… I dunno. It seems like no matter what I do I never feel worth.* (Richard)

Interactive processes between "I'm worthless" and "I'm disgusting and wrong"

Occasionally, participants described how the same attribute could trigger feelings of worthlessness and self-disgust. However, most participants described the origins of self-disgust occurring prior to their experiences of worthlessness. Therefore, a sense of worthlessness appeared to be a consequence of feeling "*disgusting and wrong"*. The process of self-criticism perpetuated worthlessness and suicidal risk. However, the language used in participant's self-critical remarks highlighted the relationship between self-disgust and worthlessness. For example, participants used expressions of wrong, dirt and contamination, such as "dudd" (Tom), "crap" (Jacob) and remarked on their perceived "disgusting" appearance.

> *I just don't think very much of me at times, at those times that I, I feel like scum.* (Jacob)

Exposure – "What if people find out what happened to me?" (Jack)

As described above, the exposure of one's "disgustingness" perpetuated distress and self-disgust. However, exposure had the potential to weave across all three concepts and increase suicide risk.

> *Interviewer – And what did that make you feel* [experiencing flashbacks]*?*
> *Weak. Disgusting… I never feel clean… what happened to me shouldn't happen to anybody. And it just makes me feel worthless, shit, I shouldn't be here.* (Luke)

Participants feared their "disgustingness" being exposed, including their mental health difficulties, suicidality, sexuality or childhood sexual abuse. One individual concealed his

abuse as he feared its *exposure* would be emasculating. This highlights a potential nuanced relationship between sexual abuse, shame, disgust and masculinity.

> *It* [trauma flashbacks and self-disgust] *pushes what's in the back of your mind, it pushes to the front. I get the feeling of I don't contribute nothing to the family…It makes you feel you'd be better off dead. I mean, no more trouble for anybody.* (Luke)

Confused by emotions – "You're talking to somebody who's never been able to label his emotions" (Jacob)

Men's suicidality was increased due to perceiving themselves as "*disgusting*", "*worthless"* and in an "*abyss"*. Far from being isolated concepts, they interacted with each other to worsen distress through the processes of *exposure*, avoidance, recoiling, concealment, distancing, repelling and self-criticism. Across the data it was apparent that this distress took place within the context of the men being *confused by their emotions,* which is indicative of alexithymia. When reflecting on their suicidality, the participants remembered struggling to place a name on their distress or understand their psychological processes. This suggests alexithymia tended to worsen the distress of the abyss and feelings of *disconnection* and *hopelessness*. Some men described difficulties in identifying emotional experiences during heightened distress, whereas others described a permanent inability to recognise emotions.

> *It was a constant mix of emotions which was really difficult to pinpoint if it was sadness, anger, regret, denial or whatever, like…It was just totally confusing.* (Tom)

Disconnection – "I felt like nobody just sat around. You just watch the world go by" (Rhys)

As distress worsened, all the participants experienced disconnection from themselves, others and the world. Disconnection moved men closer to suicide either directly or indirectly by interweaving with other categories, such as *hopelessness*. Interpersonal disconnection exacerbated feelings of loneliness and further worsened distress.

> *I was lost out there in the world on my own, I thought nobody cared, I didn't know who to turn to, you know.* (Jack)

Disconnection could be a consequence of participant's attempts to cope with self-disgust and suggestive of the emotion's 'pushing-away' characteristics. Participants disconnected through recoiling, concealing, distancing and avoidance. For one participant, this directly preceded his *suicidal point.* Furthermore, some participants saw themselves as repellent, causing them to feel disconnected from others.

> *People start noticing I'm not doing anything, I'm not going out. And when I get to the point where you just, you really, you can't answer the phone, you can't answer the door, you can't look out the windo… you don't want anyone to look in your window.* (Rhys)

> *What people recoil at, what people don't like, the behaviours that I have are quite abhorrent, you know.* (Jacob)

Inability to cope – "I just can't deal with it" (Tom)

Whilst not endorsed by all participants, some men perceived an inability to cope with their distress as they *reached their suicidal point.* This was often exacerbated by maladaptive coping strategies. Often this state of helplessness was intertwined with experiences of *hopelessness.*

> *Just that you can't cope with life. Or you feel like you're not coping as well as other people. And, you dread that, you believe that everything's just going to get worse, you know. You just don't see any future.* (Rhys)

Hopelessness – "No way forward"

All participants moved towards a sense of hopelessness as they approached their suicide attempts. Hopelessness was associated with dejection, the perception of a bleak future and with no alleviation to their suffering.

> *It's just like. It's the giving up on yourself, the hate on yourself and you just can't see no way forward. And that's what makes you, or made me, do it anyway. I just felt there's no way this is going to get any better.* (Rhys)

Figure 1 conceptualises how *hopelessness*, *disconnection* and *feeling unable to cope* can provide the context for a suicide attempt. These processes could work in isolation, or in combination to increase suicide risk.

> *It's when things stopped working, your coping strategies… you think that you run out of resources that are available to you, there is no way out, it's not going to get better. I felt shit for having mental health problems, to add on top of everything. And unlovable*. (Jacob)

Approaching a suicidal point – "Better off dead" (Luke)

The men's distress, feelings of *disconnection* and *hopelessness* and a perceived *inability to cope* led the participants to a position where suicide felt like the only available option. The majority of participants referred to the word "point", suggestive of a junction between enduring distress, or a solution through suicide. Occasionally, triggering points (e.g. relational difficulties) acted as a catalyst to move the men towards suicide, although they were not always present. What was common was a cumulative effect of the previously discussed categories and concepts resulting in the participants' suicide attempts.

> [Step one] *Self-harming's not helping. Step two; That feeling of total… even though you're with somebody you love more than anything, it can be the loneliest place in the fucking world when you're sat there. And if I get to there, that means I'm on step three* [suicide attempt]. (Luke)

All participants positioned self-disgust as a factor in their suicide attempt and four men placed it as a central component. Self-disgust's positioning during the attempt was more prominent for participants with a history of multiple adversities.

> *The two times that I've done that* [attempted suicide] *is the times that I'm really properly thinking that's disgusting behaviour, that I'm disgusting, because good people don't do that.* (Jacob)

For two individuals with multiple adversities, the *exposure* of their "disgustingness" instantly triggered their suicide attempt. All of Luke's suicide attempts were in the context of experiencing trauma flashbacks. Additionally, Huw described an intentional overdose directly after his sexuality was exposed.

> *They came into the room and started calling me faggot and things like that* [trauma details redacted]… *and I just couldn't cope…I bought lots of pills.* (Huw)

A smaller number of participants described excessive usage of mirrors when they approached their suicidal point. Routinely, these men had avoided mirrors and this suggests an intentional exposure of their "disgustingness". During this exposure, the men witnessed their self-harm and preparations to die, often whilst *disconnected*. It could be that the men were punishing themselves by facing the exposed, "disgusting-self", although one participant attributed his increased mirror usage to "saying goodbye".

> *I watch myself putting the cigarettes out on my forehead… or taking the razorblade across my face… an inversion occurs. It's like… I'm only prepared to take risks* [using mirrors] *when I know I'm going to die.* (Ian)

Discussion

This is the first qualitative study of self-disgust in males with a history of attempted suicide. The first aim of this study was to explore whether the men perceived self-disgust to be an important emotion within their suicidality. It was clear that self-disgust infiltrated the men's trajectories towards suicide from an early age. This is in keeping with the literature on the origins and the pervasive nature of self-disgust (e.g. Powell et al. 2015b). There are similarities between the men's experiences of self-disgust and those reported by females with depression (Powell et al., 2014), suggesting a potential likeness across these genders.

It was clear that childhood abuse was linked to a pervasive sense of the self being "disgusting". These findings triangulate with the literature on trauma and self-disgust, including feelings of contamination following abuse (see Badour et al., 2015; Steil et al., 2011), and the wider literature on early adversities and increased suicide risk (Fuller-Thomson et al., 2016). Contradicting societal norms was also a source of self-disgust in some individuals and supports the premise of self-disgust having sociocultural elements (Rozin et al., 2008; Powell et al., 2015a). The men's self-disgust was experienced across many aspects of the self, including their thoughts, image, feelings and behaviour. Men who had experienced multiple traumas tended to score higher on the SDS-R (Powell et al., 2015c). However, as the SDS-R is a measure of current self-disgust, it remains unknown whether these scores would have been heightened during participant's suicidality. Future research could explore this with a sample of suicidal individuals, for example inpatient populations.

Participants described self-disgust as a distinct cognitive-affective state, which is in keeping with the emotion's current conceptualisation as a unique emotional schema (Izard, 2007; 2009, Powell et al., 2015a). The men differentiated self-disgust by its embodied, visceral components (Miller, 1997; Rozin & Fallon, 1987). However, there were difficulties in participants' ability to distinguish self-disgust from other affect states, particularly shame and self-hatred. It could be that shame and self-disgust were processed at different levels and that disgust became coupled with anger to produced self-hatred (i.e. SPAARS; Power & Dalgleish, 1997; 2016). Fox et al. (2013) found similar emotional coupling with individuals with eating disorders. This demonstrates the pervasiveness of the basic emotion of disgust and its complex emotions in suicidal men. This saliency was further demonstrated by the spontaneous provoking of the disgust response during the interview process, with reports of

agitation, nausea and contamination[3]. The participants' meta-emotional experiences were in the context of difficulties in understanding their emotions. Alexithymia is reported as higher in men (Levant et al., 2009) and is associated with childhood trauma, PTSD and depression (Brownhill et al., 2005; Zlotnick et al., 2001), which saturated the current sample.

Self-disgust and the process of male suicide

A second aim of this study was to understand the processes that link self-disgust to suicidality for males. Self-disgust increased suicidal risk by interacting with the endured emotions of the "abyss" and feelings of worthlessness, hopelessness and disconnection. Self-disgust appeared more pervasive in the suicide attempts of men with multiple traumas.

Disgust-based behavioural responses, such as avoidance and recoiling, seeing oneself as repellent, and contamination-based self-criticism all perpetuated the men's distress. This is consistent with the wider literature on the distancing properties of the disgust response (Powell et al., 2014; 2015b; Rozin et al. 2008) and self-criticism's role in psychological distress (e.g. Gilbert, 2015). Interpersonal disgust has been proposed to discourage social contact (Rozin et al., 2008) and this may account for the high levels of disconnection identified in the analysis. Similarly to women with depression (Powell et al., 2014), participants reported disconnection from the self, including detachment from their reflected selves. Whilst disconnection may help participants to cope with intense levels of self-disgust, it paradoxically worsened the men's distress and increased their suicide risk.

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[3] Any reports of emotional distress during the interview, including disgust, involved the interview being paused to ensure that the participant was happy to proceed and for any risk to be managed.

Exposure of men's "disgustingness" was a key process in exacerbating suicidality. For some men this was associated with a change in mirror usage. The fear of exposure led some participants to conceal distress. Concealment has been linked to increased suicide risk (Apter et al., 2001). Future research could explore the role of disgust, exposure and concealment, as this may offer a nuance in the assessment of suicidality.

The current findings build on extant theories of suicidality. Psychological pain is central to many models of suicide (e.g. Shneidman, 1993). It is clear from this analysis that self-disgust is a pronounced component of this meta-emotional pain. The current findings support and build on the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) and the IMV model of suicide (O'Connor, 2011) as they both highlight the significance of early adversities. Self-disgust's behavioural components (e.g. distancing, repelling) exacerbated disconnection; therefore, potentially increasing feelings of burdensomeness and thwarted belongingness. This provides some support for Chu et al.'s (2013) hypothetical model of self-disgust and suicide (described earlier). However, these authors propose that disgust at others and the world increases suicidality, which was not identified in the current analysis. These findings build on the IMV model by situating the processes of disgust across the IMVs various phases. For example, having one's "disgustingness" exposed could relate to feelings of humiliation and entrapment and increase suicide risk. The analysis also builds on extant theoretical accounts of suicidality (see Barzilay & Apter, 2014) by highlighting the role of self-disgust in established risk factors, such as hopelessness and suicide as an escape from psychological pain.

Hegemonic masculinity is hypothesised to increase male suicide risk by limiting emotional expressiveness and help-seeking, and promoting maladaptive ways of coping, such as using substances and the concealment of distress (e.g. Cleary, 2012; Payne et al., 2008). Although alexithymia, substance use and concealment of distress were prominent across the current data, the negative influence of gender norms was not extensively endorsed. This may be due to the inherent sampling bias within this study. Motivation to engage may have been significantly lessened in men who conceal their distress. If concealment related to perceived gender norms, participants may have been further deterred by the presence of a male researcher. The difficulties in recruitment for this study could support the argument that most men struggle with emotional expressiveness (see Affleck et al., 2012). Although, to address the research aim a sample of men able to reflect on their emotional experiences was needed. The analysis did provide some nuanced links between disgust and masculinity, such as disgust's role in concealment and how the exposure of participant's "disgustingness" (i.e. abuse) may be emasculating. This provides a tentative hypothesis of a relationship between self-disgust, childhood abuse, suicide and hegemonic masculinity, which would benefit from future empirical research.

Implications for suicide prevention

This study highlights the importance of considering self-disgust alongside more established risk factors (e.g. hopelessness, disconnection) when assessing suicide risk in men. Risk assessment should explore the nuances in which disgust may present, such as mirror usage and exposure. These can then be formulated in risk management plans. Risk assessment should be considered in men with alexithymia (i.e. Kealy et al., 2018), particularly those with a history of early adversities. Providing men with opportunities to reconnect may potentiality reduce suicide risk (e.g. Lakeman & Fitzgerald, 2008).

The findings of this study highlight the importance of working clinically with self-disgust in men with suicidality, alexithymia or a history of early adversities. Therapeutic interventions which help individuals learn about and regulate their emotions (e.g. Dialectical Behavioural Therapy (DBT); Linehan, 1993) may support men to identify and manage self-disgust when it arises. DBT has shown efficacy in reducing suicidality in women (Linehan et al., 2006). Compassion Focussed Therapy (CFT) is effective in working with shame and self-criticism (Gilbert, 2010; Gilbert & Andrews, 1998). As shame can be conceptualised as a disgust-based emotion, it could be hypothesised that CFT may have applications in working with self-disgust (Gilbert, 2015). Further research is needed into the value of working therapeutically with self-disgust.

Public mental health campaigns are increasingly using normalising and anti-stigma messages, although these have been less efficacious for men (Henderson et al., 2013). If exposure is pertinent for men's suicide risk, future research could explore this and how it interplays with anti-stigma messages. This could also be explored in regard to current guidance (NICE, 2019), which recommend the involvement of significant others to manage an individual's suicide risk.

Limitations

This study is limited by the small sample number. This was a difficult to reach population, with sampling further affected by the COVID-19 pandemic. A sample of nine may be perceived as failing to meet data saturation. Indeed, further interviews and theoretical sampling (e.g. those without adversities) would have strengthened the analytic process and

tested developing theory. However, the emergent concepts and categories could be considered to have achieved theoretical sufficiency (Dey, 1999). The findings are strengthened by their triangulation with the extant literature on self-disgust. However, due to ethical considerations, the findings could not be corroborated with participants, lacking data triangulation in that respect.

As described above, using a self-selecting sample resulted in an inherent sampling bias. The sample were majority CMHT service users, had accessed psychological therapy, were predominately younger, heterosexual and all participants were white British. Furthermore, using healthcare professionals to identify participants, and the need for computer literacy (third sector recruitment) may further bias the sample. Future research should explore these limitations and attempt to recruit a more diverse sample.

The ability to recall specific cognitive-affective components during a particularly heightened psychological time may have been challenging for the participants. This may have been further influenced by alexithymia and the duration between their attempt and interview. However, all the men appeared able to convey their circumstance articulately.

Hypothetically, as self-disgust was prevalent across the recruitment literature, participants may have been inadvertently primed to report this emotional experience. The inductive nature of grounded theory is in contrast with the more hypothesis-driven approaches which are central to deductive and positivist methodologies (Sbaraini et al., 2011). An inductive approach is not commonly utilised to explore an issue from a particular perspective. Self-disgust was one such guiding perspective within this research project. Furthermore, the researcher's prior understanding of emotions based on his personal and professional

experiences all had the potential to become guiding frameworks within the project . Self-disgust was embedded throughout the research process, including the projects promotional material and recruitment information, interview schedule and measurements used to situate the sample (i.e. SDS-R; Powell et al., 2015c). It could be that participants were primed to think about and report this experience rather than allowing self-disgust to emerge out of the study (i.e. it was intentionally explored). It remains an empirical question as to what extent self-disgust processes may emerge when self-disgust is not embedded across the research process. However, more traditional grounded theory has been criticised for assuming that researchers approach projects as a *tabula rasa* (Charmaz, 2014). Whilst self-disgust was a guiding theory across the project, various mechanisms were employed to ensure that an *a priori* framework was not placed on the data. These included having a semi-structured interview schedule and ensuring that the data analysis explored the process of male suicide (not just self-disgust's role) which allowed for the emergence of multiple processes. This is evident in the emergence of "the abyss" concept, in which it was clear that self-disgust did not account for men's suicidality in its entirety, instead it interacted with multiple affect states and experiences of disconnection, helplessness and hopelessness. Further credibility, reliability and adherence to the grounded theory methodology was achieved through research supervision, maintaining a reflective journal and input from an independent qualitative researcher. These processes facilitated reflexivity and bracketing whilst ensuring that the researcher remained open and grounded in terms of participants' responses and that the project was not shaped by an a priori framework.

Despite these limitations, there are methodological strengths to this study. Firstly, by using a sample of men who had attempted suicide, the findings have the potential to map onto those who die by suicide (Beautrais, 2001). Furthermore, additional recruitment outside of the NHS

attempted to reduce some of the sample limitations. Grounded theory using interviewing, was an appropriate methodology to answer the research question. Multiple methods were used to foster reflexivity and credibility, with the study meeting the quality guidelines proposed by Elliot et al. (1999). Importantly, despite the emotive subject matter, several participants reported valuing the opportunity to engage in the research.

Future research

Self-disgust should be explored in homogenous samples and in populations which present with a high risk of suicide. Prospective cohort study designs, using hierarchical multiple linear regression modelling could explore self-disgust with other pertinent variables to determine what best predicts suicide risk, whilst controlling for closely situated emotions (e.g. shame). The limitations in using qualitative approaches to explore emotional experiences can be addressed using experimental designs (cf. Fox et al., 2013). By inducing disgust, future research could compare levels of disgust and self-disgust in men with suicidality when compared to matched controls.

Conclusion

Self-disgust appears to be an important process in male suicide risk and particularly pervasive in men with a history of multiple adversities. Despite the limitations, this paper adds to the self-disgust literature and provides a departure point for future empirical study.

Declaration of interest statement

The author declared no potential conflicts of interest with respect to the research.

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Appendix A. Journal guidelines: Archives of Suicide Research[4]

Journal

Archives of Suicide Research

Aims and scope

Archives of Suicide Research , the official journal of the International Academy of Suicide Research (IASR), is an international journal in the field of suicidology. The journal features original, refereed contributions on the study of suicide, suicidal behavior and self harm, their causes and effects, their prevention and intervention. The journal publishes articles investigating the biological, pharmacological, genetic, psychological, epidemiological cultural and sociological aspects of suicide. It also welcomes intervention studies designed to reduce the risk of suicide and suicidal behavior. In addition to original research articles, the journal publishes high quality literature reviews relevant to suicidal behavior.
The editors of ASR are mindful of the dichotomy between general (quantitative/nomothetic) methods of research and practice and approaches that utilize specific case studies (qualitative/idiographic). While eagerly accepting work from suicidologists situated on both sides of this division, the editors ultimately wish to cultivate a forum that attempts to reconcile and merge these oppositional modes. They aim to promote a scientific discipline that encourages the open exchange of knowledge and techniques to advance international suicide prevention efforts. And it is the mission of ASR to be the primary conduit through which the results of such exchanges will be enthusiastically disseminated.

Peer Review Policy:

All review papers in this journal have undergone editorial screening and rigorous anonymized peer review.
2018 Impact Factor: 2.316
Publication office: Taylor & Francis, Inc., 530 Walnut Street, Suite 850, Philadelphia, PA 19106

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[4] Details taken from https://www.tandfonline.com/toc/usui20/current

Readership:

Suicidologists, psychologists, psychiatrists, clinicians, researchers, mental health, social workers, graduate/undergraduate students.
Instructions for authors

COVID-19 impact on peer review:

As a result of the significant disruption that is being caused by the COVID-19 pandemic we understand that many authors and peer reviewers will be making adjustments to their professional and personal lives. As a result they may have difficulty in meeting the timelines associated with our peer review process. Please let the journal editorial office know if you need additional time. Our systems will continue to remind you of the original timelines but we intend to be flexible.

About the Journal:

Archives of Suicide Research 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.

Please note that this journal only publishes manuscripts in English.

Archives of Suicide Research accepts the following types of article: original articles.
Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be single blind peer reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

Structure:

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits:
Please include a word count for your paper. The word count limits are 4000[5] words for a regular article, 4500 words for a review, and 2000 words for a brief article.

[5] Please note, in line with Cardiff University DClinPsy submission alterations, this thesis is being submitted to adhere to the 8,000 word limit.

Style Guidelines:

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.
Please use American spelling style consistently throughout your manuscript.
Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.
Submissions to Archives of Suicide Research should follow the style guidelines described in Publication Manual of the American Psychological Association (6th ed.)6. Merriam-Webster's Collegiate Dictionary (11th ed.) should be consulted for spelling.

Formatting and Templates:

Papers may be submitted in Word or LaTeX formats. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).
Word templates are available for this journal. Please save the template to your hard drive, ready for use.
If you are not able to use the template via the links (or if you have any other template queries) please contact us here.
References:

Please use this reference guide when preparing your paper.

Checklist: What to Include:

Author details. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

Should contain a structured abstract of 250 words (Objective, Method, Results, Conclusions). You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

Between 3 and 6 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Add Highlights section after abstract. This should be three bullet points of key highlights of the manuscript. Max of 85 characters per bullet point including spaces.

[6] Please note, *Archives of Suicide Research* have updated their guidance and advised that submissions should follow APA 7th Edition, which was used throughout this thesis.

Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants
This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.

Biographical note. Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g. no more than 200 words).

Data availability statement. If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.

Data deposition. If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

Units. Please use SI units (non-italicized).

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These general article layout guidelines will help you to format your manuscript so that it is ready for you to submit it to a Taylor & Francis journal. Please also follow any specific Instructions for Authors provided by the Editor of the journal, which are available on the journal pages at www.tandfonline.com. Please also see our guidance on putting your article together, defining authorship and anonymizing your article for peer review.
We recommend that you use our templates to prepare your article, but if you prefer not to use templates this guide will help you prepare your article for review.
If your article is accepted for publication, the manuscript will be formatted and typeset in the correct style for the journal.

Article layout guide

Font: Times New Roman, 12-point, double-line spaced. Use margins of at least 2.5 cm (or 1 inch). Guidance on how to insert special characters, accents and diacritics is available here.

Title: Use bold for your article title, with an initial capital letter for any proper nouns.

Abstract: Indicate the abstract paragraph with a heading or by reducing the font size. Check whether the journal requires a structured abstract or graphical abstract by reading the Instructions for Authors. The Instructions for Authors may also give word limits for your abstract. Advice on writing abstracts is available here.

Keywords: Please provide keywords to help readers find your article. If the Instructions for Authors do not give a number of keywords to provide, please give five or six. Advice on selecting suitable keywords is available here.

Headings: Please indicate the level of the section headings in your article:

First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.

Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.

Third-level headings should be in italics, with an initial capital letter for any proper nouns.

Fourth-level headings should be in bold italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Fifth-level headings should be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Tables and figures: Indicate in the text where the tables and figures should appear, for example by inserting [Table 1 near here]. You should supply the actual tables either at the end of the text or in a separate file and the actual figures as separate files. You can find details of the journal Editor's preference in the Instructions for Authors or in the guidance on the submission system. Ensure you have permission to use any tables or figures you are reproducing from another source.

Please take notice of the advice on this site about obtaining permission for third party material, preparation of artwork, and tables.

Running heads and received dates are not required when submitting a manuscript for review; they will be added during the production process.

Spelling and punctuation: Each journal will have a preference for spelling and punctuation, which is detailed in the Instructions for Authors. Please ensure whichever spelling and punctuation style you use, you apply consistently.

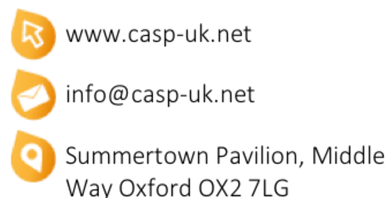
Appendix B. Examples of inclusion/exclusion screening

Author/Journal Details								Inclusion Criteria						
First Author	**Second Author**	**Year**	**Title**	**Journal**	**Volume**	**Issue**	**Pages**	**Research using established qualitative methods**	**Sample of suicide attempters**	**Research exploring the factors of male suicidal behaviour.**	**Exploring suicide as primary study focus**	**Cisgender male sample**	**English language**	**Peer reviewed**
Fenaughty	Harre	2003	Life on the seesaw: A qualitative study of suicide resiliency factors for young gay men	Journal of Homosexuality	45	1	1-22	Yes	Yes but with ideation	Yes (but focussed on resilience)	Yes	Yes	Yes	Yes
Fitzpatrick		2014	Stories worth telling: moral experiences of suicidal behavior	Narrative Inquiry in Bioethics	4	2	147-160	Yes	Yes	No	Yes	Yes but with females	Yes	Yes
Friedman	et al.	2006	The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth	Journal of Adolescent Health	38	5	621-623	No	Unclear	No	Yes	Yes	Yes	Yes
Galasinski	Ziolkowska,	2013	Experience of suicidal thoughts: A discourse analytic study	Communication & Medicine	10	2	117-127	Yes (Critical Discourse Analysis).	Unclear	Unclear	Yes	No	Yes	Yes
Holliday	Vandermause	2015	Teen experiences following a suicide attempt	Archives of Psychiatric Nursing	29	3	168-173	Yes	Yes	No	No	Yes but with females	Yes	Yes
Hubers	et al.	2016	Suicidality in Huntington's Disease: A qualitative study on coping styles and support strategies	Journal of Huntington's Disease	5	2	185-198	Yes	Unclear	No	Yes (in HD)	Yes	Yes	Yes
Im	Kim	2011	A phenomenological study of suicide attempts in elders	Journal of Korean Academy of Nursing	41	1	61-71	Yes	Yes	Unclear	Yes	Unclear	No	Yes
Jegannathan	et al.	2014	'Plue plun' male, 'kath klei' female: gender differences in suicidal behavior as expressed by young people in Cambodia	International Journal of Culture and Mental Health	7	3	326-388	Yes	Unclear	No	Yes	Yes	Yes	Yes

Article Details				Exclusion Criteria									
First Author	Second Author	Year	Title	Unsuccess-ful assisted Suicide	Absence of suicide attempt	Mixture of attempt/ ideation/ self-harm and not analysed separately or unclear how analysed.	Quantitative research	Factors of suicide not the main research focus	Mixed methods with qualitative not distinctly reported	Female only sample	Mixed gendered designs without distinct cisgender male reporting	Book reviews, opinion pieces, unpublished theses, literature reviews, non-peer reviewed journals.	Non-English
Fenaughty	Harre	2003	Life on the seesaw: A qualitative study of suicide resiliency factors for young gay men	No	YES	YES	No	No	No	No	No	No	No
Fitzpatrick		2014	Stories worth telling: moral experiences of suicidal behavior	No	No	No	No	No	No	No	YES	No	No
Friedman	et al.	2006	The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth	No	YES	Unknown	YES	No	No	No	No	No	No
Galasinski	Ziolkowska,	2013	Experience of suicidal thoughts: A discourse analytic study	No	Unclear	Unclear	No	YES	No	No	YES	No	No
Holliday	Vandermause	2015	Teen experiences following a suicide attempt	No	No	No	No	No	No	No	YES	No	No
Hubers	et al.	2016	Suicidality in Huntington's Disease: a qualitative study on coping styles and support strategies	No	Unknown	Unknown	No	No	No	No	YES	No	No
Im	Kim	2011	A phenomenological study of suicide attempts in elders	No	No	No	No	No	No	Unclear	Unclear	No	YES
Jegannatha n	et al.	2014	'Plue plun' male, 'kath klei' female: gender differences in suicidal behavior as expressed by young people in Cambodia	No	Unclear	Unclear	No	No	No	No	YES	No	No

Appendix C. Example of CASP assessments

Appendix C1. Cleary, (2012)



CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference: Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine, 74*(4), 498-505. ……………

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- What was the goal of the research
- Why it was thought important
- Its relevance

Comments:
Important and relevant as there has been no previous qualitative research into the experience of young male suicide (based on original 2005 research – studies have occurred since then). Present study aims to address that gap. To examine the emotions and meanings involved in suicidal behaviour based on a sample of young men who have made a suicide attempt. To examine whether particular types of masculinities are implicated in suicidal action and to investigate this qualitatively. Relevance and importance described within the context of male suicide, emotional expression and views of hegemonic masculinity. "The objective of the investigation was to understand the practice and to explore the background circumstances and motivations involved in the suicidal process" (p.499).

2. Is a qualitative methodology appropriate?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:
Statement that research to date has followed a quantitative paradigm, which whilst helpful "provide little insight into the process of suicidal action" (p.498). "no qualitative study of suicide has focussed specifically on young men - the group who are most at risk" (p.498). - present study aims to address that gap. The focus on the subjective meaning and patterns generated by these stories of suicide, and on the processes through which men conduct gendered lives in their socio - economic environment" (p.498).
Rationale for a qualitative approach provided.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:
Qualitative methodology based on in-depth, unstructured interviews.
Consecutive sampling.
Justification for unstructured interview provided.
Unclear as to the rationale for a "modified version of grounded theory" and whether this actually took place (i.e. over thematic analysis) – although this is more to do with analysis rather than design (why was awarded a yes).

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ✓

Can't Tell

No

- HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:
Inclusion criteria noted. Criteria of aged 18-30 justified to reflect the population group with the greatest suicidal risk.
N=52 from Dublin area (can results be generalised outside of inner city?). Sample reported as representative. Noted of one refusal to participate. Breakdown of participant demographics provided (age, socio-economic status, working status, education) and related to risk factors for suicide – Therefore, demonstrating relevance of the research project.
Suicide criteria:
- Inclusion criteria that "all men had made a suicide attempt with definite intent to die" (p.499).
- Breakdown of suicide methods provided.

5. Was the data collected in a way that addressed the research issue?

Yes ✓

Can't Tell

No

- HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus groups, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:
In-depth unstructured interviews. Completed with individuals as soon as possible after suicide attempt (normally within 24 hours).
Unstructured interview with one opening question - question reported.
Audio taped interviews (except two who declined) which were transcribed.
Interviews completed in hospital setting.
Consecutive sampling was used - Does this imply data saturation - It is not reported in these terms.

6. Has the relationship between researcher and participant been adequately considered?

Yes ☐
Can't Tell ☐
No ☑

- HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research question (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

No mention of this during the paper.
No description of the relationship between researcher and participant and the potential bias for this during the formulation of the research question and other aspects of the project designs and implementation.
No note of how the researcher responded to events in the study, if they occurred, and adapted the research design in line with this.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☑
Can't Tell ☐
No ☐

- HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

Project obtained ethical approval from hospital ethics committee.
Procedure described in relation to ethical process.
Opportunities to decline and withdraw.
Usage of pseudonyms.
Informed consent process.

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☑
No ☐

- HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:
Analysis by computer and manual methods. Data analysed using a "modified version of grounded theory... guided by Douglas' methodological approach" (p.500). Analysis method process discussed, including using a social constructionist approach. Unclear how method is Grounded theory and not thematic analysis, no description of the processes used which were grounded theory.
No description of outlying or contradictory data and how this was dealt with (if it even existed). No description about how the data was selected to support findings. General description of the analysis process and theme development in the analysis section.
No description of the researcher situating themselves in the data analysis process.

9. Is there a clear statement of findings?

Yes ☑
Can't Tell ☐
No ☐

- HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:
Results are inter-dispersed with the findings, which does lead to a mixture of linking to the evidence base during the results section. However, findings are linked to the extant literature on the relevant topics/themes which have been identified. There is a cohesive summary of the themes and findings within an overall discussion.
Although not specifically described in regard to the research question, the findings are applicable to the line of inquiry and original research question.
There is no mention of triangulation, inter-rater reliability, validation, more than one analyst and only one author.
Findings are linked to the population being studied.
There are no limitations of the research discussed – however this relates more to section 10.
There is no model of the findings - theory generation - in keeping with GT – although this has already been discussed above.

Section C: Will the results help locally?

10. How valuable is the research?

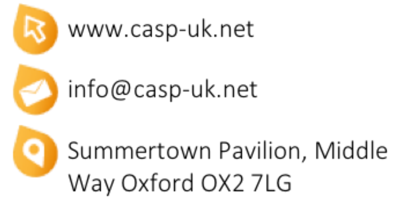
- HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

No clinical implications discussed.
No future research options discussed.
However, this is a valuable piece of research. It has one of the largest sample number of all the systematic review data and there are evidence-based arguments being made.
The author also documents the way that the research contributes to the area of masculinity, suicide and socioeconomic status, in Ireland and possibly further afield.

Appendix C. Example of CASP assessments

Appendix C2. Osafo et al., (2015)



CASP Checklist: 10 questions to help you make sense of a Qualitative research

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About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

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Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference:.Osafo et al., (2015). Attempted suicide in Ghana: Motivation, stigma and coping.- RESEARCHER CASP RATING………………………………

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	
Can't Tell	✓
No	

- HINT: Consider
- What was the goal of the research
- Why it was thought important
- Its relevance

Comments:
No clear statement of the aims of the research - does say "within the proscriptive moral system of Ghana, which condemns suicide and suicidal persons, it would be especially important to examine the aftermath experiences of suicidal persons. Such was the present purpose" (p.275). Research importance hinted due to literature stating the contextual factors that stigmatise and demonise individuals that have attempted suicide. Relevance placed within the rates of suicide in Ghana - although no data available. Relevance placed within the dearth of research into suicide in Ghana. Research doesn't state an aim relating to males - however, it's unclear whether this is a particular aim of the research, or just what happened in relation to recruitment. Importance placed within the fact that suicide attempters are at a greater risk of suicide - although this isn't very clear.

2. Is a qualitative methodology appropriate?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:
Participants were asked to provide "in-depth interviews about their experiences after an attempt" - suggests rationale for a qualitative approach - however, this is not clearly stated. However, the tentative aims is suggestive at illuminating the experience of suicidal individuals.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:
Interviews appear appropriate although no discussion on whether they were structured, unstructured, or the rationale for an interview design. Three questions asked - one which explored suicidal process. Thematic Analysis used - Description of this provided although no rationale why it was chosen over other methods, bar its usage of looking for themes and "Flexibility". However, did say that this allowed for a "deep engagement with the informants in a dialogue", as would other methods which weren't discussed.

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	☐
Can't Tell	✓
No	☐

- HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:
Unclear as the aims of the research are not necessarily set. The sample size n=10 appears sufficient for a thematic analysis. However, the sample is all men and it is unclear whether this is an aim of the research and, if not, then there is a bias in the recruitment (males 30-41). The recruitment process appeared extremely laborious and is described in full. It may be that this relates to the context of the study and the cultural significance. However, this is not clearly stated. There was no discussion on whether individuals declined to take part and why.
There was a suicide intervention provided to participants and there is no note about how this may have influenced the findings.
Suicide Factors:
- Methods reported (poisoning, hanging, stabbing)
- No age at suicide or time since attempt occurred, or previous number of attempts, or notes on intent.

5. Was the data collected in a way that addressed the research issue?

Yes	☐
Can't Tell	✓
No	☐

- HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus groups, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:
Interviews were completed - no note as to whether these are semi-structured - but the three questions are provided. Hints that these were completed in the village - however, it is not explicit. No justification as to why these methods were chosen. Interview questions provided but no note as to whether they used prompts and probes - no note on how the interview guide was constructed. No description on whether the methods were adapted or changed. No note of data saturation. No note of how the data was recorded or transcribed.

6. Has the relationship between researcher and participant been adequately considered?

Yes ☐

Can't Tell ☐

No ☑

- HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research question (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:
No note on this. Including how the provision of a suicide prevention strategy may have influenced the interview data. Cultural factors are also not discussed regarding bias i.e. the village chief had to be informed and this may add bias to the research - a potential ethical point. No note of the potential impact that the researcher had on the data, any bias or preconceived ideas and how this was dealt with. No note of how the researcher had any bias in the recruitment process.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐

Can't Tell ☐

No ☑

- HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on participants during and after the study)
- If approval has been sought from the ethics committee

Comments:
No note of ethical approval. Suggestion that consent was obtained but there is no note of "informed consent" and how this was achieved. There is a description of the process of obtaining the sample including the researcher attending local villages, providing suicide intervention and having to engage with village chiefs around this. This may impact on an individual's ability to provide informed consent. No description of how data was kept anonymous, whether there were any withdrawal opportunities and how the participants were debriefed. There is note of an individual ending their life two months after the study.

8. Was the data analysis sufficiently rigorous?

Yes ☐

Can't Tell ✓

No ☐

- HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:
There is no description of the data analysis process. Thematic analysis used and it does state that it followed the process of Braun and Clarke, however there is no statement about how these themes were generated (such as how each stage of the data analysis process was followed). Quotes are provided to describe most salient and pertinent themes although there is no note of how these were decided on. No note of any contradictory information or how this was dealt with. No note of how the researcher explored and considered their own role and the potential of this impact on the data.

9. Is there a clear statement of findings?

Yes ☐

Can't Tell ✓

No ☐

- HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:
Clear statement of findings and discussion around these findings with some linkage back to the evidence base on male suicide and mental health and gender in Ghana. Evidence is provided for the statements, however no note of any findings which conflict with their data or evidence against the researchers' arguments. There is no discussion about who analysed the data and whether any inter-rating of data was completed or triangulation of data findings. Unclear of the credibility of the data findings. Paper says that the study has "delineated the specific community contextual factors for suicidal behaviour", (p.278) – Potentially a big claim and unclear if backed up in the evidence. Findings are reported in relation to how they are supported by the previous research - but some of these links (i.e. name calling) are tenuous - more robust for partner infidelity.

Section C: Will the results help locally?

10. How valuable is the research?

- HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:
Findings are linked to a rural context (around trauma) which is important as unclear whether these results can be generalised - do link some findings to other cultures in Africa. Limitations of the research are noted - not include significant others, cannot be generalised due to other ethnic groups differing views on suicide. No limitation noted about lack of female participants and the rationale for this (considering it did not appear a male only study aim) or the limitations on the research methodology and data analysis process.
Contributions of the research are discussed describing its addition to the extant literature. The significance and the importance of the research are noted in relation to suicide as suicide attempt is the biggest risk factor for suicide completion. Some note of implications - engaging with religious and other factors which may increase hope - and this is linked to the wider evidence base on HIV. Suicide risk assessment implications - they should assess the impact of the post-suicide experience on individuals who have attempted suicide as this may pose a further risk factor. Wider implications on public education and wider systemic influence on reducing stigma may produce change - currently being done through education programmes and are linked to the policy and evidence context. No future research directions noted except in other communities. There is a note that the research may not be able to be generalised. No note about females and whether findings can be transferred.

Appendix D. Stage 4 of meta-synthesis

Appendix D1 – Table of key concepts Key: *Italics – Themes/concepts etc.*

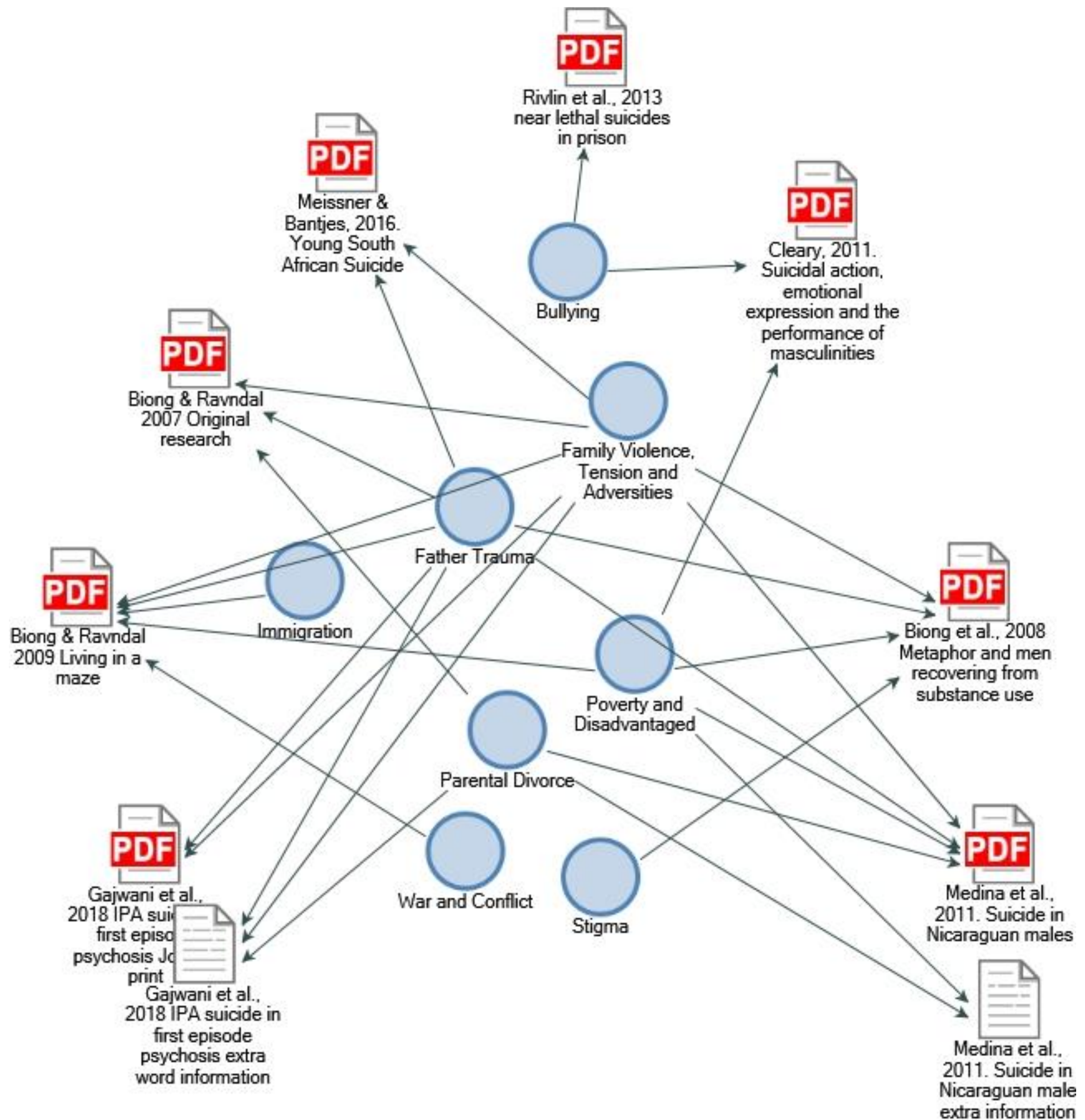
Biong & Ravndal (2007)	Biong et al. (2008)	Biong & Ravndal (2009)	Cleary (2012)	Gajwani et al. (2018)	Knizek & Hjelmeland (2018)
Between Death as an Escape from Pain and the Hope of a Life Hope: Turning points, optimistic, belonging, increased self-worth, relationships Pain: Isolated, deteriorating substance use, no future, suicide to escape pain. *The Meaning of Acting* Attributions for actions: Social relationships, inability to cope, hopelessness, death as a solution, intoxicating self, being heard, fluctuating actions. *The Meaning of Reflecting* Reflections on life death, freedom and responsibility, loneliness, anger, historic abuse, confusion on gender roles, death as a release, substance use as release. *The Meaning of Relating* Positives and negatives of social relationships, worthlessness, loneliness, guilt, shame, anger, historic abuses, father-son dyad, negative relationship to self, helplessness, divorce, belongingness, abandonment.	*Sense of Self* Being outside of society, abandonment, existential reflections, being alienated, grief and anger, father-son dyad difficulties, helplessness, substance use, major life stressors increasing suicide risk. *Being Close to the Point of no Return* Substance use increasing suicide risk, disconnection from reality, accumulating difficulties, existential chaos, feeling unable to cope, stigma and marginalisation, feeling trapped, empty, and having no alternatives. *Still Being on the Edge* Ambivalence to failed attempt, fear, determination to die, uncertain future, turning points, feeling responsible, interpersonal struggles, sense of hope in self. *Being Isolated* Isolation, negative feelings towards self, feeling like an outsider, rejection, victimised sense of self, using substances to cope, suicide as a final solution.	*Living in a Maze* Feelings of insecurity, loss of direction, feeling different, managing tradition in a new society, meeting obstacles, adapting, shame, substance use increasing suicide risk, suicide as escape, ambivalence, defeat. *Getting in a Tight Spot* Unclear identity, low self-worth, conflicted state of self, insecurity, self-medication with substance use, managing difficulties of emigration, conflict, father-son difficulties, history of abuse, language barriers and isolation, hopelessness, PTSD, suicide as a solution. *Being in a Burning Bed* Experiences of insecurity providing motivation for suicidal action, managing problems from emigration, existentialism, isolation, feeling defeated, family conflict, motivation to recovery, barriers to engagement, gaining control, psychological pain. *Being in a Fog* Drug use as self-medication, existential crisis, lacking belonging, unclear identify, disconnection, death as release, ambivalence to live.	*Trying to Cope: The usage of Alcohol and Drugs* Substance use to self-medicate and prepare for act, problems associated with substance use. *Diminishing Options: Moving Towards Suicide* Feeling trapped, panic, impossible situations, sleeplessness, dwindling options, accumulating problems, alcohol for courage and anaesthetic. *The Surveillance of Masculine Behaviour* Leaning about 'normal' masculinity, bullied for sensitivity, gender rules, emotionless, fearful of other men, cues not to talk, emotions = weakness, emotions can be weaponised, feminine = gay, being different, monitoring. *Concealing Distress* Not showing emotions, stigma of emotional pain, fear of disclosure, vulnerability, pressure to conform, project masculinity *A Narrative of Long Term Pain and Distress* Intense pain, sadness, anxiety, panic, unfamiliarity of pain, alexithymia, fearful of disclosing distress.	*Appraisal of Cumulative Life Events as Unbearable: Unresolved Early Adverse Experiences* Childhood adversities, negative global impact, anger, shock. *Social Isolation* Isolation, loneliness, withdrawal, active avoidance, exclusion, disconnected. *self as vulnerable (inter and intrapersonal relationships). Fathers as Critical, Distant or Absent.* Turbulent interactions, early traumas, lack of care. *Lost Self-Identity* Rapid changes in experiences, loss of self-identity, self in crisis, powerlessness. *meaning of recovery marked by shared sense of hope and imagery for the future. Hope Vs Hopelessness.* Ambivalence. Catching up on lost time, mastery, speaking openly, nothingness, fragile position. *Shared Meaning and Burden* Rebuilding relationships, connection, being supported, relationships with support, ambivalence around future, troubled self relationship.	*Perceived Reasons or Triggers of the Suicidal Act:* *"To die"* Relationship problems, loneliness, separation, helplessness, inability to cope, illness, low quality of life, burdensomeness, gender norms, tired of life, hopelessness, disconnection, lacking belonging. *"Not to Die"* Loss of partner, accumulating problems, relationship problems, let down, excluded, ridiculed, shamed, loneliness, financial difficulties, aloneness, impotence, betrayal. *Attributed Responsibility for the Suicidal Act:* *"To Die"* Took responsibility, embarrassment, disconnection, shame, distancing, hopelessness, worthlessness, deliberate intention, suicide as best option, ambivalence around the future, lost courage. *"Not to Die"* Not taking responsibility, not in possession of faculties at time, alcohol use, distancing from the act, interpersonal difficulties, lack of money.

Medina et al. (2011)	Meissner & Bantjes (2016)	Osafo et al. (2015)	Ribeiro et al. (2016)	Rivlin et al. (2013)
Structural Conditions: Normative Expectations Cultural norms, hegemonic masculinity, breadwinner, show no weakness. *Material Circumstances* Unplanned parentage, chronic poverty, dysfunctional families, violence, maltreatment, absent father, school difficulties, nomadic lifestyle, strict or permissive parents. *Frustration* Shame, low status, perceived personal shortcomings, unemployment, failure, marginalisation *Inability to Cope* Suicide contagion, using alcohol and drugs to cope. *Suicide Attempt* Conflict with loved ones, personal failure, impulsive, "soft methods", increased severity with increased attempts. *Recovery* Turning to a positive future, readjustment, support from others, ambivalence due to lack of support. *Fear and Hopelessness*	*Turning Away from Others and Oneself:* *Relationship with Parents* Rules, expectations, control, disconnected from father, emotional unavailability. *Relationship with Peers* Disconnected, comparing, different, deviant. *Coping by Disconnection* Gender roles, bottling up feelings, conforming to masculinity, wanting control, "manliness", alcohol and drugs, work, self-harm, isolation, religion. *Romantic Relationships* Isolation, struggling to form relationships, avoidance, sexuality, relational triggers, heterosexism, identity. *Suicide as Disconnection* Distancing, lost sense of identity, suicide and autonomy, escape, communication, relational. *Returning to Others and Self* *Talking instead of Killing* Communication of emotions, challenging masculinity, seeking help and support. *Free to be Me* Courage, autonomy, coming out, independence, developing identity. *Another Chance at Living* Rebirth, beginning, reasons for living, reconnection,	*Motivation* Hopelessness. Despair. Illness. Loss of work. Social taunting. Perceived partner infidelity. Cultural significance. *Stigma* Social ostracism. Community. Physical molestation. *Coping* Withdrawal and isolation. Social support, family, and friends. Religious faith.	*Attempted Suicide Triggered by the Family Lifeworld* Lack of family interaction, substance use in family, conflict and arguments, interpersonal difficulties, substance use (and effects on relationships), perceived burdensomeness, feeling a "nuisance", roles of men in family systems, gender rules, failure to assume gender roles, loss of status, social positioning. *Attempted Suicide Triggered by Everyday Feelings* Biographical situation, relationships triggers, impact of daily substance use, losses through life, disconnection through substance use, feeling a hindrance, isolations, fragile relationships, solitude. *Attempted Suicide Triggered by Alcohol and Drug Use* Substance use as societal norms, masculine rules on substance use, wasted childhood, relational triggers, death as a solution, potential to harm others, guilt, anger, aggression, punishment, benefits of substance use, effects of substance use increasing suicide risk.	*The Initial Idea of Making a Suicide Attempt* Adverse live events, relationship break up, bereavement, "last straw". Criminal/prison issues, anxieties around trial, segregation, staff relations. Substance use, low mood, depression, anxiety, psychosis. Isolation and accumulating difficulties. *Planning and Preparation* Writing notes, communicating intent, depression, sadness, anger – before act; relief, pleased, calm, happiness – after act. Imagery, time between act and precautions against discovery. *Carrying Out the Act* Location and timing, timing to reduce discovery, methods used and reasons why, justification of choice, including only available, speed, less pain and increased lethality. *After the Act* Being discovered, emotions after act (angry, annoyed, disappointed, upset), consequences of act, reactions to the act and reflections on the act. Support received after act.

Appendix D. Stage 4 of meta-synthesis

Appendix D2. example concept map

Relationship between historic traumas and adversities across papers suggesting potential concept related to childhood trauma and adversities.



Appendix E. Translation process for the 'alone' concept

		Biong & Ravndal (2007)	Biong et al. (2008)	Biong & Ravndal (2009)	Medina et al. (2011)	Cleary (2012)	Rivlin et al. (2013)
Feeling alone, isolated and lonely	**First order concepts**	"I have always felt alone with this". "My parents have never wanted to talk about it afterwards. Sort of something we didn't talk about".	Per felt like "a lost soul toward God". "Vacuum"	"I withdrew more and more" "I had no relationship to society any more"	"I've missed my father so much"	"Hiding" "… Just feeling isolated all the time, you know that way. Wanting to scream and shout but you can't say anything, you know that way…"	"I couldn't eat anything. I couldn't really talk. I wouldn't ring my family. I couldn't speak to the staff. I wouldn't come out of my cell." "Missing my baby"
	Second order concepts	Loneliness deteriorates mood Interpersonal difficulties in family which exacerbates isolation Loneliness and isolation significantly exacerbated psychological pain. Being alone and isolated (both intra and interpersonally) exacerbated psychological pain, increasing suicide risk.	All participants had loneliness and "emptiness". Isolated as a result of interpersonal rejection and relationship difficulties. Isolation increased negative thoughts to self and others. Isolation in the context of addiction. Addiction exacerbating isolation. Isolated in relationships. Experiences of isolation exacerbated distress.	Loneliness as a result of emigration. Isolation led to feelings of being trapped. Isolation as a result of psychological pain and low self-worth. Feeling distanced from others/Social isolation. Lack of belonging (also leading to substance use). Being isolated and left without hope led to attempt as a solution to hopelessness.	Limited or no friends/social network. Limited opportunities to socialise. Lack of friends increased suicide risk. Loneliness exacerbated disconnection	Isolation as a result of substance use.	Participants had "no one to disclose their suicide attempted to – they were alone. Being isolated was one of the interrelated complexities in the participants (including rejection, loss, substance use and bullying).

		Osafo et al. (2015)	Meissner & Bantjes (2016)	Ribeiro et al. (2016)	Gajwani, et al. (2018)	Knizek & Hjelmeland (2018)	Emerging Third Order Concept
Feeling alone, isolated and lonely	**First order concepts**	–	"Sometimes you find yourself in such a dark space…you don't see that there is actually people that are loving, that can help you". "you completely isolate yourself from the world" – Link between alone and rejecting sub-theme of rejection.	"[...] The moment I'm alone I get this agonising feeling (SUICIDAL IDEATION), I think I have to have someone to talk to, if you don't have anyone to talk to, then there's no escape [...] because then I have that feeling, that desire to kill myself". (H7) "[...] I attempted suicide because I had no friends because I was everyone's enemy – linked to rejection". "I keep to myself"	"I felt out of place with everyone". "Just a bit isolated, and lonely really". "It [psychosis] makes you feel isolated" "I just go through periods of feeling very, very low and lonely really" "Umm, because of my feelings of loneliness, I – I felt that life – don't know, life was just very difficult… and so I thought of various ways of committing suicide" (Chris). "Sometimes as I say I can feel pretty-pretty lonely". "I just thought I was the one person in the world and that it wasn't happening to anyone else in the world. That made me feel low and something different, not human" (Amir).	–	**Alone – providing a context for being disconnected from the self and others** (also interlinking nature with other core themes)
	Second order concepts	–	Participants felt disconnection from family and friends. Isolated experience as a result of rejection. Being alone and disconnected – however, this was in the context of being rejected. Isolating self which exacerbated distress. Disconnection from others "profound" feelings of isolation An isolated existence.	Substance use accounting for isolation and the interconnecting nature exacerbating suicide risk. Substance use increased risk of rejection which caused feelings of loneliness and increased suicide risk. Lack of interpersonal relatedness (particularly with family) – gap between family and participants triggered suicide. Burdensomeness triggering loneliness.	Isolation, loneliness and withdrawal from society were reflected on as the nadir of distress. Not knowing how to rebuild relationships/lacking skills Existential sense of loneliness.	All participants felt lonely, alone or rejected (in the not to die group) Living in a "Vacuum" Having no friends. Participants "ended up alone"	

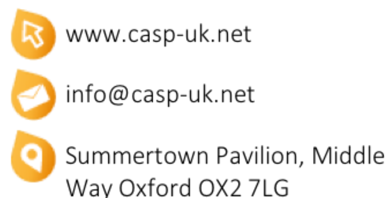
Appendix F. Line of argument synthesis

Concept	Second-order Interpretations	Third-order interpretations	
Psychological distress: enduring distress; multiple emotional experiences; psychological pain; anger; sadness; panic; shame.	Suicidal men experienced endured psychological pain consisting of multiple emotions. The worsening of this pain could lead the men to an experience of hopelessness in which suicide is perceived as a solution. ***(1) Second order core theme – "The pain"***		***(8) Overarching theme: Disconnection from the self and others.*** Synthesising the second order themes of (1) the "pain"; (2) alone; (3) masculinity; (4) trauma and adversities; (5) using substances and third order interpretations of (6) feeling different and (7) rejection, identified that the outcome of all these themes was the men feeling disconnected from themselves and others. This feeling of disconnection caused a deterioration in distress and increased suicidal risk. Interpersonal disconnection was experienced in many ways e.g. rejection, alone, substance use. Disconnection was also experienced at an intrapersonal level (e.g. masculinity rules led men to feel disconnected from emotions; substance use caused disconnection from feelings)
Identity: sexuality; having a different identity feeling an outsider; being a migrant.	Suicidal men experienced a thwarted identity. This could be related to having a minority sexuality, having an unclear identify or being an outsider.	Within these multiple reports of a thwarted identify were individual's descriptions of "feeling different" and "being different". Across the papers this exacerbated distress. ***(6) Third order interpretation of – Feeling different.***	
Interpersonal relationships: difficulties in peer relationships; difficulties in family relationships; difficulties in romantic relationships; difficulty in communicating; feeling ostracised from others; relationships ending and divorce; intentionally isolated oneself	The participants experienced multiple interpersonal difficulties, these often led the men to feel alone and isolated and worsened their psychological pain. This could also relate to feelings of burdensomeness. Some men felt isolated and ostracised from their communities. Some participants intentionally isolated themselves.	The analysis of participant's interpersonal difficulties highlighted the role of rejection. The men experienced rejection from others and also rejected those close to them. This led the men to feel isolation and alone, exacerbating feelings of disconnection. ***(7) Third order theme of Rejection*** (rejecting/rejected sub theme)	
Being alone, isolated and lonely: feeling isolated; feeling lonely and alone; feeling withdrawn; feeling isolated as a result of substance use.	Suicidal men were often isolated and reported feelings of loneliness. Often this was associated with other interpersonal difficulties and substance use but could be due to multiple factors. Feeling alone and empty, the men experienced a deterioration in their psychological distress and emotional pain, viewing suicide as a solution. ***(2) Second order core theme - Alone.***		
Masculinity: describing rules around gender and mental health; describing rules around gender and emotional expression; distress = weakness; wanting to protect others; masculinity rules.	Gender scripts and rules around how men should convey emotions and express distress caused the men to conceal their distress for fear of it being weaponised or showing weakness. Hegemonic masculinity factored as a cause to move individuals towards suicide. ***(3) Second order core theme – Masculinity***		

Historic adversities: Bullying; family violence, tension and adversities; father trauma; immigration; parental divorce; poverty and being disadvantaged; stigma; war and conflict.	A history of trauma and adversities provided a context for individuals to struggle with their identity, experience psychological pain, feeling alone and difficulties in interpersonal relationships. This could also lead to substance use and rules around masculinity. ***(4) Second order core theme – Trauma and adversities***	
Substance use: using drugs and alcohol to cope; self-medication; using drugs to prepare for the act; drugs to escape from living; experiencing the negative effects from substance use.	Men had initially used drugs for different reasons such as identity, to feel connected or to self-medicate for their distress. However, as substance use endured, individuals experienced the negative effects from substance use, both at an interpersonal and intrapersonal level. Substance use caused significant experiences of disconnection. ***(5) Second order core theme – Using substances***	
Suicide as a solution; feeling hopeless; struggling to cope with hopelessness and distress; death as an escape; death as a solution.	Participants experienced enduring hopelessness as a result of their distress and difficulties. Hopelessness was felt as enduring and led the men to perceive suicide as a solution to their hopelessness. ***(9) Second order theme – Seeing suicide as a solution to hopelessness.***	
Reflections after the attempt: reflections on the act; reflection on impulsivity; reflections on the future; hope after the act; an anxious and ambivalent future; reconnecting.	Participants reflected on their act. For some men they reflected on the intention and responsibility for their act. For many men they commented on how they experienced a positive view towards the future and a hopeful outcome. They perceived a future with less suicidality and more connection with others. Some, however, reported on-going suicidality, dejection and psychological pain. ***(11) Second order sub-theme: An ambivalent future.***	***(10) Third order sub-theme Hope through reconnection***: within individuals' stories of hope and positivity were aspects of reconnection with the self and others. This included an increased sense of identity, a connection to others (including God) and connection to support and help. Within this connection was a movement away from suicidality, towards recovery.

Appendix G. CASP consensus rating (for study reviewed in Appendix C2)

Appendix G1. Independent researcher rating



CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference:.Osafo et al., (2015). Attempted suicide in Ghana: motivation, stigma and coping – Independent researcher CASP Rating………………………….

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- What was the goal of the research
- Why it was thought important
- Its relevance

Comments:
Not written very clearly but is stated at the end of the introduction, following the rational for why this is an area that is worth exploring.

2. Is a qualitative methodology appropriate?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:
The aim is to explore individuals' experiences and therefore qualitative methods are appropriate for this research goal.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:
Used thematic analysis which is designed to explore themes of people's experiences. They have provided a statement about how thematic analysis allowed them to explore the data, could be considered a rationale.

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:
Recruitment is explained, and the researchers explain which participants chose to take part in the research. There is rationale in the introduction for wanting to speak to participants from Ghana. There is no rationale for why they chose men or the age of participants that they did. No discussion around anyone not taking part. There is one overall sentence on the methods of suicide attempt - nothing on age of attempt, writing notes, previous attempts etc.

5. Was the data collected in a way that addressed the research issue?

Yes	
Can't Tell	✓
No	

- HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus groups, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:
Setting is not justified, although they do express an interest in Ghana in the introduction and provide some rationale for this. Researchers state they use interviews to gather data and provide three of the questions they ask to explore the area but there is no mention of an interview schedule or how structured the interviews were. The form of data is not provided. The researcher does not discuss saturation of data. There is no discussion of modifying the methods.

6. Has the relationship between researcher and participant been adequately considered?

Yes ☐
Can't Tell ☐
No ☑

- HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research question (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:
There is no mention of any of the above in the paper.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☑

- HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on participants during and after the study)
- If approval has been sought from the ethics committee

Comments:
There is no statement about how ethical issues were explained, although it does state that oral consent was gained ahead of the interviews. No mention of seeking approval from the ethics committee.

8. Was the data analysis sufficiently rigorous?

Yes ☐

Can't Tell ☐

No ☑

- HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:
There is no in-depth description of thematic analysis and they do not make it clear how the themes were derived from the data. The researcher does not explain how the data presented were selected from the original sample. The researcher does not critically examine their own role, potential bias or influence during analysis. Sufficient data is presented to support the findings.

9. Is there a clear statement of findings?

Yes ☐

Can't Tell ☑

No ☐

- HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

The findings are made explicit and there is some discussion around how they relate to the original question. However, there is no discussion of evidence both for and against the findings, and the credibility of the findings.

Section C: Will the results help locally?

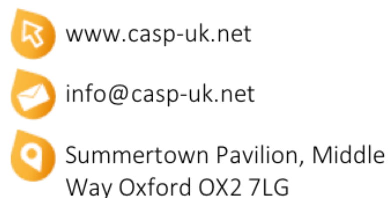
10. How valuable is the research?

- HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:
The researchers discuss the contribution the study makes to existing literature as well as considering its clinical relevance. They have briefly highlighted areas for further research. There is no discussion about how the findings can be transferred to other populations but there is some consideration of ways in which the research may be used to inform practice within Ghana.

Appendix G. CASP consensus rating (for study reviewed in Appendix C2)

Appendix G2. Consensus agreement



CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.
For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.
Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*
©CASP this work is licensed under the Creative Commons Attribution – Non-CommercialShare A like. To view a copy of this license, visit http://creativecommons.org/licenses/by-ncsa/3.0/ www.casp-uk.net

Paper for appraisal and reference:.Osafo et al., (2015). Attempted suicide in Ghana: Motivation, stigma and coping. – Consensus rating between researcher and independent researcher…………

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	
Can't Tell	✓
No	

- HINT: Consider
- What was the goal of the research
- Why it was thought important
- Its relevance

Consensus:
Initially there was disagreement between the independent researcher and the researcher. The researcher scored this question 'can't tell', whereas the independent researcher rated as 'yes'. Upon discussion and comparing with the p aper, it was agreed that there was no clear statement of the aims and that the research aims had to be inferred. Furthermore, there was no note whether the researchers were aiming to solely research male suicide.
Outcome – Agreement that readers 'can't tell' the aims of the research (Independent rescored from 'yes' to 'can't tell').

2. Is a qualitative methodology appropriate?

Yes	✓
Can't Tell	
No	

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Consensus:
Both researcher and independent researcher agreed that a qualitative methodology was appropriate for this research.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research

Yes	
Can't Tell	✓
No	

- HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Consensus:
There was agreement on this item between the independent researcher and the project researcher. However, both changed their rating. Initially, both had ticked 'yes', but during discussion and constant comparison of the data – whilst looking at the checklist advice, both researchers felt that the item should be re-rated as 'can't tell'. The main factor in this decision making was related to the provision of a suicide intervention to the village in order to access the sample. Whilst this may have been important to access participants, there was no consideration regarding whether this may have influenced participants' interviews or data and whether there was another approach which may have mitigated this.
Outcome – Both researchers rerated as 'can't tell'

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☑
No ☐

- HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Consensus:
Initially there was disagreement between the independent researcher and the researcher. The researcher scored this question 'can't tell', whereas the independent researcher rated as 'yes'. Upon discussion and comparing the paper with the checklist and the inferred aims of the paper, it was agreed that it was unclear whether the recruitment strategy was appropriate. This mainly related to the lack of rationale for having a specific age range (31-40) or whether the recruitment strategy resulted in a biased sample (this age group and men). This relates to the lack of unclear research aims.
Outcome – Agreement that readers 'can't tell' how appropriate the recruitment strategy is (independent rescored from 'yes' to 'can't tell').

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☑
No ☐

- HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus groups, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Consensus:
Both researcher and independent researcher agreed that readers 'can't tell' whether the data was collected in a way that addressed the research issue. There was agreement based on referring to the original paper, exploration of the individual CASP ratings and comparing with checklists.

6. Has the relationship between researcher and participant been adequately considered?

Yes	
Can't Tell	
No	✓

- HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research question (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Consensus:
Both researcher and independent researcher agreed that there were no reflexivity aspects discussed in the paper at any part of the research process.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	
Can't Tell	
No	✓

- HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on participants during and after the study)
- If approval has been sought from the ethics committee

Consensus:
Both researcher and independent researcher agreed that ethical issues had not been taken into consideration in this research. This related to the areas noted in the individual CASP ratings and comparing with data. Pertinent issues related to lack of ethical approval and lack of clarity around informed consent.

8. Was the data analysis sufficiently rigorous?

Yes	☐
Can't Tell	☐
No	✓

- HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Consensus:
Initially there was disagreement between the independent researcher and the researcher. The researcher scored this question 'can't tell', whereas the independent researcher rated as 'no'. Upon discussion and comparing the paper with the checklist and the data analysis process, it was agreed that the data analysis lacked rigour. This related to the lacking of an in-depth description of the analysis process, no description of how data was analysed and no section on data analysis. There is no description about the role of the researcher or how the thematic structure was arrived at.
Outcome – Agreement that the research was not sufficiently rigorous (researcher rescored from 'can't tell' to 'no').

9. Is there a clear statement of findings?

Yes	☐
Can't Tell	✓
No	☐

- HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Consensus:
Both researcher and independent researcher agreed the reader 'can't tell' if there is a clear statement of the findings. Whilst the findings are discussed, it's unclear whether they are credible or whether there is sufficient evidence to support the findings.

Section C: Will the results help locally?

10. How valuable is the research?

- HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Consensus:
The researcher and independent researcher reflected on the checklist for this item and the details across the paper. Whilst some limitations were noted, there was a consensus on that there is some novelty for the research in Ghana and there is some discussion around future researcher. However, both researchers agreed that there are significant limitations to this paper.

Overall consensus:
Initially, there was a majority agreement between the researcher and the independent researcher. Out of the scored questions, 6 were in agreement and the final questions also shared many similarities, providing an initial consensus of 7/10 (70%).
After discussion and constant comparisons with data and the quality assessment literature, there was total agreement 10/10 (100%) on all items. This included 3 individual changes of scores. Furthermore, on one item, both the independent researcher and researcher decided to re-rate to a ‘can’t tell’ rating.

Appendix H. Study strengths and weaknesses used in Q.10 CASP assessment

Paper	Strengths	Limitations
Biong & Ravndal (2007)	• Contributed to area of substance use and suicide which is highly comorbid. • Clinical implications provided. • Future avenues of research identified. • Description of how findings support and refute current literature.	• Small sample. • Lack of generalisability outside sample demographic. • Unclear of suicide methods or intent. • Method and number of previous attempts not provided.
Biong et al. (2008)	• Clinical implications provided. • Highlighting the importance of attending to language use.	• No future research directions. • Small sample. • Specific sample group may lack generalisability. • Limited description of analysis process. • Some of the clinical implications reported have limited evidence-base. • Method and number of previous attempts not provided.
Biong & Ravndal (2009)	• Implications for clinical practice. • Implications based on extant literature. • Generalisability discussed. • Exploring under-researched group. • Findings discussed in regard to policy development.	• Unclear of generalisability of findings to other immigrant groups. • Small sample. • Future research advised but no further discussion around what this may look like. • Limited description of previous suicidality.
Cleary (2012)	• Implications discussed. • Large sample number. • Contributes to suicide and wider areas of masculinity and socioeconomic status.	• No clinical implications noted. • No future research directions. • No mention of generalisability – unclear if can be generalised outside of Ireland or young men.
Gajwani et al. (2018)	• Clinical applications discussed. • Applications are linked to the extant literature and recovery focussed. • Future research avenues discussed. Including exploring emergence of suicidality pre and post psychosis. • Robust methodology and analysis. • Exploring high risk group (first-episode psychosis).	• Unclear if result can be generalised outside of first-episode psychosis. However, the authors do suggest that their findings can be linked to suicide outside of first-episode psychosis (unclear of rationale for this).
Knizek & Hjelmeland (2018)	• Only paper to explore similarities and differences based on intent to die. • Clinical implications provided. • Findings relate to risk assessment, particularly awareness of the contextual, interpersonal and individual experiences of suicidal individuals. • Authors highlight how their findings challenge the biomedical view of suicide. • Explored intent to die in analysis. • New research areas discussed.	• Smaller sample size. • No discussion on ability to generalise. • No discussion on the usefulness and validity of measuring intent to die.
Medina et al. (2011)	• Implications to clinical practice – including encouraging discussions with service users and formulating their difficulties. • Expressed the importance of clinicians discussing suicidality. • Implications for risk assessment discussed. • Future research directions discussed – including testing causality of their model and looking at other populations. • Aids theoretical understanding of suicide.	• Lack of generalisability noted. • Obtained sample may not fully relate to research question/aims.

Meissner & Bantjes (2016)	• Aids theoretical understanding of suicide. • Clinical implications discussed. Including developing relatedness, aiding communication and links with suicide prevention and treatment options. • Some discussion of generalisability to women – although there does not appear evidence to support this.	• Small sample number. • Lack of generalisability – impacted by recruitment process. • Unclear if recruitment (undergraduate) meets research aims or generalisability claims.
Osafo et al. (2015)	• Findings discussed as contributing to the extant literature and a novel area of research. • Implications for risk assessment – including the assessment of post suicide experiences – particularly related to stigma and assault. • Relate to wider topics of stigma and society.	• Lack of generalisability. • Unclear if research aims were met. • Unclear of recruitment strategy. • Potential for bias not discussed. • Data analysis and findings not rigorous. • No discussion on future research except duplicating in other communities. • No discussion on whether the research aimed to recruit just males.
Ribeiro et al. (2016)	• Clinical Implications discussed – although not in great detail – implications around working with men who use substances. • Future research discussed – although slightly more general. • Some discussion around contribution but does not expand greatly on this.	• Unclear of generalisability outside of specific area in Brazil - or if findings relate to non-drug users. • Lack of demographic/participant information. • There are some statements on changing policy, however these do not appear linked to the study findings.
Rivlin et al. (2013)	• Insight into prison suicidality. • Paper discusses its addition to the extant literature. • Findings are discussed in relation to supporting current policy, whilst providing nuanced findings and suggestions for future policy. • Clinical implications identified. • Future research identified – such as risk assessment in prison. • Larger sample may aid generalisability.	• Unsure if implications are considered within the current prison healthcare delivery. For example, implication that suicidal men should access support – however, their findings also suggest that this support was requested but not received – and no further exploration of this.

Appendix I. Operationalised plan of risk assessment and management[7]

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide – Operationalised plan of risk assessment and management (Version 3.0)

1) Introduction

- There is a potential for disclosures of suicide risk in all participants recruited to the project. This document will detail the possible circumstances during which disclosures of risk may be made. This document will also describe how the researcher will respond to disclosures of risk.
- To meet the project's inclusion criteria, individuals will have made a suicide attempt in the past. This makes individuals at higher risk of future suicidality (WHO, 2012). Therefore, the assessment and management of risk is an essential aspect of the project.
- The project has two recruitment arms. Individuals will be recruited through CMHTs in two South Wales Health Boards [DETAILS REDACTED]. This will furthermore be referred to as *CMHT Recruitment Arm*. Individuals will also be recruited through Third Sector organisations. A third-sector agency, [REDACTED], have also agreed to promote the project through advertising the research through their website, social media and newsletter publications, whereby individuals will self-select to take part. [DETAILS REDACTED] Registered Charity number [REDACTED]). Individuals recruited through [REDACTED] will hereby be referred to as *Third Sector Recruitment Arm*. Individuals will self-select to take part in the research by following an online link which will take them to a Qualtrics survey designed by the researcher.
- The management off all risk will follow NHS Wales Guidance in 'Suicide Prevention: Supporting Guidance for Practitioners" (Barber & Evans, 2017) and will also follow a range of policies from Department of Health and the National Suicide Prevention Alliance (NRSA). The research will follow guidance from the Department of Health relating to Information sharing and suicide prevention (DoH, 2014).
- Any disclosures of risk within the CMHT recruitment arm will be feedback to the healthcare professionals (HCP) and/or duty worker and risk will be managed following the policies and procedures of the relevant health board. The researcher will be aware of these policies prior to recruitment.
- Whilst not an exhaustive list, the following are potential suicidality risks which the individual may report during the research (Each will be discussed specifically):
    - Current suicidal ideation.
    - Current suicidal planning, intent and behaviour.
    - Current active suicide attempt.
    - Non-suicidal self-injury (self-harm) ideation, planning, behaviour or active attempt.

[7] Information blacked out in this document is redacted information to ensure anonymity

- The following are additional risk factors which may present during the research and will be discussed generally with plans of how to manage them.
    - Threats to others.
    - Risk to under eighteens.
    - Disclosures of non-recent (historic) sexual abuse.

2) Terminology

This risk assessment and management plan uses the following definitions cited in O'Connor and Nock (2014 p.73):
Suicide – the act of an individual intentionally ending their own life.
Suicidal behaviour – thoughts **and** behaviours related to an individual intentionally taking their own life. These thoughts include the more specific outcomes of suicidal ideation.
Suicidal ideation – an individual having thoughts about intentionally taking their own life.
Suicide plan – the formulation of a specific plot by an individual to end their own life.
Suicide attempt – engagement in a potentially self-injurious behaviour in which there is at least some intention of dying as a result of the behaviour.
Self-harm – intentionally self-poisoning or self-injuring irrespective of motive.

3) Details taken to mediate risk factors

Individuals will be informed that a number of personal details will be taken to mediate risk factors. This will be part of gaining informed consent to participate in the research. Declining to provide these details will mean the individual cannot be recruited to the study.

- Name
- Date of birth
- Address (address will allow identification of relevant police force, ambulance service, multi-agency safeguarding hub (MASH) team and crisis team).
- Contact phone number and e-mail
- GP
- These details will be known for individuals recruited through the CMHT pathway.
- Individuals recruited through the third sector pathway will be required to submit these details via a Qualtrics survey. The individual will be unable to proceed to expressing an interest in participating until all these details are provided.
    - Qualtrics survey: (https://cardiffunipsych.eu.qualtrics.com/jfe/preview/SV_bEeiHzfLKfKgtUN?Q_SurveyVersionID=current&Q_CHL=preview)
    - Individuals are given an option to decline consent to provide these details, however, this will end the Qualtrics survey and inform the individual that they are unable to participate.
- Healthcare professional details.
    - If recruited via the CMHT pathway this will be the individual's care coordinator (often a Community Psychiatric Nurse (CPN), social worker or Occupational Therapist).
    - If recruited via the third sector pathway there is an opportunity for individuals to record any other professionals (e.g. CMHT staff) that they are working with via the Qualitrics survey, however this is not a requirement as individuals may not be working with any services.

4) Further factors to mediate risk

- The chief investigator (CI) will be made aware of all scheduled client contact.
- The principal investigator (PI) and CI will be made aware of all client contact (CMHT arm).
- Interviews completed within working hours of 9-5 Monday to Friday.
- Interviews for third sector arm to be completed at Cardiff University or via Skype[8].
- The researcher will have contact details for participant's local police force, local ambulance service, local crisis team and GP prior to all scheduled contact with individuals.
    - For CMHT arm this will be based on the health board used for recruitment.
    - For third sector arm this will be based on details provided on Qualitrics.
- Informed consent will detail situations during which confidentiality will be breached due to risk. This will also be documented on the participant information sheet.
- The researcher will take part in a post interview debrief with CI and PI (if CMHT arm) after every interview.

5) Assessment of Risk

- Assessment of risk will be based on clinical experience and in discussion of cases with the CI (third sector arm) and PI, CI and client's HCP (CMHT Arm).
- The possibility of WARRN training is also under discussion with the project supervisor/course director.
- There are multiple opportunities for the disclosure (and thereby assessment) of current suicide risk, hereby referred to as stages of the project:
    - Collateral information provided from HCPs currently working with the participant (CMHT recruitment arm only).
    - Details provided on Qualitrics survey (third sector recruitment arm only).
    - Initial contact between researcher and participant.
    - Informed consent process.
    - Qualitative interview.
    - Debrief
    - Any contact after qualitative interview.
        - There is no plan for the researcher to contact individuals post debrief, however participants may contact the researcher.
- A historic suicide attempt is an inclusion criterion for the project. Therefore, all individuals reporting suicidal ideation will be assessed as high risk of future suicide.
    - Additional risk factors will be assessed (see WHO, 2012) including demographic, social, personal background and clinical features will be used to assess contributing risk factors.

[8] Although ethical approval was obtained for Skype interviews, all interviews were completed face-to-face.

The tables below summarise the operational and risk management plan of how disclosures of risk will be managed. In all situations the chief investigator will be updated and the principal investigator and relevant HCP (if participant is recruited through the CMHT arm).

6) **Disclosures of current suicidal ideation – (The same procedure applies for non-suicidal self-injury ideation).**

6.1) CMHT recruitment arm

Stage of Project	Possible Risk	Management Plan
Collateral information provided by HCP	HCP reports that client is currently expressing suicidal ideation. HCP reports that individual has expressed suicidal ideation recently although denied any current suicidal ideation.	Individual to not be recommended for recruitment. Contact to be made between researcher and prospective participant although suicidal ideation to be specifically discussed during the next phase. Inform PI and CI.
Initial contact between prospective participant and researcher	Prospective participant discloses suicidal ideation.	Individual not to be recruited. HCP to be informed of suicidal ideation so that clinical risk can be managed by CMHT. If HCP not present inform duty worker, PI and CI.
Informed consent	Individual discloses suicidal ideation. Individual declines consent to share information with HCP or GP. Individual declines consent and then discloses current suicidal ideation.	Individual not to be recruited. HCP to be informed of suicidal ideation so that clinical risk can be managed by CMHT. If HCP not present inform duty worker, field and project supervisor. Inform CI and PI. This will equate to the individual declining consent to participate and will not be able to be recruited to project. Inform PI and CI Inform individual that due to risk confidentiality will be broken and follow above plan. Inform CI and PI.
Qualitative interview	Individual discloses suicidal ideation. If individual discloses suicidal ideation and requests that information not be shared.	Stop qualitative interview. HCP to be informed of suicidal ideation so that clinical risk can be managed by CMHT. If HCP not present inform duty worker, CI and PI. Inform individual that due to risk confidentiality will be broken and follow above plan.
Debrief	Individual discloses suicidal ideation	Follow above plan.

Any contact after interview	Individual discloses suicidal ideation	Advise client to contact HCP and/or GP. Advise client to contact crisis team. Signpost to relevant services. Inform HCP so that clinical risk can be managed by CMHT. If HCP not present inform duty worker. Inform CI and PI.

6.2) Third sector arm

Stage of Project	Possible Risk	Management Plan
Details provided on Qualtrics survey	Prospective participant discloses that they are currently experiencing suicidal ideation during an open dialogue text box	Qualtrics survey advises client of appropriate management plan (e.g. contact GP, police, crisis team). Survey also informs individual that survey is not a support service nor staffed 24 hours. Inform CI.
Initial contact between prospective participant and researcher (phone call)	Prospective participant discloses suicidal ideation. Individual discloses suicidal ideation although does not engage in risk assessment over phone or ends phone call/becomes uncontactable.	Individual not to be recruited. Assess risk over phone (if identified as actively suicidal to follow plans in below sections 7.2). GP informed. Individual signposted to appropriate services including GP, local crisis team and Samaritans. Update CI. Inform GP Contact CI for further guidance (i.e. discussion around referring to emergency services).
Informed consent	Individual discloses suicidal ideation. Individual declines consent to share information with HCP or GP. Individual declines consent and then discloses current suicidal ideation.	Above plan followed. Inform CI. This will equate to the individual declining consent to participate and will not be able to be recruited to project. Inform CI. Inform individual that due to risk confidentiality will be broken and follow above plan. Inform CI.
Qualitative interview	Individual discloses suicidal ideation.	Stop qualitative interview. Researcher to complete assessment of risk (if identified as posing a risk of suicidal planning, behaviour or intent to follow plans below in 7.2). Inform GP. Individual signposted to appropriate services including GP, local crisis team and Samaritans. Update CI and request advice.

	If individual discloses suicidal ideation and requests that information not be shared.	Inform individual that due to risk, confidentiality will be broken and follow above plan.
Debrief	Individual discloses suicidal ideation	Follow above plan.
Any contact after interview	Individual discloses suicidal ideation Individual discloses suicidal ideation although does not engage in risk assessment over phone or ends phone call/becomes uncontactable.	Assess risk over phone (if identified as suicidal behaviour/planning to follow plans in below sections 7.2). GP informed. Individual signposted to appropriate services including GP, local crisis team and Samaritans. Update CI and request advice. Inform GP Contact CI for further guidance (i.e. whether to refer to emergency services).

7) <u>Current suicidal planning and behaviour – (The same procedure applies for current non-suicidal self-injury planning and behaviour).</u>

- If individuals are reporting suicidal ideation complete with a plan and behaviour, it should be assessed as high risk.
- The following table documents the process of responding to disclosures of suicidal planning and behaviour within the CMHT recruitment arm at each possible stages of the project.

7.1) CMHT recruitment arm

Stage of Project	Possible Risk	Management Plan
Collateral information provided by HCP	HCP reports that client is currently expressing suicidal planning and behaviour. HCP reports that individual has expressed suicidal planning and behaviour recently although denying any current suicidal ideation.	Individual not to be recommended for recruitment. Update PI and CI. To continue with recruitment if recent suicidal planning and behaviour is over six months, and if PI, CI, HCP and researcher agree that research project would not distress individual further or cause additional risk. If so, contact to be made between the researcher and prospective participant although suicidal ideation to be specifically discussed during the next phase.

Initial contact between prospective participant and researcher	Prospective participant discloses suicidal planning and behaviour.	Individual not to be recruited. HCP to be informed of risk so that clinical risk can be managed by CMHT. If HCP not present inform duty worker. Update CI and PI. If unable to contact HCP or CMHT contact crisis team in local area.
Informed consent	Individual discloses suicidal planning and behaviour during consenting for research project. Individual does not remain at service.	Individual to be requested to remain at service. HCP to be informed of suicidal ideation so that clinical risk can be managed by CMHT. If HCP not present inform duty worker. Update CI and PI. Inform HCP and follow above plan. HCP/CMHT to assess risk as appropriate (e.g. contact police/crisis team).
Qualitative interview	Individual discloses suicidal planning and intent. If individual discloses suicidal ideation and requests that information not be shared. Individual does not remain at service.	Stop qualitative interview and request individual remains at service for risk assessment by HCP. HCP to be informed of suicidal intent and planning so that clinical risk can be managed by CMHT. If HCP not present inform duty worker. Update CI and PI. Inform individual that due to risk, confidentiality will be broken and follow above plan. Update CI and PI. Inform HCP and follow above plan. HCP/CMHT to assess risk as appropriate (e.g. contact police/crisis team).
Debrief	Individual discloses suicidal planning and behaviour.	Follow above plan.
Any contact after interview	Individual discloses suicidal planning and behaviour.	Contact crisis team. Inform HCP so that clinical risk can be managed by CMHT. If HCP not present inform duty worker. Update CI and PI. Additionally, advise client to contact HCP and GP. Advise client to contact crisis team. Signpost to relevant services.

7.2) Third sector recruitment arm

Stage of Project	Possible Risk	Management Plan
Details provided on Qualtrics survey	Individual is asked if they are currently actively suicidal.	If say 'yes' individuals are taken to a page which advises them to contact emergency services and GP.
	Individual says 'No' to actively suicidal question although then remarks later in questionnaire in an open question that they are currently actively suicidal.	At the end of Qualtrics survey individuals are advised that the survey is not staffed 24 hours a day and they are advised to contact GP/crisis team/emergency services if they are actively suicidal. Update CI.
Initial contact between prospective participant and researcher (over phone).	Prospective participant discloses suicidal planning and behaviour.	Individual not to be recruited. Assess risk over phone (if identified as currently engaging in suicidal activity to follow plans in below section 8.2). Referral to local crisis team if client agreeable and safe to await their contact. GP informed. CI Updated.
	Prospective participant discloses suicidal planning and behaviour and does not feel safe to wait for referral to crisis team.	Refer to emergency services. Update GP. CI updated. Inform local crisis team.
	Prospective participant discloses suicidal planning and behaviour and the ends phone call/becomes uncontactable.	Contact local police force. Update GP. CI updated. Inform local crisis team.
Informed consent	Individual discloses suicidal planning and behaviour during consenting for research project.	Individual to be requested to remain at interview site (Cardiff university). Senior staff/CI consulted to assess risk further. Refer to emergency services. Update GP/local crisis team.
	Individual does not remain at interview site (Cardiff University).	Contact local police force. Contact GP. Update CI and seek advice. Update crisis team in participant's local area.
	Individual ends Skype call/becomes uncontactable (if interview completed over Skype)	Contact participant's local police force. Contact GP. Update CI. Update crisis team in participant's local area.

Qualitative interview	Individual discloses suicidal planning and behaviour	Stop qualitative interview Individual to be requested to remain at interview site (Cardiff University). Senior staff/CI consulted to assess risk further. Refer to emergency services. Update GP.
	Individual does not remain at interview site (Cardiff University).	Contact local police force. Contact GP. Update CI. Update crisis team in participant's local area.
	Individual ends Skype call/becomes uncontactable (if interview completed over Skype)	Contact participant's local police force. Contact GP. Update CI. Update crisis team in participant's local area.
	Individual requests that details not be shared.	Advise due to risk, confidentiality will be broken and follow above plan. Update CI.
Debrief	Individual discloses suicidal planning and behaviour.	Follow above plan. Update CI.
Any contact after interview	Participant discloses suicidal planning and behaviour.	Assess risk over phone (if identified as currently engaging in suicidal activity to follow plans in below section 8.2). Referral to local crisis team if client agreeable and safe to await their contact. GP informed. CI updated.
	Prospective participant discloses suicidal planning and behaviour and does not feel safe to wait for referral to crisis team.	Refer to emergency services. Update GP. CI updated. Inform local crisis team.
	Prospective participant discloses suicidal planning and behaviour and then ends phone call/becomes uncontactable.	Contact local police force. Update GP. CI updated. Inform local crisis team.

8) <u>Current suicidal activity – (The same procedure applies for current non-suicidal self-injury activity).</u>

- There is a risk that individuals may disclose to the researcher that they are currently engaging in suicidal activity. This could include an individual disclosing that they have just taken an intentional overdose or injured themselves.

- If a HCP states that an individual has recently engaged in suicidal attempt within the past six months then they will not be suitable to participate in the project. The exception to this is in the CMHT recruitment arm when the HCP, participant, CI, PI and researcher are all in agreement that the project will not overly distress the individual or increase risk.

8.1) CMHT recruitment arm

Stage of Project	Possible Risk	Management Plan
Collateral information provided by HCP	N/A – It is not likely that a HCP would refer an individual to the project if they are currently engaging in a suicidal activity.	N/A
Initial contact between prospective participant and researcher	Prospective participant discloses current suicidal activity/attempt.	Police, ambulance and crisis team to be contacted. HCP to be informed of risk so that on-going clinical risk can be managed by CMHT. If HCP not present inform duty worker. CI and PI to be updated.
Informed consent	Individual discloses current suicidal activity/attempt during consenting for research project. Individual does not remain at service.	Individual to be requested to remain at service. Seek support from CMHT clinical staff (including duty medic) CMHT clinical staff (nursing/medical) to manage clinical risk. HCP, duty worker, CMHT manager, CI and PI to be updated. Contact police. HCP to be informed. If HCP not present, inform duty worker. Update CI and PI.
Qualitative interview	Individual discloses current suicidal activity/attempt. If individual discloses current suicidal activity/attempt and requests that information not be shared.	Stop qualitative interview and request individual remains at service. Seek support from CMHT clinical staff (including duty medic). CMHT clinical staff (nursing/medical) to manage clinical risk. HCP, duty worker, CMHT manager, CI and PI to be updated. Inform individual that due to risk, confidentiality will be broken and follow above plan. Update CI, PI and HCP.

	Individual does not remain at service.	Contact police. HCP to be informed. If HCP not present inform duty worker. CI and PI updated.
Debrief	Individual discloses current suicidal activity/attempt.	Follow above plan. Update CI and PI.
Any contact after interview	Individual discloses current suicidal activity/attempt. Individual discloses current suicidal activity/attempt and does not provide further details (for example location or ends phone call and is non-contactable).	Obtain clients location. If client is at home advise to open doors to provide access. Advise client to remain at location and researcher to contact police/ambulance. HCP to be informed. If HCP not present inform duty worker at CMHT. CI and PI to be updated. Refer to emergency services with as much information as possible. HCP to be informed. If HCP not present inform duty worker at CMHT. CI and PI to be updated.

8.2) Third sector recruitment arm

Stage of Project	Possible Risk	Management Plan
Details provided on Qualtrics survey	Individual is asked if they are currently actively suicidal. Individual says 'No' to actively suicidal question although then remarks later in questionnaire in an open question that they are currently engaging in suicidal behaviour/attempt.	If say 'yes', individuals are taken to a page which advises them to contact emergency services and GP. Update CI. At the end of Qualtrics survey, individuals are advised that the survey is not staffed 24 hours a day and they are advised to contact GP/crisis team/emergency services if they are actively suicidal. Update CI.
Initial contact between prospective participant and researcher (over phone).	Prospective participant discloses current suicidal activity/attempt. Prospective participant discloses current suicidal activity/attempt and then ends phone call/becomes uncontactable.	Individual not to be recruited. Refer to emergency services. Inform local crisis team. GP informed. CI updated. Contact local police force/ambulance. Update GP. CI updated. Inform local crisis team.

Informed consent	Individual discloses current suicidal activity/attempt during consenting for research project.	Individual to be requested to remain at interview site (Cardiff University). Refer to emergency services. Senior staff/CI informed. Update GP. Update local crisis team.
	Individual discloses current suicidal activity/attempt and individual does not remain at interview site (Cardiff University).	Contact local police force. Contact GP. Update CI. Update crisis team in participant's local area.
	Individual discloses current suicidal activity/attempt and ends Skype call/becomes uncontactable (if interview completed over Skype)	Contact participant's local police force/ambulance. Contact GP. Update CI. Update crisis team in participant's local area.
Qualitative interview	Individual discloses current suicidal activity/attempt.	Stop qualitative interview Individual to be requested to remain at interview site (Cardiff University). Refer to emergency services. Senior staff/CI updated. Inform crisis team in participant's local area. Update GP.
	Individual discloses current suicidal activity/attempt and Individual does not remain at interview site (Cardiff University).	Contact local police force/ambulance. Contact GP. Update CI. Update crisis team in participant's local area.
	Individual discloses current suicidal activity/attempt and individual ends Skype call/becomes uncontactable (if interview completed over Skype)	Contact participant's local police force. Contact GP. Update CI. Update crisis team in participant's local area.
	Individual requests that details not be shared/referrals not made.	Advise due to risk, confidentiality will be broken and follow above plan. Update CI.
Debrief	Individual discloses suicidal planning and behaviour.	Follow above plans. Update CI.
Any contact after interview	Participant discloses current suicidal activity/attempt.	Refer to emergency services. Inform local crisis team. GP informed. Update CI.

	Participant discloses current suicidal activity/attempt and then ends phone call/becomes uncontactable.	Contact local police force/ambulance. Update GP. Update CI. Inform local crisis team.

9) <u>Risk to others</u>

- As part of gaining informed consent, participants will be informed that any disclosures which indicate that others are at risk will result in a breach of confidentiality.
- The research will follow legislative guidance outlined in The Care Act 2014 and Children's Act 2004 and national and local guidelines and policies.
- These will include reports that an adult may be at risk of neglect, physical abuse, domestic violence, sexual abuse, psychological/emotional abuse, financial/material abuse, modern slavery, discriminatory abuse and organisation/institutional abuse.
    - CMHT recruitment:
        - HCP, (duty worker if HCP not available), CMHT manager, CI and PI will be informed.
        - If immediate risks are concerned police and relevant MASH team to be informed (this decision will be made in consultation with the above).
    - Third sector recruitment:
        - CI will be informed.
        - Relevant MASH team to be informed (this decision will be made in discussion with the CI).
        - If immediate risks are identified, police to be contacted and CI updated.
    - Participants will be informed unless this poses a risk to the adult (decision made in discussion with the CI and MASH team).

- If during the interview participants disclose information that the researcher assesses as posing a possible risk to children (this include risk of neglect, sexual abuse, physical abuse and emotional/psychological abuse), the following plan will be followed:
    - CMHT recruitment:
        - HCP, (duty worker if HCP not available), CMHT manager, CI and PI will be informed.
        - If immediate risks are concerned police and relevant MASH team to be informed (this decision will be made in discussion with the above).
    - Third sector recruitment:
        - CI will be informed.
        - Relevant MASH team to be informed (this decision will be made in discussion with the CI).
        - If immediate risks are identified, police to be contacted in discussion with CI.
    - Participants will be informed unless this poses a risk to the child (decision made in discussion with the CI and MASH team).
- Disclosures of non-recent (historic) sexual abuse
    - Any disclosures of non-recent (historic) sexual abuse will follow published guidance from the British Psychological Society (BPS, 2016).
    - Prospective participants will be informed of this in the participant information sheet and this will form part of informed consent.

References

Barber, M., & Evans, R. (2017). *Suicide Prevention: Supporting Guidance for Practitioners. Relating to Adults, Children & Young People at risk of self harm and suicide.* Cardiff and Vale University Health Board.

British Psychological Society, 2016. *Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.* The British Psychological Society (BPS): Leicester.

Department of Health, (2014). *Information sharing and suicide prevention: Consensus statement.* [Online]. Department of Health (DoH): Crown Copyright. Retrieved from: http://www.nspa.org.uk/resources/information-sharing-and-suicide-prevention/ [Accessed on: 26/09/2018].

O'Connor, R. C., & Nock, M. K. (2014). The psychology of suicidal behaviour. *The Lancet Psychiatry, 1*(1), 73-85.

World Health Organisation. (2012). *Public Health Action for the Prevention of Suicide: A Framework.* [Online]. The World Health Organisation (WHO): Switzerland. Retrieved from: http://www.who.int/mental_health/publications/prevention_suicide_2012/en/ [Accessed on: 26/09/2018].

Appendix J. Word version of online Qualitrics questionnaire

The role of self-disgust in males who have attempted suicide

Start of Block: Default Question Block

Q39 **Welcome to the research project into the role of self-disgust in males who have attempted suicide.**

Page Break

Q01
Thank you for taking the time to consider participating in this research project. This research is being undertaken by Cardiff University, with support from [redacted][9] and other third sector agencies.

The aim of this project is to consider the role of the emotion of self-disgust in males who have attempted suicide. Self-disgust may not be a term which you are familiar with, although you don't need to have any knowledge of self-disgust to take part. This project will interview males who have attempted suicide to consider what role (if any) self-disgust plays in suicidal behaviour.

In order to take part in this research you will need to be male, over eighteen years old and have attempted to kill yourself in the past. Your safety is of the upmost importance to us and if your suicide attempt has been in the past six months, participating in this research may have the potential to be unhelpful. Therefore, we are unable to accept people whose suicide attempt has been in the past six months.

Suicide is the biggest cause of death in males under 40, making this an important area to study. Taking part in this research will involve being interviewed by a member of the research team about your experiences. Discussing suicide can be difficult and emotional; therefore, it is important that you understand what taking part may involve.

This survey will take about 10 minutes to complete and aims to provide some details about what taking part will involve and will ask you some questions about yourself and suicide. After answering certain questions the survey may inform you that it may not be appropriate for you to take part in the project. Please do not be offended if this occurs as it could be that taking part in an interview may not be helpful for you at this current moment in time.

This survey is related to the research project described above and it not staffed 24 hours.

[9] The names of third-sector organisations have been redacted to ensure anonymity

Whilst responses will be checked regularly it is important that you are aware that this is not a support website and if you are currently looking for support for suicide it is recommended that you exit this survey and contact you GP and The Samaritans on 116 123 or https://www.samaritans.org/

Page Break

Q2 Suicide is a highly emotional topic and therefore, it is important that you understand what will happen if you agree to take part. Before describing the research in more detail it is central that you are aware that this project is not suitable for individuals who are actively suicidal. This term refers to anyone who is currently planning to take their own life, or having thoughts to end their life which they intend on acting on. This term also refers to individuals who may be acting on a plan to end their own life (for example, currently taking an overdose). For individuals who are actively suicidal we would recommend the following: If you have currently acted on a plan (for example, currently overdosing or wounded yourself): - Please dial 999 (if not in the UK please dial the appropriate number for the emergency services) and ask for an ambulance. If you are currently planning to end your life: - Please call your GP (of family doctor/physician). - If you are currently working with a mental health service, such as a Community Mental Health Team (CMHT), please contact your named worker, or you can speak to a duty worker. - Please contact your local crisis team who can assist you in a psychiatric crisis. You can search for these online, additionally your GP can refer you. You can also find details by contacting NHS Direct Wales (0845 46 47) or contacting the NHS on 111. (If not in UK please contact your local psychiatric services). - You can access confidential support from the Samaritans (116 123). - You can access NHS support by calling 111 or by dialing 999 in an emergency (if not in the UK please dial the appropriate number for the emergency services). By following the above plan you will be able to access the most appropriate care and support in a timely fashion.

Q3 Please tick one response below which describes how you CURRENTLY feel

○ I am NOT actively suicidal (1)

○ I AM actively suicidal (2)

Page Break

End of Block: Default Question Block

Start of Block: Block 1

Q4 Thank you confirming that you are not currently actively suicidal and for continuing to find out more about the research project. The safety of you and your information is our priority. Therefore, it is important that you are aware that the details provided on this website are confidential. This survey relates to the previously described research project and it not staffed 24 hours. Whilst responses will be checked regularly it is important that you are aware that this is not a support website and if you are currently looking for support for suicide it is recommended that you exit this survey and contact your GP and The Samaritans on 116 123 or https://www.samaritans.org/ If you become actively suicidal during the process of this research, or in the future, we recommend the following: - Calling your GP (of family doctor/physician). - If you are currently working with a mental health service, such as a Community Mental Health Team (CMHT), contacting your named worker, or a duty worker. - Contacting your local crisis team who can assist in a psychiatric crisis. You can search for these online, additionally your GP can refer you. You can also find details by contacting NHS Direct Wales (0845 46 47) or contacting the NHS on 111. (If not in UK please contact your local psychiatric services). - You can access confidential support from the Samaritans (116 123). - You can access NHS support by calling 111 or by dialing 999 in an emergency (if not in the UK please dial the appropriate number for the emergency services).

Q5 Please select ONE statement below

○ If I become actively suicidal during the process of this project, I WILL follow the above advice (1)

○ If I become actively suicidal during the process of this project, I WILL NOT follow the above advice (2)

Page Break

End of Block: Block 1

Start of Block: Block 2

Q6 Thank you for continuing to express your interest in this research project. If you agree to take part in the project an interview will be arranged. During this interview you and the researcher will discuss your history of suicide attempts and whether this may be associated with the emotion of self-disgust. As mentioned earlier, you do not need to have any knowledge of self-disgust to take part. Previous research which has interviewed people about suicide report that individuals have found participating in research as a helpful experience. However, the research team are mindful that we will be asking you questions of a highly emotional nature and there may be a risk that you may become upset as part of the interview process. There will be time at the end of the interview to discuss your feelings about being asked these questions to ensure that you do not leave feeling distressed. Additionally, you always have the right to end the interview and withdraw your information, even after completing the interview. As your safety is our primary concern we will need to take additional steps to ensure that you are safe in the event that you report active suicidal behaviour or planning before, during or after the interview. These steps will require you to provide your name, address, contact details and GP details. If during the interview you report any details that cause the researcher to be concerned about your wellbeing your GP will be informed. Your GP will be informed in the following situations: - A report that you are currently actively suicidal. - A report that you have intent to end your life in the future. - A report of deliberate self-harm, or plan to deliberately self-harm, without the intent to end your life. - A report of any plan to harm someone else. - Any report which may make the researcher concerned of the welfare of anyone under eighteen.

Q7 Please select ONE of the statements below

○ I understand the above statement and CONFIRM to provide my name, address and GP details (1)

○ I understand the above statement and DECLINE to provide my name, address and GP details (2)

End of Block: Block 2

Start of Block: Block 6

Q8 Please select your gender

○ Male (1)

○ Female (2)

End of Block: Block 6

Start of Block: Block 6

Q9 Please write your name in the box below

____

Q10 Please write you date of birth in the space below in the format dd/mm/yyyy

____

Q11 Please write your address in the space below

- Address Line 1 (1) ____
- Address Line 2 (2) ____
- Town (3) ____
- County (4) ____
- Postcode (5) ____

Q12 Please enter your phone number in the space below (please ensure you place the area code if applicable)

____

Q12b Please enter your e-mail address in the space below

____

Q12c Please write your GP details in the space below

- ○ GP Surgery Name (1) ____
- ○ GP Address Line 1 (2) ____
- ○ Town (3) ____
- ○ County (4) ____
- ○ Postcode (5) ____
- ○ Telephone Number (6) ____

Q13 In addition to their GP, some people may access specialist support (for example, community mental health teams; CMHTs). If you are accessing any additional support and are happy to provide consent for the researchers to contact them, please write their details below. The same criteria for contacting your GP would apply to any additional services you provide consent for.

- ○ Name of Service (1) ____
- ○ Address Line 1 (2) ____
- ○ Address Line 2 (3) ____
- ○ Town (4) ____
- ○ County (5) ____
- ○ Postcode (6) ____
- ○ Telephone Number (7) ____
- ○ Name of worker (8) ____

End of Block: Block 6

Start of Block: Block 7

Q14 These next questions relate to your experience of suicide attempts. Whilst we realise that some of these questions may be difficult to answer we would appreciate if you would answer each question to the best of your ability.

Q15 Have you ever attempted to kill yourself?

○ Yes (1)

○ No (2)

End of Block: Block 7

Start of Block: Block 3

Q16 When did you last attempt to kill yourself?

○ 0-6 months ago (1)

○ 6-12 months ago (2)

○ 12-24 months ago (3)

○ Over two years ago (4)

End of Block: Block 3

Start of Block: Block 8

Q17 During your most recent attempt to kill yourself, did you want to die?

○ I attempted to kill myself, but did not want to die (1)

○ I attempted to kill myself, and really wanted to die (2)

Q18 During your most recent attempt to kill yourself, did you leave a suicide note?

○ No (1)

○ I thought about writing a note but didn't (2)

○ I wrote a note although tore it up/threw it away (3)

○ Yes (4)

Q19 During your most recent suicide attempt, did you tell anybody or did anybody find you?

○ I told somebody I was planning to kill myself (1)

○ I told someone after I had acted on my plans to kill myself (for example, taken overdose and then contacted someone) (2)

○ Somebody disturbed me/found me (3)

○ None of the above (4)

○ Other (5) ____

Q20 Did you require medical treatment as a result of your most recent attempt to kill yourself?

○ I woke up in hospital (1)

○ I took myself to hospital (2)

○ I called an ambulance (3)

○ I was conscious and someone else called an ambulance (4)

○ No medical treatment was accessed (5)

○ I informed my GP some time after (6)

○ Other (7) ____

Q21 In the box below please describe the method that you attempted to kill yourself and any other information you feel may be relevant to your most recent suicide attempt.

____
____
____
____
____

Q22 Prior to your most recent attempt to kill yourself, how many previous attempts have you made?

- ◯ None (1)
- ◯ One or Two (2)
- ◯ Three or More (3)

Page Break

Q23 Thank you for taking the time to complete this information, whilst we understand that the questions are difficult we appreciate you taking the time to complete them. The information that you have provided indicates that you may be suitable to take part in the research project. Taking part in the project will involve completing an interview about your attempts to kill yourself and whether in anyway self-disgust was a factor. You will also be asked to complete two questionnaires. There will be an opportunity before and after the interview to discuss any questions you have. It is important that you know what is involved if you agree to participate in the project. It is therefore recommended that you read the participant information sheet attached. This information sheet also provides contact details for the research team in case you have any further questions. Iras project id 256996 – research project – participant information sheet version 4.0 The interview will be arranged for a time that is convenient for you. The interview can be conducted face to face or via Skype and you will be reimbursed for any travel expenses. All information you provide during an interview, including the information on this website, will be kept confidential unless the research team are concerned around possible risk.

Q24 Would you be interested in participating in the research project?

- ◯ Yes (1)
- ◯ I would like some more information and would like to talk to a member of the research team (2)
- ◯ No (3)

End of Block: Block 8

Start of Block: Block 8

Appendix K. Participant demographic and suicide questionnaire

NHS logos redacted for anonymity

Third-sector logos redacted

This form asks you certain demographic questions. We would be grateful if you could complete each question. If you would prefer not to answer a question, please write either n/a or tick the 'rather not say' box. The information you provide will be helpful in the data analysis. The information you provide on this form will be anonymised and will remain confidential and you will not be able to be identified by any of the answers you give. Any information that you provide will be stored and used in accordance with Data Protection and GDPR legislation. If you have any questions, please ask the researcher.

Please write you age in the following space ______________________________

How would you describe your ethnic group?

White – British	
White – Irish	
White – Gypsy or Irish Traveller	
White – Other	
Mixed/Multiple Ethnic Group – White and Black Caribbean	
Mixed/Multiple Ethnic Group – White and Asian	
Mixed/Multiple Ethnic Group – White and Black African	
Mixed/Multiple Ethnic Group – Other	
Asian/Asian British – Indian	
Asian/Asian British – Pakistani	
Asian/Asian British – Bangladeshi	
Asian/Asian British – Chinese	
Asian/Asian British – Other	

Black/Black British - African	
Black/Black British – Caribbean	
Black/Black British – Other Black	
Other Ethic Group – Arab	
Other Ethnic Group – Other	
Prefer not to say	

How would you describe your sexual orientation?

Heterosexual (straight)	
Gay	
Bisexual	
Other	
Prefer not to say	

What is your marital status?

Divorced or Separated	
Married/civil partnership/cohabiting	
Single	
Widowed	
Prefer not to say	

If you have ever been diagnosed with any mental health conditions, please write these below

____

____

____

These next questions relate to your experience of suicide attempts. We appreciate that some of these questions may be very difficult to answer, however we would be grateful if you could try to answer each question. Please speak to the researcher if you have any concerns or questions.

When did you last attempt to kill yourself?

0-6 Months ago	
6-12 Months ago	
12-18 Months ago	
18-24 Months ago	
Over 24 Months ago	

During your **most recent** attempt to kill yourself, did you want to die?

I attempted to kill myself, but did not want to die.	
I attempted to kill myself, and really wanted to die.	

During your **most recent** attempt to kill yourself, did you leave a suicide note?

No	
I thought about writing a note but didn't.	
I wrote a note although tore it up/threw it away.	
Yes	

During your **most recent** suicide attempt, did you tell anybody, or did anybody find you?

I told someone I was planning to kill myself.	
I told someone after I had acted on my plans to kill myself (for example taken an overdose and then contacted somebody).	
Somebody disturbed me/found me.	
None of the above.	
Other ______________________	

Did you require medical treatment as a result of your **most recent** attempt to kill yourself?

I woke up in hospital.	
I took myself to hospital.	
I called an ambulance.	
I was conscious and somebody else called an ambulance.	
No medical treatment was accessed.	
I informed my GP some time after.	
Other ____________________________________	

We appreciate that these questions can be very difficult to answer and thank you for taking the time to complete this form. In the box below, we would be grateful if you would be able to describe the method that you used in your most recent suicide attempt and any other information you feel may be relevant to your **most recent** suicide attempt.

Prior to your most recent attempt to kill yourself, how many previous attempts have you made?

None	
One	
Two	
Three	
Four or More	

Thank you very much for taking the time to fill out this questionnaire. If you have any questions, please ask a member of the research team.

Appendix L. The revised Self-Disgust Scale (SDS-R), Powell et al. (2015)

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide – The Self-Disgust Scale Revised (SDS-R; Powell, Overton & Simpson, 2015 p.255).

This questionnaire is concerned with how you feel about yourself. When responding to the statements below, please circle the appropriate number according to the following definitions:

1 = Strongly disagree; 2 = Very much disagree; 3 = Slightly disagree; 4 = Neither agree nor disagree; 5 = Slightly agree; 6 = Very much agree; 7 = Strongly agree.

		Strongly disagree						***Strongly agree***
1	I find myself repulsive	1	2	3	4	5	6	7
2	I am proud of who I am	1	2	3	4	5	6	7
3	I am sickened by the way I behave	1	2	3	4	5	6	7
4	Sometimes I feel tired	1	2	3	4	5	6	7
5	I can't stand being me	1	2	3	4	5	6	7
6	I enjoy the company of others	1	2	3	4	5	6	7
7	I am revolting for many reasons	1	2	3	4	5	6	7
8	I consider myself attractive	1	2	3	4	5	6	7
9	People avoid me	1	2	3	4	5	6	7
10	I enjoy being outdoors	1	2	3	4	5	6	7
11	I feel good about the way I behave	1	2	3	4	5	6	7
12	I do not want to be seen	1	2	3	4	5	6	7
13	I am a sociable person	1	2	3	4	5	6	7
14	I often do things I find revolting	1	2	3	4	5	6	7
15	I avoid looking at my reflection	1	2	3	4	5	6	7
16	Sometimes I feel happy	1	2	3	4	5	6	7
17	I am an optimistic person	1	2	3	4	5	6	7
18	I behave as well as everyone else	1	2	3	4	5	6	7
19	It bothers me to look at myself	1	2	3	4	5	6	7
20	Sometimes I feel sad	1	2	3	4	5	6	7
21	I find the way I look nauseating	1	2	3	4	5	6	7
22	My behaviour repels people	1	2	3	4	5	6	7

Powell, P. A., Overton, P. G., & Simpson, J. (2015). *The revolting self: Perspectives on the psychological, social, and clinical implications of self-directed disgust.* Karnac books.

Appendix M. Participant information sheet

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide

Participant information sheet (version 4.0)

We would like to invite you to take part in a research study to help us understand more about the role of self-disgust in male suicide. We understand that suicide can be an extremely emotive and sensitive topic, therefore it is important that you know what taking part in this study may involve. This information sheet provides details about the study. Before you decide to take part, it is important for you to understand why the study is being done and what will be involved if you take part. Please read the following information sheet carefully before deciding whether to take part and ask the researcher any questions if there is anything you don't understand or would like more information on.

The researchers

My name is David Mason and I am a Trainee Clinical Psychologist on the South Wales Doctoral Programme in Clinical Psychology based at Cardiff University. I am carrying out this project as part of my training. The research is being supervised by Dr John Fox (Clinical Psychologist and Clinical Director, South Wales Doctoral Programme in Clinical Psychology). The project also has additional supervisors in the NHS which will apply to you if you have been approached to take part in this study from an NHS mental health service.

What is the purpose of the research?

This study aims to gain an understanding of the experience of men who have attempted suicide and whether an emotion called self-disgust was an element in this. You do not need to have heard of self-disgust to take part. Research in the past has focused largely on feelings of depression, helplessness and stress on men who have considered or attempted suicide. However, there is growing evidence that self-disgust plays an important role in some mental health difficulties. It is hoped that this research will see whether this emotion plays a role in male suicide. This will help healthcare professionals to be better able to assess suicide risk and also consider interventions which may help individuals who experience self-disgust.

Why have I been invited to take part in the research?

You have been invited to take part because you have attempted suicide in the past. The research is being promoted by [redacted], or other organisations and you may have responded to an advert on their website, social media or newsletters. You may have also been approached by a member of your NHS care team because you are eligible to take part. To summarise, you have been invited to take part in the research because you are: male; have attempted suicide in the past; are not currently suicidal; and agree to provide your name, address, contact details and GP details in case of an emergency. If these details are not correct please contact the researcher (contact details below), unless you are currently suicidal, in which case we recommend you contact your GP and the emergency services.

What exactly is involved if I agree to take part?

If you decide to take part in the research, you will be interviewed about your experiences of suicide and self-disgust. As mentioned earlier you do not need to know about self-disgust to take part. The interview may take up to an hour, although this will depend on how much you want to talk. You may wish to take some breaks during the interview and you can take as many as you need. Please inform the researcher if you feel that you need a break. To make sure I do not miss any of the important things you say I will record the interview with an audio-recorder. Following this, I will write out the interview 'word-for-word', which is called an interview transcript. The interview will be completed at a time and day that is convenient for you and will take place at Cardiff University or via Skype. If you have been approached to take part by your health care professional, the interview can also take place at your local community mental health team (CMHT) or therapy service (if open to [details redacted]

Before the interview, you will also be asked to complete two short questionnaires. This will take around 5-10 minutes to complete. We will be able to provide you with any support you might need to complete these.

We understand that discussing suicide is a very sensitive topic. Therefore, we will ensure that there is plenty of time after completing the interview and questionnaires to ensure that you are feeling okay.

What will happen after my interview?

You will not need to do anything else once you have completed your interview although you will be able to contact the research team if you have any further questions. The researcher will be completing other interviews and will be comparing these transcripts with yours to see if there are common themes. These themes will then form the basis of a report which we aim to get published to help increase awareness of self-disgust and male suicide.

Do I have to take part?

It is entirely up to you to decide to take part in the study. Please ask the researcher if you have any questions or worries around taking part. If you are interested in participating, you will be asked to sign a consent form and you will have an opportunity to ask questions before the interview begins. Whether you choose to participate in the study, or not, will have no impact on any current or future support you receive from [redacted] or the NHS.

What are the possible disadvantages of taking part?

It is important to know that during the interview you will be asked about your experience of suicide. This will include describing suicide attempts you have made in the past and the thoughts and emotions which were present at this time. You will also be asked questions on what was happening in your life during the period leading up to, and since, your suicide attempt(s). We understand how sensitive and emotional these questions may be and whilst every attempt will be made to provide a safe environment, it is possible that you could find the interview upsetting. We will only talk about things which you feel comfortable and able to discuss and you do not have to talk about anything that you do not wish to. You can take as many breaks as you need to during the interview and you are also able to stop the interview. After the interview we will have a debrief. This is an opportunity to discuss any feelings or thoughts which came up as part of the interview and to provide a space for you to talk about what it was like answering questions on suicide. During the debrief there will also be an opportunity for you to ask any further questions about the research. This discussion will not be audio-recorded. As part of the debrief you will also be provided with details on helplines, support services and advice on what to do if you ever feel suicidal in the future.

What are the benefits of taking part?

Whilst taking part in the study will not benefit you directly, it is hoped that the project will lead to a greater understanding of the reasons why some men choose to attempt suicide and to a greater knowledge of the role of self-disgust in mental health difficulties. This may help services to be better able to assess and support individuals who are suicidal in the future. The findings may also lead to future research in the area of male suicide to add to the literature.

Will my participation in the study be confidential?

Your participation in the research will be kept strictly confidential. Only the research supervisors and I will know that you have taken part. If you have been asked to take part by your health care professional in an NHS service, then this member of staff may also know that you have taken part. After the interview, an anonymised transcription will be made of the recording which you will not be able to be identified from. There is a possibility that an external transcription service may be used to transcribe the interviews and these services will have a confidentiality agreement with Cardiff University to ensure your confidentiality. All information will be made anonymous and you will not be able to be identified by reading any report of the project's findings. All names of participants, services and geographical locations will be removed to protect your identity. Sometimes, direct quotes from interviews will be used to demonstrate findings in the final report and a pseudonym will be used to prevent identification. The anonymised transcripts and copies of the questionnaires will be kept at the university for 15 years in a secure location and will then be destroyed. All of your personal information is used in adherence to data protection legislation and General Data Protection Regulation (GDPR). If applicable, this includes information entered on the Qualtrics website.

Are there any situations when the researcher may have a duty to disclose my information?

Your safety and the safety of others is of paramount importance and there may be times when your confidentiality cannot be maintained. It is important that you are aware of under what circumstances your confidentiality will be broken, which are described below:

- *If you tell the researcher that you are currently thinking about committing suicide.*
- *If you tell the researcher that you have a plan to end your life in the future.*
- *If you tell the researcher that you are currently attempting suicide.*
- *If you tell the researcher about any thoughts or plans to harm yourself without the intention to die.*
- *If you tell the researcher about any plans to harm somebody else.*
- *If you mention details which raises concerns about a vulnerable adult.*
- *If, during the discussion, you mention details which raises concerns about someone under 18.*
- *If you have previously been a survivor of childhood sexual abuse and you disclose that you are aware that the perpetrator still has access to children.*

It is important that you are aware that if you mention any of the above, that your information will be passed to services to support you and keep you, and others safe. These services may include your GP, your local crisis team, the emergency services and the police. This includes concerns raised during discussions with the researcher before, during or after the interview. Discussions regarding how to best ensure your own and other's safety will be held with the research supervisor. You will be informed of any information that is shared with other services.

IF YOU HAVE ANY QUESTIONS ABOUT CONFIDENTIALITY, PLEASE ASK THE RESEARCHER BEFORE THE INTERVIEW.

Research Sponsor's General Data Protection Regulation (GDPR) Statement:

Cardiff University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Cardiff University will keep identifiable information about you for 15 years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection. The University's Data Protection Officer can be contacted at: inforequest@cardiff.ac.uk

Cardiff University will collect information from you for this research study in accordance with our instructions.

The NHS and Cardiff University will use your name and contact details to contact you about the research study, and to make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from Cardiff University and regulatory organisations may look at your medical and research records to check the accuracy of the research study. The NHS will pass these details to Cardiff University along with the information collected from you. The only people in Cardiff University who will have access to information that identifies you will be people who are conducting the research and analysing the information and those who might need to contact you to audit the data collection process.

Cardiff University will keep identifiable information about you from this study for 15 years after the study has finished.

What happens if I decide after the interview that I don't want to take part?

You can withdraw from the research at any time by letting me know. If during the interview you wish to stop you can just tell me. If after the interview you decide you want to withdraw you can contact me and ask me to remove your information and interview recording. You will not need to provide a reason for deciding to withdraw. If you withdraw, it will not affect any current or future support you receive from services, including [redacted] and the NHS.

What will happen with the study's findings?

The findings will be written in a report which will be sent to a journal for publication. You will not be able to be identified in any report or publication that follows this study. The findings will be written up and submitted to Cardiff University in order to fulfil the requirements for a Doctorate in Clinical Psychology.

Will I be paid for this study?

You will not be paid to take part in this study. Travel expenses can be paid for you to travel to an interview, but you will be asked to provide a receipt. You will receive a cash refund when you attend for your interview.

Who has reviewed this study?

This study has been reviewed and approved by Wales Research Ethics Committee 6. This review is to protect your safety, rights, dignity and wellbeing (REC Reference: 19/WA/0025; IRAS Project ID: 256996).

What if I have a concern or complaint about this study

If you have any concerns or complaints about this project, please direct these in the first instance to Dr John Fox (Clinical Director). 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. Telephone: 02920 870582.
You can also receive advice relating to concerns and complaints by contacting Cardiff University's Research Governance Team by e-mailing resgov@cardiff.ac.uk

Further Information and Contact Details
If you have any further questions about taking part in this study, please do not hesitate to contact the research team. In the first instance please contact the project lead:

	Project Lead	**Chief Investigator**	**Research Team** [Details Redacted]	**Research Team** [Details Redacted]	**Research Team** [Details Redacted]
Name	**David Mason**	**Dr John Fox**	[Details Redacted]	[Details Redacted]	[Details Redacted]
Organisation	Cardiff University	Cardiff University	[Details Redacted]	[Details Redacted]	[Details Redacted]
Role	Trainee Clinical Psychologist	Clinical Psychologist/ Clinical Director	Clinical Psychologist	Lead Consultant Clinical Psychologist	Consultant Clinical Psychologist
E-mail	MasonD2@ Cardiff.ac.uk	FoxJ10@ Cardiff.ac.uk	[Details Redacted]	[Details Redacted]	[Details Redacted]
Telephone	02920 870582	02920 870582	[Details Redacted]	[Details Redacted]	[Details Redacted]
Address	South Wales Doctoral Programme in Clinical Psychology, School of Psychology, 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT.		[Details Redacted]	[Details Redacted]	[Details Redacted]

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION AND FOR YOUR INTEREST AND CONSIDERATION IN TAKING PART IN THIS RESEARCH

Appendix N. Participant informed consent form

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide – Participant consent form

Research into the role of self-disgust in men who have attempted suicide.

Please read all six pages of the participant information sheet before completing this form.

Below is a list of statements. Please read each statement and initial the box next to it to confirm that you agree with the statement.

After placing your initials next to the statements, please sign page two of this form if you wish to participate in the research project.

If anything on this form is unclear, please speak to the researcher before signing.

I have read all six pages of the participant information sheet (Version 4.0) and have been given a copy to take home. ☐

Before agreeing to take part, I was given the opportunity to ask any questions about the research project and have had any questions answered to my satisfaction. ☐

I am aware that any identifiable information and details I provide will be removed. This information will then be documented in a report that will be shared both within and outside the NHS, Cardiff University and [redacted]. ☐

I am aware that any information I provide will be made anonymous and used in a report based on the research findings. This includes direct quotes from interviews. I will not be able to be identified by any report based on the research findings. ☐

I am aware that if I share any information suggesting that myself, or anyone else may be at risk of harm, that this information will be shared with the appropriate services. ☐

I am aware that if I report any thoughts, plans or actions to harm myself that the project supervisor, my GP and my current care team (if relevant) will be notified. In an emergency the research team may also contact the emergency services and/or my local crisis team. This includes any concerns reported to the researcher after the interview. ☐

I understand that my participation is voluntary and that I can withdraw my consent to take part at any time. I can withdraw my consent after the interview has been completed. I do not need to provide a reason for withdrawing and this will not affect any current or future treatment. ☐

I consent to completing two questionnaires and to take part in an interview which will be audio-recorded and transcribed. ☐

I consent to take part in the research project. ☐

Name of participant ……………………………………………………………. Date ……………………………

Signature of participant ……………………………………………………………….

Name of researcher ……………………………………………………………. Date ……………………………

Signature of researcher ……………………………………………………………….

Appendix O. Participant debrief sheet

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide – Participant debrief sheet (version 1.2)

Research into the role of self-disgust in men who have attempted suicide.

Thank you very much for taking part in this study. This project aims to explore the experiences of males who have attempted suicide and to see whether the emotion of self-disgust was relevant to people's experiences. This project will be talking to people about their experiences of suicide and they will also complete an interview, similar to the one that you just completed. The interviews will then be compared to see if there are any common themes across the men who took part.

You completed two questionnaires prior to the interview; one which asked questions around suicide and another around self-disgust. The answers you gave will be converted into scores which will also be compared to the scores of other men who took part in the study. Your responses on the questionnaires and the interview will remain confidential and anonymous.

Suicide remains the biggest cause of death for men under 45 in the UK. This study will add to the literature on this area and it is hopeful that this project will provide further insights into the complex area of suicide and will provide ideas for future research. The findings of this project will be submitted to an academic journal to enrich the literature on male suicide. You will not be able to be identified by any reports based on the findings of the project.

Individuals who have participated in the project will be able to receive a summary of the findings of the study. If you are interested in receiving a summary of the results, please fill out the information on page three of this form.

Further support

Talking about your experiences of suicide and self-disgust can be upsetting and this may have been a difficult conversation for you. This is understandable and some people may feel slightly low after talking about difficult times in their life. It may be good to make arrangements to do something nice (like meeting a friend for a coffee) after the interview. If you are feeling low after the interview, please speak to the researcher before you leave.

If you feel low and would like to access support after the interview you can get help from the following:

- You can contact your GP and ask for an emergency appointment or a phone consultation, during which you can discuss any feelings you have after the interview.
- You may have some individual strategies which help when you are feeling low. These may include talking to friends or family, or other self-care strategies like listening to your favourite music, watching your favourite film or eating a nice meal.
- If you are working with a community mental health team you can contact your worker there and discuss how you are feeling. If, for any reason, your worker is not there, you will be able to speak to a duty worker.
- If you feel in a mental health crisis you can contact your local crisis team who are available over the phone. If you do not have the contact details for your local crisis team you can contact NHS 111, by dialling 111, or NHS Direct in Wales, by dialling 0845 46 47.
- In an emergency you can always contact the emergency services or attend A&E.

Helplines

There are also a number of organisations and charities that offer support. You may find some of these helpful.

Mind provide advice and support to empower anyone experiencing a mental health problem. They campaign to improve services, raise awareness and promote understanding. Mind provide local services and helpful information and resources, including information in the Welsh language.

They provide advice and information on their website https://www.mind.org.uk/ and also have a Mind Info Line open 9am – 6pm, available by calling 0300 123 3393.

"We offer a safe place for you to talk any time you like, in your own way – about whatever's getting to you. You don't have to be suicidal. We're here round the clock, 24 hours a day, 365 days a year. If you need a response immediately, it's best to call us on the phone. This number is FREE to call. You don't have to be suicidal to call us".

You can contact Samaritans by calling 116 123 or e-mailing jo@samaritans.org

Samaritans also have a Welsh Language Line (Llinell Gymraeg): 0808 164 0123

The Campaign Against Living Miserably (CALM) is an award-winning charity dedicated to preventing male suicide. Their helpline is open daily, 5pm-middnight 0800 58 58 58. They also have information and webchat facilities on their website https://www.thecalmzone.net/

If you have any further questions in relation to this study, please contact the research team on the details below. You can also receive advice relating to concerns and complaints by contacting Cardiff University's Research Governance team by e-mailing resgov@cardiff.ac.uk.

Project Lead:	Name:	David Mason
	Role:	Trainee Clinical Psychologist
	E-mail:	MasonD2@Cardiff.ac.uk
	Telephone:	02920 870582
	Address:	South Wales Doctoral Programme in Clinical Psychology, 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT.
Chief Investigator:	Name:	Dr John Fox
	Role:	Clinical Psychologist and Clinical Director
	E-mail:	FoxJ10@Cardiff.ac.uk
	Telephone:	02920 870582
	Address:	South Wales Doctoral Programme in Clinical Psychology, 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT.

ONCE AGAIN, THANK YOU FOR YOUR TIME AND FOR TAKING PART IN THIS RESEARCH PROJECT

If you would like to receive a summary of the results please provide your name and address on the details below and return the slip to the researcher before you leave. These details will be stored in adherence to data protection legislation and GDPR regulations

- -

Name ……………………………………………………………….

Address ……………………………………………………………

……………………………………………………………

Post Code ………………………………………………………

Appendix P. Approval letters

Appendix P1. Confirmation of research sponsorship from Cardiff University

Research and Innovation Services

Gwasanaethau Ymchwil ac Arloesi

Cardiff University
McKenzie House, 7th Floor
30-36 Newport Road, Cardiff
CF24 0DE, Wales, UK
Tel +44(0)29 2087 5834
www.cardiff.ac.uk

Prifysgol Caerdydd
Tŷ McKenzie, 7fed Llawr
30-36 Heol Casnewydd, Caerdydd
CF24 0DE, Cymru, DU
Ffôn +44(0)29 2087 5834
www.caerdydd.ac.uk

26th November 2018

Dr John Fox
School of Psychology
Cardiff University
Tower Building
Park Place
Cardiff
CF103AT

Dear Dr Fox,

A qualitative examination into the role of self-directed disgust in males who attempt suicide: a grounded theory approach (Self-Disgust in Male Suicide)

I understand that you are acting as Chief Investigator and Academic Supervisor for the above DClinPsy project to be conducted by David Mason.

I confirm that Cardiff University agrees in principle to act as Sponsor for the above project, as required by the UK Policy Framework for Health and Social Care Research.

Scientific Review
I can also confirm that Scientific Review has been obtained from: Dr Dougal Hare and Dr Heledd Lewis (members of the DClinPsy clinical and teaching staff).

Insurance
The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals
On completion of your IRAS form (required for NHS REC and HRA/HCRW/NHS R&D permission), you will be required to obtain signature from the Research Governance team for the 'Declaration by the Sponsor Representative'. Please note that you are also required to provide the Statement of Activities and Schedule of Events to the Research Governance team for review prior to submission to HRA/HCRW.

Please then submit the project to the following bodies for approval:

- an NHS Research Ethics Committee;
- Health & Care Research Wales (HCRW)- to arrange HCRW Approval for Welsh NHS sites.

The University is considered to have accepted Sponsorship when Research and Innovation Services has received evidence of the above approvals. **Once an NHS organisation has confirmed capacity and capability, responsibility lies with the Chief Investigator (or their appropriate delegate) to follow an appropriate 'green light' procedure to open the study at that Site.**

Roles and Responsibilities
As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the UK Policy Framework for Health and Social Care Research. In accordance with the University's Research Integrity & Governance Code of Practice, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfil their delegated roles including ensuring adequate supervision, support and training.

Registered Charity, no. 1136855
Elusen Gofrestredig, rhif 1136855

If your study is adopted onto Health & Care Research Wales Clinical Research Portfolio you are required to upload recruitment data onto the portfolio database.

Contracts

- The HRA statement of activities will act as the agreement between the sponsor and participating NHS organisations.

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

- register clinical trials in a publicly accessible database before recruitment of the first participant and ensure that the information is kept up to date
- ensure you are familiar with your responsibilities under the UK Policy Framework for Health and Social Care Research;
- undertake the study in accordance with Cardiff University's Research Integrity & Governance Code of Practice (available on the Cardiff University Staff and Student Intranet) and the principles of Good Clinical Practice;
- ensure the research complies with the General Data Protection Regulation 2016/679;
- where the study involves human tissue, ensure the research complies with the Human Tissue Act and the Cardiff University Code of Practice for Research involving Human Tissue (available on the Cardiff University Staff and Student Intranet);
- inform Research and Innovation Services of any amendments to the protocol or study design, (including changes to start /end dates) and submit amendments to the relevant approval bodies;
- respond to correspondence from the REC and NHS organisation R&D offices within the required timeframes;
- co-operate with any audit, monitoring visit or inspection of the project files or any requests from Research and Innovation Services for further information.

You should quote the following unique reference number in any correspondence relating to Sponsorship for the above project:

SPON1703-18

This reference number should be quoted on all documentation associated with this project.

Yours sincerely

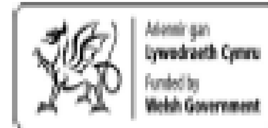
Dr K J Pittard Davies
Head of Research Governance and Contracts
Direct line: +44 (0) 29208 79274
Email: resgov@cardiff.ac.uk

Cc: David Mason.

Appendix P. Approval letters

Appendix P2. Wales Research Ethics Committee (REC) 6 approval REC reference: 19/WA/0025

Gwasanaeth Moeseg Ymchwil
Research Ethics Service



Wales REC 6
Fourth Floor
Institute of Life Science 2
Swansea University
Singleton Park
Swansea
SA2 8PP

Telephone : 01792 606334
E-mail : penny.beresford@wales.nhs.uk
Website : www.hra.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

25 February 2019

Dr John Fox
Clinical Director/ Senior Lecturer in Clinical Psychology
Cardiff University (Hon)/Cardiff and Vale University Health Board
Cardiff University School of Psychology
11th Floor Tower Building
Park Place, Cardiff
CF10 3AT

Dear Dr Fox

Study title:	**A Qualitative Examination into the role of Self-Directed Disgust in Males who have Attempted Suicide. A Grounded Theory Approach.**
REC reference:	**19/WA/0025**
IRAS project ID:	**258998**

The Research Ethics Committee reviewed the above application at the meeting held on 20 February 2019. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request.
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below:

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. The name of the reviewing REC [Wales Research Ethics Committee 6] should be added under the heading "Who has reviewed the study?" on the information sheet.

2. Points 3 & 5 on the consent form are the same, therefore one of these points can be removed.

3. Please reword the word 'anonymised' on the consent form to be more understanding.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

Notice of no objection must be obtained from the Medicines and Healthcare products Regulatory Agency (MHRA).

The sponsor is asked to provide the Committee with a copy of the notice from the MHRA, either confirming no objection or giving grounds for objection, as soon as this is available.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Extract of the meeting minutes

Social or scientific value; scientific design and conduct of the study

The Committee agreed that this was a fairly straightforward project which involves recruiting 15 males and asking them to complete 3 questionnaires. The subjects will have in the past attempted suicide. This is a non interventional study which is attempting to give a better understanding about how the issue of self-disgust fits into the process that culminates in attempted suicide. The study follows a grounded theory model and the Committee is being asked to look at the first part of the study. The Committee agreed that this was well planned and documented. It was also agreed that this was a thoroughly worthwhile study and may lead to improvement in predicting those at risk.

The Committee noted that the reference of a service user panel featured strongly in the project design. *Dr Fox explained that they had commissioned a service user group including a gentleman who has experience and a manager, and the input was in regards to all aspects of the project. They looked over all the documents, to look at whether it was accessible, understanding and emotive to take part, and to gain expert advice into the project.* The Committee suggested considering using potential patients.

Informed consent process and the adequacy and completeness of participant information

The Committee noted that there was a reasonably lengthy recruitment process and that group 2 would be wholly self-selective. There would be a telephone conversation with the researcher, at least 24 hours before the interview and the consenting process is clearly set out in the application.

The Committee questioned whether there was an upper limit for reimbursement of travel expenses. *Dr Fox stated that there was a research budget of up to £400 but there was scope in terms of the research budget and there would also be some facility within the programme.*

The Committee noted that the GP would only be notified if there was a problem.

The name of the reviewing REC should be included under the heading "Who has reviewed this study?"

The Committee noted that points 3 & 5 on the consent form were essentially the same. It was agreed that one of these points should be deleted and also that the word 'anonymised' should be revised.

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor (Cardiff Uni) Insurance Evidence]	1.0	02 July 2018
HRA Schedule of Events [HRA Schedule of Events (IRAS Project ID 256996)]	Version 1.0	21 December 2018
HRA Statement of Activities [HRA Statement of Activities (IRAS Project ID 256996)]	Version 1.0	21 December 2018
Interview schedules or topic guides for participants [Interview Guide (IRAS Research Project ID 256996)]	Version 1.0	18 December 2018

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

19/WA/0025	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp
Dr Matthew Lawrence
Chair

E-mail: penny.beresford@wales.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers" [SL-AR2 for other studies]

Copy to: *Helen Falconer, Cardiff University*
Jeanette Wells, Aneurin Bevan University Health Board
Lead Nation : research-permissions@wales.nhs.uk

Wales REC 6

Attendance at Committee meeting on 20 February 2019

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mrs Jill Burgess	Lay Member	Yes	
Ms Anne Cowper	Lay Member	Yes	
Miss Sarah Rebecca Davies	Advanced Nurse Practitioner	Yes	
Dr Iveta Garalova	Senior Research Manager	Yes	
Dr Gail Holland	Trials Unit Manager	Yes	
Dr Matthew Lawrence	Research Officer	Yes	
Dr Ryan Lewis	Clinical Scientist	Yes	
Dr Nadja Melo	Infectologist & Andrologist	Yes	
Mrs Kate Murphy	Specialist Biomedical Scientist	Yes	
Mr Amol Pandit	Urologist	No	
Mrs Roberta Parker	Retired	No	
Dr Suresh Pillai	Consultant in Emergency Medicine & Intensive Care	Yes	
Dr John Rees	GP - retired	Yes	
Dr Ahmed Sabra	Cardiology Registrar	Yes	
Mrs Dalila Tremarias	Translator	Yes	
Dr Mark Turtle	Consultant Anaesthetist & Pain Management Physician	Yes	
Dr Alan Watkins	Senior Lecturer in Statistics	Yes	
Professor Paul Willner	Emeritus Professor of Psychology	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Ms Penny Beresford	REC Manager

Appendix P. Approval letters

Appendix P3. Health Care Research Wales (HCRW) approval

Dr John Fox
Clinical Director/ Senior Lecturer in Clinical Psychology
Cardiff University (Hon)/Cardiff and Vale University Health Board
Cardiff University School of Psychology
11th Floor Tower Building
Park Place, Cardiff
CF10 3AT

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

14 March 2019

Dear Dr Fox

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A Qualitative Examination into the role of Self-Directed Disgust in Males who have Attempted Suicide. A Grounded Theory Approach.**
IRAS project ID:	**256996**
REC reference:	**19/WA/0025**
Sponsor	**Cardiff University**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

IRAS project ID	256996

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Helen Falconer
Tel: 02920 879131
Email: resgov@cardiff.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **256996**. Please quote this on all correspondence.

IRAS project ID	258888

Yours sincerely

Ann Parry (Health and Care Research Wales)
Permissions Service Manager

Email: Research-permissions@wales.nhs.uk

Copy to: *Helen Falconer, Cardiff University*
Jeanette Wells, Aneurin Bevan University Health Board
David Mason, Cardiff University

Appendix Q. Coding examples

Appendix Q1. Examples of initial line-by-line coding

Raw interview data – Jack	Initial line-by-line coding
[00:26:53] Jack – I was just thinking, I've got to get out of this habit.	Needing to break habits
IN – Okay.	
Jack – You know. But I couldn't see a way out and I couldn't find a way out. I was stuck…stuck in a rut. I had nowhere to go and no one to turn to. I didn't know what to do. So I just carried on fucking living like that. And then when I drove my van into the wall, that's when I thought 'I've had enough'. That… I woke up that day knowing I was going to take an overdose, a big one, and just fucking lay in the van with the vodka, music on, and that was gonna be my last fucking hit.	Perceiving no way out. Feeling "stuck in a rut" Being alone/Not knowing Maintaining the status quo Crashing his car intentionally Reaching a critical point/Having "enough"/Deciding to act/Waking with a death conviction Describing planned death Envisioning the "last hit"
IN – Okay.	
Jack – But then, I fuc…I hadn't ate for like five days. I went down the fish shop, bought sausage and chips. Seen the police behind me, they were pulling me all the time because they knew I was on the edge. And erm, I thought 'fuck it'. I just fucking sped off, and just fucking looked in my mirror, seen him and went 'fuck you'. Turned my van and just drove into a fucking six-foot wall.	Losing appetite Describing food intake Seeing police Suggesting others were concerned Having a "fuck it" moment Looking in the mirror/Being angry at him Crashing the car intentionally/Attempting suicide.
IN – Okay.	
Jack – I never ever thought I would have woken up from that.	Conveying surprise that survived
IN – And the, the fuck you, sorry, was that to the police?	
Jack – Yeah, yeah, to the, ah… to the police and everyone else butt, family the lot of them.	Expressing frustration to everyone
IN – Oh right, okay.	
Jack – Yeah. I went to my missus 2 o'clock in the morning, crying asking her for help. She, you know, she'd only let me in by the door. 'no, no you can't stay here like this, you can't st…' I understand that, social services would have took the kids, you know. But, she's my missus, we've been together thirty fucking	Visiting wife during early hours Being upset/Seeking help Being denied access Having help refused Understanding the consequences Suggesting wife should act differently

odd years. I just wanted her to hold me. I wanted a cwtch. That's what I fucking wanted. But I was out there on my own butt. It's a sad fucking situation to be in [upset tone]. And I know people who's in the same boat now. It's fucking very sad. I'm, I'm glad, I'm glad I've come through it and I'm alright. I can say 'no' all the time and I do regular. But I tend not to go now, visit some boys who I know sniffing all the time. But I, I know they won't, they won't tempt me. I watched them scratching fucking sixteen lines off them the other day. And they were like 'oh are you sure you don't want one now, just a little one?' Like 'no I'll never touch that drug again'.	Wanting intimacy Facing world alone Expressing the sadness Seeing same difficulties in others Expressing the sadness Conveying relief he's in a better place Regularly declining offers for drugs Choosing to not visit drug using friends Conveying belief in his abstinence Describing other's drug use Being offer drugs Declining drugs Declaring life-long abstinence

Raw interview data – Lewis	Initial line-by-line coding
[00:20:01]	
Lewis – I think it just went from one thing to another. Erm… I… you know… it went from feeling sad, to feeling angry, to feeling frustrated, to feeling worthless to feeling [pause] [exhale]… just that there wasn't any point in me being there. It… it… each day was getting worse and worse and worse and it progressively got worse until that very night.	Accumulating difficulties Feeling sad Defining transition through emotions/ Feeling worthless/Experiencing multiple emotions/Feeling pointless/Lacking belonging/Worsening distress Reaching a critical point
IN – And what kind of… that… so those thought… that around 'I'm'… 'There 's no point in me being here', what, kind of, feelings and emotions do you think are attached to that? What were you feeling at that time?	
Lewis – I was… I'll be honest with you, I'll feel… I was… I felt disgusted in myself because… [pause] just because, how would other people feel if I wasn't here? [Pause], you know?	"Being honest" Feeling disgusted with self Wondering how others would react to suicide
IN – Can you tell me a bit more about that?	
Lewis – You know, I… Erm, my… my parents, erm, sat me down to… I think it was about a day or two after it happened, and said [pause] 'we would be devastated if we lost you' and then it hit me that [pause] there's a purpose and a reason why I'm here and [pause] [exhales] er… yeah there's a purpose and a reason in to why I'm here, you know and… and er… [pause] yeah, I felt disgusted at the time because [pause] I was, like, 'why am I thinking the way I'm thinking?' and…	Recalling communication with parents Measuring days after attempt Remembering parents words/sadness Having a realisation Realising purpose Realising purpose/Reiterating self Remembering feeling disgusted Being confused around thinking process

IN – And what were you thinking?	
Lewis – That, [exhales] you know, I… I was disgusted in myself. I felt really depressed and… and low. I felt angry at myself, because… but angry at myself but also at the system at… at… at our local NHS [coughing] excuse me, [coughing] er… I felt angry at… at my NHS, er, sort of Health Board, because they were failing to safeguard me as a person. They didn't seem to care. Erm… and looking back on it now, I don't think I was knocking the door hard enough. I don't think I… I… It seems to me that you have to scream before someone will hear you. But now, you know, that I'm… I'm a bit older, I'm starting to understand that I need to speak out about things. So, nowadays I work with an organisation called [organisation name] and it… it's main aim is to end… er, the stigma and discrimination surrounding mental health and that's… that's… that's me in a nutshell now. I do that because it needs to be publicised.	Being disgusted with self Expressing intensity of depression Feeling angry with self Expressing anger to NHS Expressing anger to NHS Feeling failed/let down Believing NHS didn't care Believing he wasn't loud enough Perceiving loudness equals more help Screaming to be heard Gaining an understanding with age Needing to speak out Describing charity involvement Conveying charity's aims Personifying charity aims with self Situating self with charity
IN – Yeah.	
Lewis – You know, men, er… er… there's a huge talking point around men's mental health now, at the minute, [organisation name] are doing this big thing and [pause] that's my purpose now and that's why I… I speak out about my own mental health.	Measuring the size of campaign Highlighting male mental health issues Describing charity campaign Realising his purpose Providing the rationale to speak out
IN – From your own experiences?	
Lewis – Yeah.	
IN – It sounds like, and some of the difficulties you've had.	
Lewis – Yeah.	
[00:24:26]	
IN – Thank you. Erm… I wondered, if I can, go back… you mentioned that you were, kind of, having that feeling of disgust about yourself. You mentioned anger was there as well but disgust was there. What was it that particularly that you felt disgusted about?	
Lewis – That [pause] I… I would take one more life away from the world. You know, er… that [Pause] [Exhale] I'm just disgusted in myself that, why… why would… why do I… Why was I thinking the way I was thinking? Er… it wasn't normal for me, you know, for	Linking suicidal thinking to disgust Being disgusted with self Being confused around thinking process Perceiving thinking as abnormal

me to be thinking that way. Ah… Ah… But I was also disgusted in myself as a person, because at the time I had really low self-confidence, I couldn't even look myself in the mirror, because I was disgusted in the way I was, you know, I looked. I'm not too bad anymore, but, at the time [Pause] you know, all these [unclear] all these factors leading up to it just added fuel to the fire. Erm, [Pause 5 seconds]…	Critiquing thinking process Having additional self-disgust Experiencing low self-confidence Being unable to look in mirrors Conveying disgust at image Being in a better place Implying accumulating difficulties "Adding fuel to the fire"

Raw interview data – Ian	Initial line-by-line coding
[00:44:00] IN – What is your understanding of the emotion of self-disgust? Ian – Um, well, I think I'm quite, um, an authority on it.	Believing he is synonymous with self-disgust
IN – Okay. What do you understand it to mean? Ian – A revulsion that no one else could ever possibly understand. No matter how much you articulated it. Write a song or a book or an essay. But no one can-, will know that-, no one can ever really understand. People will say, like, 'Don't be so hard on yourself,' and they have no idea how hard you actually are being on yourself. You're plagued by it, can't you? Do you know what I mean? Absolutely plagued by it.	Conveying revulsion/Expressing intensity Describing others inability to understand Expressing the inability to understand Remembering other's support Expressing other's lack of insight/other's not knowing. Feeling "plagued"/Reiterating self
IN – Can you try-, Ian – Insane. Absolutely insane-,	Conveying the "insanity of it"
IN – Can you try-, Ian – The things people do to themselves.	Expressing distress is self-directed
IN – Yeah. Could you try to put it in words, what it's like? I know you said you'd never-, it never matches up with the intensity like-, that it's like inside. Ian – Just an-, just an intellectual plague being constantly reminded by it, whether you want to or not, um, triggered by it, um, self-disgust.	Explaining the "plague" Highlighting the constant and intrusive nature/ Being triggered by self-disgust
IN – And what is it? What is it like for you? What-	

Ian – It's guilt I suppose. Or it's in the same flavour as guilt.	Likening self-disgust to guilt
IN – Could you tell me a bit more about that?	
Ian – Like, everybody knows [pause]… it, it, it, it'll, it'll feed into everything you do, it, it'll, it is quite like guilt, I think, in a way. Um-,	Believing "everybody knows" All encumbering Likening self-disgust to guilt
IN – Are there any particular-, like I guess with some emotions we have things like 'I am' statements, so like an anxiety might have, 'I'm, I'm in danger,' or, 'I'm scared,' or-,	
Ian – Mm.	
IN – What-, do you notice any thoughts that self-disgust brings with it?	
Ian – I'm wrong.	Seeing self as flawed/"wrong"
IN – Okay.	
Ian – Fundamentally flawed. A net negative on society.	Seeing self as flawed/judging worth in society
IN – Say that again, sorry.	
Ian – A net negative on society.	Judging worth in society
IN – Um, and do you remember when you first experienced those-, that feeling, those thoughts?	
Ian – It'll be very young. From, um, from five to 18 I was picked on for my height, my stutter, my surname, my hair colour and my shyness and at, at the time, mild effeminacy. So I just-, I just got it relentlessly all the way through school, from, from, from my parents, my teachers and, and my peers. Um, so it was nicely fed throughout the entire time. So very young. Just always being told-, always being pointed at for some immutable characteristic, you know?	Recounting the first instance/early experiences/Measuring in years Listing the reasons why bullied Measuring levels of femininity Experiencing relentless bullying/Naming the bullies/Being bulled at home Having disgust fed/Expressing youngness Having characteristics constantly pointed out/Being highlighted

Appendix Q: Examples of coding

Appendix Q2. Further examples of coding process

Raw data	Initial coding	Focused coding	Category	Concept
Rhys – The last one was December just gone [2018] [pause].	Situating most recent attempt	Describing the attempt	Reaching a suicidal	
It was like a, it come [pause]. I was, all my medications were	Stopping mid-sentence		point	
getting changed all the time, cos I felt like I was going down.	Having medication frequently changed			
I could feel it you know. You, I'd just start feeling different	Noticing a decline/Feeling different	Multiple emotions	Enduring distress	"The abyss"
so, my medications were all changed [pause], erm and then I	Having medication changed	Feeling Different	Disconnection	
ended up not any medication. I wasn't taking any drugs. [IN	Being without drugs or medication			
– Okay], [pause], and I could, it just, it starts off, you know, I	Positioning the start	Describing the attempt	Reaching a suicidal	"Disgusting and
don't want to go anywhere or I don't want to see anybody,	Withdrawing from others and world	Avoiding others/Recoiling	point	wrong"
and then it's, I'm shutting all the blinds, cos you feel like, I	Attempting to block others out		Disconnection	(recoiling)
don't know, you just don't want anyone to see you, or feel,	Not wanting to be seen by others			
being weak, you know.	Feeling weak/Avoiding being seen as weak	Feeling weak	Endured distress	"The abyss"
IN – Okay				
Rhys – And then, I just thought there's like no way out now. I	Feeling trapped/Being alone and "stuck"	Feeling trapped	Hopelessness	"Disgusting and
was stuck on my own, in the flat. I don't want to open the	Avoiding contact with others	Avoiding others/Recoiling	Disconnection	wrong"
door or answer the phone. Nothing. And that's when you	Questioning "the point"	Feeling hopeless	Hopelessness	(recoiling)
just think, there's no point and [pause], I was like, I said to	Retelling distress to social worker/			
[social worker], like [Social worker], I was looking in the	Checking self in mirror/Experiencing self-	Increasing mirror usage		
mirror and you do just hate yourself, it's like it's not you. You	hatred with mirrors/Feeling detached	Experiencing self-hatred	Endured distress	"The abyss"
look in and you think… that's… when you're well, I'm fine, I	from self/Differentiating mirror use	Being detached from a reflected	Disconnection	
look in the mirror, nothing, no problem. When I'm bad, I	when "well"/Differentiating reflection	self		
look in the mirror and it's like I'm looking at someone else.	experiences/ Feeling detached from self			
It's strange.	Conveying the "strangeness"	Identifying a change in mirror use		
Break for review and discussion whether to continue. Jacob				
wishes to continue. Interview recommences [00:52:33]				
Jacob – Okay… So I'm finding that I'm getting agitated… Not	Experiencing current agitation			
with you… cos I'm incredibly uncomfortable…[pause] about	Feeling uncomfortable/Feeling hatred			
that… and, and, and it is, it's not just hatred, it is [pause],	Noticing presence of other emotions	Multiple emotions	Endured distress	"The abyss"
yeah, it is disgust. Er, I don't… the things… and, there are	Identifying disgust's presence	Delineating self-disgust		"Disgusting and
times when… back to the point of this, is that [sighs] there	Returning to the topic			wrong"
are times when I act out and cry for help and, and "poor me"	Describing "cry for help" behaviours	"Disgusting ways"	Experience of SD	
and everything and cause people emotional distress because	Blaming himself for causing distress	Self-criticism		
of how I, how I am, and not taking grip of things, and doing	Perceiving an inability to cope	Being unable to cope	Unable to cope	
[makes noise appearing to struggle for words], I've got	Struggling to find the words			

Raw data	Initial coding	Focused coding	Category	Concept
abhorrent behaviours, what I find abhorrent behaviours, that scare people, and I knowingly scare them, threaten that I'm gonna do something and leave them, leave them dangling. And then that reinforces and so the, the, the two times that I've done that is the times that I'm really properly thinking that's disgusting behaviour, that I'm disgusting, because good people don't do that.	Labelling behaviours as "abhorrent" Intentionally scaring others Threatening to leave/go/leaving others Reinforcing own behaviour. Situating disgust within suicide attempts Thinking that he's disgusting Comparing himself to "good people"	"Disgusting ways" Situating disgust in attempt Describing the attempt "Disgusting ways"	Experience of SD Reaching a suicidal point	"Disgusting and wrong"
Richard – And…er…[pause] I think I get the…that kind of…I think I get that kind of feeling when [pause] I guess I look in the mirror and [pause 6 seconds] I guess around my mental health in…in [pause] the way I act sometimes [pause]. IN – Could you tell me a bit more about that…when you said about when you look in the mirror. What happens then? Tell…talk me through that. Richard – I think it's like [pause 5 seconds] I don't…I don't…I don't look in the mirror very much [laughs to self]. Erm…[pause 6 seconds]. I don't know. I think it's like…I think when [pause] I think it's [pause]…like a lot of people used to say, erm, I think the term is 'you're fighting above your weight', like, when I was with my wife and that, so… IN – Okay, right. Richard – She was…she's, erm…good looking maybe [clears throat] [pause]. I think I've always kind of, felt like that was the case, you know, like…like I'd think 'oh, how the heck and…is someone like that with me' and [pause] erm…[pause] like I've had problems…I have got [REDACTED] and I've got problems with my [REDATED] and [pause 5 seconds] lack of hair and I think I've always, kind of…like I lost my hair at a young age and [pause]…and, you know, and people talk about it and talk about my [REDACTED] and…and that's all I can kind of see when I look in the mirror is…is like [pause] the faults I guess mainly.	Getting a "feeling" Experiencing self-disgust when using mirrors/Relating disgust to his mental health/ Judging his behaviours (with disgust) Limiting mirror use/Laughing Appearing unsure how to answer Remembering other's words Having appearance judged by others Relating comments to marriage Judging wife's appearance Describing default thinking Questioning why attractive people would like him Having "problems" Having a [REDACTED] condition/Lacking hair/Listing critical parts of self Explaining early hair loss Having image talked about Having "faults" reflected back	Finding their appearance disgusting Experiencing disgust with mirrors "disgusting ways" Avoiding reflection Identifying flaws/?Self-criticism Self-criticism Identifying flaws/Self-criticism Identifying flaws	Experience of SD Exposure Experience of SD Avoiding (attempting to cope with S/D) Exposure Exposure	"Disgusting and wrong" "Disgusting and wrong"

Raw data	Initial coding	Focused coding	Category	Concept
Tom – [Pause 8 seconds]. Erm… [pause 15 seconds, with exhales, sniffs and crying] Basically it just got to the point where I… [pause] [sniffs] I kept, erm… burying my head in the sand and I just kept hiding how I felt and [sniffs], erm [pause] I just genuinely thought that, erm, [sniffs]… er, that I was a dudd, basically. I just felt that I didn't fit. Erm… [pause] [sniffs] so obviously all that time I was thinking, that, effectively… can't solve my problem, so what's… what's the matter with me [sniffs]… er, it's… 'there's nothing wrong with me, I've got a nice car, I've got a nice missus, I've got a good job, I've got good money, I've got good prospects, I'm good at my job, I live in a tidy area. What more do I need?' [sniffs] [pause] Yet, I still felt like… the way I felt. I thought I was ungrateful. I thought [sniffs]… I, erm, didn't deserve it and, erm, [pause] [sniffs] [starts speaking quieter] every night I'd come home from work and I just felt like [pause] 'shall I do it?' [sniffs] and, erm, [pause] and one… one… one day I came home from work and, erm [pause] [sniffs]… I took my belt and just wrapped it around my neck and [sniffs] I just pulled with all my strength [pause] I… [pause] [sniffs] and erm, [pause 4 seconds] [sniff] just got really light headed and fell to the floor [pause 5 seconds] [sniffs]. I come around, before [wife's name] got home from work [pause 10 seconds] [sniff] and I carried on like nothing happened [pause 4 seconds] [sniffs]. IN – Say that again, sorry, you… Tom – I carried on again, like nothing happened [pause]. IN – Well done [Tom], you're doing really well. I know this is really tough. Do you want to take a break for a minute?	Being upset in interview Reaching a point Implying ignored distress/"Burying" Hiding emotions Feeling like a "dudd" Feeling different Explaining thought process Lacking ability to solve problems Blaming self Providing reasons why "nothing's wrong" Listing why he should feel okay Asking self critical questions. Remaining distressed Feeling ungrateful/Feeling undeserving/ Feeling worthless/Speaking quietly Having daily suicidal thoughts/Motivating self/Contextualising suicide attempt Retuning home Using belt as a noose Attempting to hang himself Becoming drowsy/Losing consciousness Remembering awakening after attempt Long Pause "Carrying on like nothing happened" "Carrying on like nothing happened"	Describing the attempt Concealing distress Self-criticism Feeling different Being unable to cope Feeling incompetent/Self-criticism Feeling incompetent/Self-criticism Worsening and enduring distress Multiple emotions Feeling worthless Describing a suicidal mindset Describing the attempt Making the decision	Reaching a suicidal point Disconnection Unable to cope Endured distress Endured distress Reaching a suicidal point Reaching a suicidal point	"The abyss" "The abyss" "I'm worthless"
Luke – It's, erm… cos I've got a… I've got a voice a lot of the time… I mean, it don't tell me what to do because I'm an adult and I know it's a fucking voice in my head. But, it grinds you down after all day and som… like I said, sometimes, nine o'clock like, when you're being told you're fucking useless, you know, you're no good to anybody, you may as well not fucking be here. Sometimes, I just need that joint.	Describing critical inner voice Denying control Acknowledging it is a voice Being ground down Reaching a certain time Having inner-critic comment on worth Suggesting suicidality Needing cannabis to help.	Self-criticism Worsening and enduring distress Multiple emotions Self-criticism Navigating distress with drugs and alcohol/ Maladaptive coping	Endured distress	"The abyss" "I'm Worthless"

Appendix R. Memo examples

Appendix R1. Interview memo – Luke[10]

Interview memo
Interviewee – Luke
Interview date – 08/01/2020
SDS-R data – Physical 35/35; Behavioural 19/35; Total 85/105

Client was anxious prior to and during the early parts of the interview and often gave just one-word answers at the beginning.
Luke described some very detailed trauma experiences. This was an extremely difficult interview to engage in, transcribe and to repeatedly listen to. Although there is no hierarchy of trauma, this is probably some of the most traumatic experiences which I have ever bore witness to.

Luke scored the highest of all participants so far on the SDS-R and strongly endorsed many aspects of self-disgust throughout the interview. This was despite him not hearing of this emotional experience before.

As reported in the previous interviews, there appears to be a strong link between trauma and self-disgust. Almost like they are "polluted" by these experiences. Indeed, Badour and Adams (2015) describe "contamination by trauma". He experienced flashbacks which he described as "disgusting" and related some visceral disgust responses around his trauma experiences (including flashbacks) – "It's sickening", "I constantly feel like I smell" and avoided toilets. He also remarked how he felt unclean during the interview (not because of the interview, but because he had a toilet break), although could be both.

He provided a nuance in his experience of self-disgust and trauma (childhood sexual abuse), in that he described disconnection from his earlier (abused) self. He expressed some strong self-criticism and hatred to this younger self and blaming him for not stopping the abuse. He remarked how he "wished he was dead" and "I hate him". He expressed strong disgust towards this disconnected self. However, is it self-disgust when the aspect of the self which elicits disgust is disconnected from your sense of self? – To discuss at supervision. It could be that disconnection helps as a strategy to manage such intense levels of self-disgust.

As with other interviews, Luke had a history of substance use in an attempt to cope with distress (including disgust) and regular outburst of anger and aggression. He also reported self-harm and using food to manage his mood – Although a strategy to manage self-disgust, paradoxically self-harm appeared to perpetuate it. However, this was only when the self-harm was exposed by [Details redacted]

He provided an interesting step-analogy to his distress: Step one – "shitty day"; Step two – self harm and other strategies don't help "it's the loneliest place in the world"; and finally step three – suicidality "with my hand on the fucking door". This is an interesting analogy and similar to other accounts, such as Rhys's 'valley'. What they all have in common is a period of worsening

[10] Some details in this memo have been redacted to ensure anonymity/prevent re-traumatisation.

and enduring distress with multiple emotions (including self-disgust) which lead individuals to perceive themselves as not being able to cope.

As with other interviews, Luke had some difficulty in delineating these emotional experiences, particularly self-disgust, shame and self-hatred (not surprising as self-disgust was a novel concept for him). However, self-disgust was related to a stronger intensity of the "dislike" aspects and he related it more to the actions of the abuse "I'm hate what happened, but I'm disgusted at what they done" – and he appeared to internalise this disgust response. Also, exposure (or potential exposure) was linked to shame, increased distress and suicidality. This was related to masculinity norms and suggestive of hegemonic masculinity "What if she [wife] finds out what happened to me, I'd be fuck all". Again, linking shame, self-disgust, masculinity and increased distress. Luke also related this to an increase in his suicidal risk.

Mirrors were pertinent again. Luke completely avoids all reflections and appeared to describe dissociation when using mirrors. There was some slight nuance as the avoidance related to a trauma experiences [details redacted]. However, Luke's trauma related to disgust so this may be intermingled. Interestingly, he noted that he did increase mirror usage during his suicide attempts (similar to other interviews). He remarked that he would stare at himself and make self-critical remarks such as "what a twat". He also remarked that this was to "say goodbye".

Ideas/emerging ideas/constant comparison with other themes:

- The link between trauma and self-disgust is appearing significant – How do I tease these apart? Can I? And do I need to? Maybe not, as self-disgust relates to a pervasive sense of the self as being contaminated.
- Emerging concept of worsening and enduring distress – inability to cope and then suicidality increases. It's as if individuals are journeying towards their suicidality. Self-disgust appears intermingled with this. Luke also described experiences of worthlessness which appeared to increase distress.
- Why is mirror usage different for some individuals as they approach their suicide attempts? Are they checking their "disgustingness" or punishing themselves more? Or just "saying goodbye".

Notes for future interviews:

- It would be interesting to theoretically sample individuals without traumatic experiences. Third sector individuals interviewed also had a history of adversities and recruitment is beginning to slow. Where could I access this sample from?
- The questions around differentiating self-disgust are helping to delineate their emotional experiences. At times I wondered whether I'm leading them, however the first question is always "do you think there's a difference" rather than "tell me the difference".
- Behavioural questions, such as "what did you do" were really helpful in teasing out some of the avoidance behaviour. These will be useful to ask more of, particularly when participants struggle to answer questions around what they were thinking and feeling.

Reflexivity and reflection points:

- This was a very difficult interview. Luke went into great detail about some of his traumas and his suicide attempts. This was often unprompted. It made me reflect on how emotive this interview is for myself and the participants. Despite regular check-in's, reminders that he does not need to disclose trauma and offers of breaks, it was a difficult interview to bear witness to. All participants have remarked how they are

taking part in the interviews because they want to help suicidal men. Whilst this is spurring me on to get work published (and will continue to motivate me to do this), I must be careful that any findings remain grounded in the data and not because participants want to help and I want to add to the research and tell their stories.

- This interview reinforced how important the debrief is. The participant was fine throughout the interview (although reported feeling unclean when going to the toilet). However, we were able to spend time reflecting on what was more or less difficult for him in the interview. He gave positive feedback on my approach.
- This interview has also reinforced how important it is for my self-care. I felt very upset after the interview (and still do when writing this). It's important that I discuss this with John. It's important that I look after myself as well as the interviewees!
- Finally, the sadness that I felt towards this participant's life story, and the pervasive and pertinent data which he gave around self-disgust, means that I need to ensure that I am not biasing and privileging his stories when it comes to write up. I.e. that I don't excessively use his quotes or make substantiated claims around the impact of childhood sexual abuse and disgust. It will also be essential to ensure that any quotes of Luke which I do use do not a) inadvisably identify him or b) retraumatise him. This goes for all other participants too and may limit the quotations I can use.

Appendix R. Memo examples

Appendix R2. Category memo – "Exposure"

Exposure
[Was: Having the disgusting self exposed; Being exposed; Having/Risking the truth discovered]

<u>Category description</u>

This category emerged after making constant comparisons across all the different aspects of data (codes, data, memos etc.) What emerged is the theme of exposure. This was already understood (and coded) within 'being exposed' FC. This category describes the different ways in which individuals are exposed to a "disgusting" self. This exposure could be directly and purposeful (e.g. looking in a mirror), it could be indirect (being exposed by others), it could be hypothesised (perceiving self through others eyes), it could be physically (e.g. feeling unclean). Regardless of how it initiated, being exposed to the "disgusting" self, resulted in distress and provided links to other categories such as **"the abyss", reaching a suicidal point** and coping using avoidance, concealment etc.

By comparing the data, nodes and memos, it appears that this category consists of two sub categories; having the "disgusting" self exposed and fearing exposure of the "disgusting" self.

<u>Category Properties</u>

The properties of this category include:
The methods that are used to expose - For example, mirrors, behaviour, disease, senses (e.g. smell), 'symptoms' (e.g. trauma flashbacks).
Who is doing the exposure - Self, others, hypothesised others, disconnected self.
The situating of (self) disgust when exposed - or exposure of factors which are described as "disgusting" (e.g. image).
The outcome of this exposure – And how does this link to other categories?

Focused codes included in this category include: Being labelled; Being accused; Being exposed; Seeing a reflection of their distress (including: Having distress witnessed; Perceiving self through others eyes); Finding their image disgusting; Identifying flaws; Feeling unclean; Experiencing disgust with mirrors.

A key property of this category is that it must relate to the exposure of the disgusting self. This required delineation of the individual codes, as some individuals may have felt exposed and this may have caused acute distress, however, was not related to feelings of disgust, so therefore does not relate to this category - Again this is further evidence across the data that whilst my research and data suggests the role of self-disgust in male suicide - it does not fully explain it. It will be important to delineate these using constant comparison to see if any participants did not experience exposure and if so, why not.

<u>How does the category arise, be maintained or changed?</u>
<u>*Sub-category 1 - Having the "disgusting" self exposed*</u>

Individuals had their disgust exposed in numerous ways, including **feeling exposed, having distress witnessed, seeing a reflection of their distress, finding their image disgusting, identifying flaws and experiencing disgust with mirrors.** Each individual memo provides more descriptions of these specific focused codes, although pertinent points are described below with regards to how it arises, maintains and changes.

Huw - They came into the room and started calling me faggot [█etails redacted[11]] *and I just couldn't cope. So yeah, yeah, I went to the [xxxxx] and bought lots of pills. It's always pills.*

Tom – That I could almost be vulnerable, effectively. And that I… I… I just didn't want other people sort of seeing me in that way and you… you… you could almost see it… you could almost describe that as a disgust, because I… I… I… I strongly… I strongly didn't want that to happen.

Image and mirrors are closely associated with having the "disgusting" self exposed which was often associated with individuals' perceived **flaws**, in which mirrors were used to identify them and often associated with experiences of disgust. The exert from Lewis below also describes some visceral aspects of disgust - particular nausea, providing further evidence that this is a disgust response once he's exposed to his flaws. With both Lewis and Ian describing mirror use in the context of disconnection.

Lewis – Like, sometimes I look in the mirror, you know, like, when I'm in a really low point and I think 'what is this thing looking back at me?' I… I almost feel sick to the point, because… in… it's just, that's my low state of mind at that point, when I'm feeling really low, I'm feeling depressed.
IN – So… and you feel that in your body, do you?
Lewis – Yeah, you… you feel that cramp in your stomach [gestures cramp].. and it feels like I'm about to throw up or something.

IN – Um, would you be able to say a little bit more about that relationship with mirrors? About what is going through your mind at those times about what you're seeing in mirrors and-,
Ian – I just don't-, I just don't feel like I look human or normal. I feel like I look deformed.
IN – Do you say any kind of things to yourself or-,
Ian – You're disgusting

Sub category 2 - Fearing exposure of the disgusting self

Fear of the exposure of the disgusting self was a key aspect across the data, although heavily situated with individuals who had experienced childhood sexual abuse (CSA). Individuals who had experienced CSA associated this with self-disgust (e.g. Luke) and the fear of this being exposed was often associated with their distress as they **approached a suicidal point**.

Jack – Yeah. I just, you know, what if people find out what happened to me? And, you know, what will I be labelled? [Sniffs] It was them type of thoughts.

Luke – [Pause 4 seconds] [Laughing] I couldn't sit there and say to [Wife's name], [Trauma details described and redacted] *I mean, to me, in [Wife's name] eyes then, I'd be fuck all… Yeah. She wouldn't look at me the same way ever again.* Interesting to note links towards masculinity and scripts of gender here.

Luke – I'm scared of getting old and getting Alzheimer's or something and telling… telling the family.

Luke – It makes me nervous around people in case I smell… It makes me feel like I don't want to be sat close to anybody. I don't… I can't stand people touching me anyway, But…

[11] To ensure anonymity and reduce re-traumatisation, some details of specific details and quotes of traumas have been redacted.

Luke providing the context for his exposure as relating to the **development of the disgusting self** based on a history of childhood traumas.

Another aspect of the fear of being exposed was related to individuals' **abnormal and wrong thinking** (focused code) which was particularly associated with sexuality (i.e. Huw) and mental health issues (e.g. Tom) - both sources of self-disgust for those individuals. For Huw, he was worried that his father finding out about his sexuality [details redacted] and for Tom, he experienced a significant increase in anxiety as he worried about the reactions of his colleagues and friends being exposed to his "disgusting" thinking.

Huw - Yeah. So I figured that maybe he knew I was a weirdo so perhaps [details redacted].

Both Rhys and Ian explained how the fear of exposure of their distress (which contained self-disgust – Ian to professionals and Rhys being seen from other people's perspective – including how he looks different and abnormal) increased acute anxiety and vulnerability - resulting in the desire for suicide for Ian (although this is ideation) and Rhys to avoid.

Rhys - It's horrible. That's what makes you lock yourself away. You don't want to be seen. You think people can see the weakness because you don't look yourself, like.

Ian - I used to leave appointments here and I'd be walking down the road going, 'I shouldn't have said that. I shouldn't have said that. I shouldn't-, I shouldn't have been so vulnerable. I shouldn't have painted myself that way. I shouldn't have questioned that. I'm subservient, I'm an idiot, I'm a moron. You should kill yourself.'

Consequences of this category - The outcome of exposure

The consequence of this category appears to be the distress of exposure, either real or feared. It appears to lead individuals to face aspects of themselves which they find "disgusting" - their trauma, their image, their sexuality, their mental health difficulties etc. What is the consequence of this exposure? - described below it links to other categories as individuals' distress worsens as they **reach a suicidal point**. However, what also has emerged from studying the data is that people use other strategies to manage their distress. What has emerged from this data is a further category around how individuals cope with their disgust, by using avoidance, concealment, distancing, recoiling etc. However, this appears to exacerbate their distress (although may potentially limit exposure risk).

Relationship to other categories

Individuals often described other emotions around their experiences of having the disgusting self exposed which often situates itself within the **"abyss"** concept. This suggests the interaction between the abyss and self-disgust and how exposure worsens this and increases suicidality. This often included feelings of **"weakness",** suggesting that self-disgust and its exposure interlinks across all these concepts. For example, whilst the following participants experienced disgust around their exposure, Jacob "hates" his reflection, Luke experiences anger, worthlessness and feeling weak around his reflections, Tom expressed shame and embarrassment around the exposure of his mental health difficulties, Huw experienced multiple emotions and Ian hates his reflection.

The data also suggests a direct link between exposure and suicide, connecting with the **Reaching a suicidal point** category. However, these appear more marked in individuals with multiple traumas.

Huw - And then he went and did it and told everybody and I couldn't cope with that. Because it should have been me that told people. And so I was really mean to him and told him that no, I wasn't, he was disgusting, get out of my house. And then a period of time went by and I just-, well, I don't know whether I was disgusted by how I treated him, disgusted with myself, but, yeah, that's why I went to mum's tablet cupboard and just took the lot. So there you go. That's why.

Luke – *If I self-harm and then I feel awful because [wife's name] will know [details redacted]... Erm...So, I go straight to the fridge.* Interesting to note here around Luke's usage of coping strategies and how these relate to disgust, for Luke experiencing trauma symptoms was associated with disgust, he will often self-harm to manage the distress of this disgust and other difficulties. This self-harm is then exposed by [redacted] and he will then revert to **using food to manage mood.**

Huw – [Quotation Redacted]. Huw describes further links with trauma and exposure and how this relates to his views of **abnormal thinking.** Both the above showing connections between **exposure** and **developing a disgusting self** – via **trauma and adversities.**

Rhys provides a summary of how **fearing exposure** [Rhys describes fear of exposure that people can see weaknesses in mirrors]**, reaching a suicidal point** and **situating self-disgust** [part of I'm disgusting and wrong"].

Ian provides support for the connection between the impact of trauma in **trauma and adversities**, **having the disgusting self exposed** whilst **approaching a suicidal point.** as the self harm he is talking about was during one of his "fuck you" overdoses which he describes as the "serious" suicide attempts. This suggests that exposure is a condition for journeying to a suicidal point.

Ian - I cannot tolerate-, I don't have any mirrors in my house. I, I just-, I just don't see a human being in the mirror and the attacks on my face that I did is because of this obsession with, like, trying to stay young-looking and, um, but, but I got a lot of bullying for my appearance in school, because I, I, I was taller than everybody else and everything.

As the journey towards suicide got closer towards the critical point, it's interesting to note how an individual's relationship with mirrors and exposure changed, with increased mirror usage for individuals who had previously avoided it. It is interesting to note the change in exposure activity towards the critical point and also associated with disconnection, however this would benefit from more data and theoretical sampling to tease out the nature of this exposure:

Rhys – Well I go to the point, on, in, just before December, where I was like pacing back and forth. Cos I was, I was looking in the mirror and I was thinking 'you don't look, you don't look right, you don't feel right' and like, then I'd walk back out and I'd walk back in. And it was like, so I wouldn't avoid it, I was doing it even more. But on my own, with everything shut. Just looking in the mirror, and thinking.

Appendix R. Memo examples

Appendix R3. Concept memo – "The abyss"

Worsening emotional distress – "The abyss"

Definition

Tom describes the "abyss" as an endured period of multiple emotions with a downward trajectory. The word abyss appears synonymous with a lot of individual's descriptions of this concept which explains worsening distress. During the process there are multiple trigger points, including relational triggers and meta-emotional experiences. Common emotional experiences include anger, sadness, shame, guilt and anxiety. It was felt that the emotional experiences previously coded under the category of '*situating self-disgust in a confusing and diverse emotional landscape'* actually fitted better within this concept, and suggests the reciprocal nature between self-disgust and the abyss. The concept is described by Rhys below (with links to **disconnection**):

Rhys – Erm, they start, they start off with, like my mother will notice I'm not going out, I'm not doing anything. Where before I'd be going running crazy, doing everything, trying to make money and this, that and whatever. [Pause]. And then, people start noticing I'm not doing anything, I'm not going out. And when I get to the point where you just, you really, you cant answer the phone, you can't answer the door, you can't look out the windo… you don't want anyone to look in your window. [Pause]. And you just think, you know, you just… you don't want, you don't want to be in the world. You just think you don't belong., you know, you don't want nothing from it. You have, you don't want a job, you don't want to [pause], I know it sounds sad, but you don't want the responsibility of your children. You just, everything's too much and you just think [pause], I don't mean to swear, but you think 'fuck it', and you just do it. And it's just there and then. It's just, I don't know, It's not premeditated, or….

How does it arise

The origins of the abyss are not that clear to see. Individuals appeared more able to describe triggering aspects (describing the interaction with the focused code 'describing a triggering incident'). Rhys above describes how his mother notices the deterioration, whereas many individuals had just noticed distress and difficulties since birth – often related to **trauma and adversities**. What is interesting is that the start appears to be more insidious and unnoticeable, with metaphors like "brewing" and descriptions of accumulating difficulties.

Jack – Plus, you know, the thoughts about abuse, you know, the thoughts about my [redacted]. I felt hard done by. I'd lie in the [redacted], sniffing, crying my eyes out. Fo… you know, not just for an hour, all fucking night.

Lewis – It was a… yeah… It was just brewing, it wasn't, sort of like, er… er, you know a couple of hours sort of thing. It was brewing over that… the course of the months. Er… well the weeks rather. Erm, you know, I'd lost my job, about a week before it happened and I was just struggling to find work. I Just didn't know what to do, where to go, erm… you know, er…. [pause] and for young people [pause] especially, it's really difficult for them to find work. So, I was in that… you know, I was in that big boat of 'where do I go from here?'. I didn't… nobody was signposting me to anywhere, erm… I couldn't find… couldn't find any… anything to, sort of, keep me going. – Lewis appearing to make links to feelings of **hopelessness.**

How does the concept be maintained or changed?

The factors which appeared to maintain and endure this worsening distress are multiple relational and situational triggers and multiple emotions.

Rhys – Yeah, not so much feeling the weak, feeling the weakness. It's the, it's more like you've dealt with the weakness and that only grinds, wears you down. And then, other feelings come in and it's just.

Jacob - The fact that I didn't love him, and in the end he was, you know, pathetic man by the time he'd died you know, with the tumour. Completely vulnerable and, and everything and, and, and yet I still had this anger and hatred, fear… Yeah, all of them. [clears throat].

Lewis – I think it just went from one thing to another. Erm… I… you know… it went from feeling sad, to feeling angry, to feeling frustrated, to feeling worthless to feeling [pause] [exhale]… just that there wasn't any point in me being there. It… it… each day was getting worse and worse and worse and it progressively got worse until that very night.

Tom – It's just… just felt [pause]… it… it wasn't just one of those things where 'oh, that's it, just move on', it was more [pause]… it's almost that 'straw that broke the camel's back' type of thing, it just kept… it almost kept breaking my back [laughs to self]…

What are the consequences

The consequences of this category appear highly linked to feeling of **hopelessness** and **unable to cope** as individuals **reached a suicidal point**.

Jack – Well it was bad. I was crying all the time. Even when I was sniffing and drinking vodka in the, in the, in the [redacted]. I'd constantly be crying and thinking, you know, how can I get out of this? And I felt the only way was just fucking end my life.

Richard – And I think that's kind of like this nagging feeling all the time [pause], is like [pause 3 seconds] kind of, 'what's the point' kind of thing. Erm… [Pause 4 seconds] I think it just builds, to then… to an attempt and then [pause 5 seconds]… yeah [pause]

Connections with self-disgust

Although difficult to separate the exact processes of self-disgust with the abyss of worsening distress, what was apparent was that they were connected and self-disgust was part of the abyss for many individuals. It appears that the **"I'm disgusting and wrong"** concept is heavily reciprocal with the abyss and that they exist on a continuum with each other. The focused code of 'situating self-disgust' helps to position self-disgust within individual's worsening distress.

Rhys – But, I, It's like, oh I, I can't even be bothered to make myself bet.. look better. Because when I do, I'm still not happy with it, like. So, like one day, I was feeling really bad, but I thought 'right.. come on', cut, I cut my own hair right, so I was trying to cut my hair, and it's like, everything is still not happy. I have a shower, because I won't shower for like two weeks, and then… so you do that, but everything you do to try and make yourself better makes you feel worse. Rhys describing fruitless attempts to get better when attempting to cope with distress (including self-disgust) and what is interesting is him stating that he will attempt to clean himself due to stopping washing – This may seem like an attempt to rid oneself of "disgustingness" or contaminations and he also describes a reduction in washing and cleaning – i.e. becoming more disgusting, as the abyss worsens.

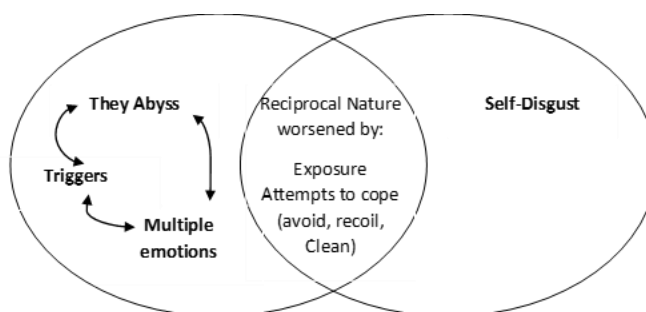
Rhys – Um, it's just that thing of, like I've said, it just that when you, when you get to that point of looking in the mirror. It's like, that's like the last thing you feel is the self-disgust, is like when you've already gone, you've had like months of going down. And you hit, like you hit the bottom and then you start having them feelings of self-d.., like, I dunno. There's no word I can say, like, or image I could say, it's just a feeling. Rhys here links the abyss concept with the "I'm disgusting and wrong" concept as all providing a context for **reaching a suicidal point.**

Rhys - It's horrible. That's what makes you lock yourself away. You don't want to be seen. You think people can see the weakness because you don't look yourself, like. When I'm bad I stop eating and you don't go out so you don't get no fresh air so you start losing you tan. You know, you just deteriorate. And then… Rhys provides further evidence that his worsening distress is reciprocal with disgust, stopping eating could be seen as a way to avoid contamination, and is situated here as a strategy to attempt to manage distress by *avoidance* However, this appeared to paradoxically worsen his distress. Interesting to note how self-disgust "that's what makes you lock yourself away" appears to function as a recoiling property which again is indicative of the disgust response.

Tom - And, [pause] it was almost that point of where it was all gonna start coming out. I was physically shaking with anxiety and stress and all those emotions in there and, you know, I… you could almost argue that there was a disgust in there as well Tom tentatively placing disgust within this concept.

Processes identified with disgust and within the abyss

There is a clear reciprocal nature between the abyss and self-disgust with feedback loops which maintain this reciprocal nature. As described above, self-disgust can be the context for the abyss, but the abyss can perpetuate self-disgust, for example both Lewis and Tom described feeling disgusting for the way they were thinking which came out of the abyss. Also the abyss appears to be worsened by attempts to cope which are related to disgust such as recoiling, avoiding, exposure and attempting to clean. E.g. Rhys feels disgusted and recoils due to this, the abyss then worsens, he doesn't wash, this worsens the abyss and disgust, he then cleans, this doesn't make him feel better, the distress is then worsened and increases suicidal risk. So, it appears the interaction between the abyss and self-disgust is a covariance relationship with unhelpful coping strategies.



Appendix S. Interview schedule

Appendix S1. Final interview schedule: Interview schedule 1.4 (audit trail below)

NHS logos redacted for anonymity

Third-sector logos redacted

The role of self-directed disgust in males who have attempted suicide – Interview guide

Before commencing the interview, revisit confidentiality and ensure the consent form is signed and the participant has read the participant information sheet. Participants are reminded that the interview is being recorded and transcribed and that they have the right to withdraw.

Introduction:
At the start of the interview, begin with: *Thank you for taking part in this interview. The questions will be looking at your personal experiences and understanding of disgust directed towards the self, or self-disgust, and whether this is associated with suicide. I understand that the topic being discussed is very sensitive, therefore if you would like to stop the interview at any time please let me know. If you need to stop the interview and take a break then that is fine, please just let me know. Also, if you have any concerns during the interview please let me know. Do you have any questions before we begin?*

1) During this interview, I will ask you some questions about what you were thinking and feeling at a particular time. Do you find it easy to know what you are feeling? These don't have to be big events, but…
    a. Can you give me an example of a time when you've felt angry?
    b. Can you give me an example of a time when you've felt sad?
    c. Can you give me an example of a time when you've felt worried?
    d. Could you give me some examples about how your body reacts to certain feelings (for example, people might smile when they feel happy)?

2) When did you first experience suicidal thoughts?
    Prompt – What were you thinking then?
    Prompt – What feelings come up when you have suicidal thoughts?

3) Could you please tell me about your most recent suicide attempt?
    Probe – What was going on in your life then?
    Probe – What were you feeling then?
    Probe – Could you describe the events that led up to your attempt?
    Prompt – What was going on for you in the days, weeks and months leading up to this attempt?

4) How would you describe the person that you were then?
    Probe – How would you describe the person you are now?

5) Could you please tell me about any other suicide attempts?
    Probe – What was going on in your life then?
    Probe – What were you feeling then?
    Probe – Could you describe the events that led up these attempts?
    Prompt – What was going on for you in the days, weeks and months leading up to these attempts?

6) What is your understanding of the word disgust (or revulsion)?
   Probe – What words, phrases and images pop into your head when you think about disgust or when I just asked you that question?

7) What do you do when you find something disgusting?
   Probe – Can you give me an example of a time you've felt disgusted with something or someone?
   Probe – What did you do?
   Probe – What did you notice going on in your body when you thought of that?

8) What is your understanding of the emotion of self-disgust?
   Probe – What words, phrases and images pop into your head when you think about self-disgust or when I just asked you that question?

9) Do you ever feel disgusted with yourself?
   Prompt – When, if at all, did you first experience self-disgust?
   Prompt – Can you describe a time when you have felt disgusted with yourself?
   Probe – What do you do when you feel like that?

10) What are you able to do with feelings of self-disgust when they arise?
    Probe – In which way are these similar, or different, to what you're able to do with suicidal feelings and thoughts when they arise.
    Probe – Has it always been like this?
    Probe – Some people interviewed for this project mentioned that they drank alcohol or used drugs to manage feelings of self-disgust. Has this ever applied to you?

11) As you look back on your suicide attempt(s), do you think that any thoughts, images or feelings of self-disgust were present at that time?
    Probe – What were they like?
    Probe – Did they seem stronger than any other thoughts or feelings?
    Probe – What relationship did they have to your suicide attempt?

12) Has your experience of self-disgust changed since your suicide attempt?
    Probe – In what way?

13) Do you think self-disgust is different to other emotions such as self-hatred, self-dislike, shame and guilt? In what way?
    Probe – Can you tell me of a time when you felt shame?
    Probe – Do you think, and in what way, is shame different to self-disgust?
    Probe – Are you able to notice the difference between times when you feel ashamed and times when you feel self-disgust?
    Prompt – What helps you to distinguish between these.

14) The next questions relate to some common areas which have come out of other people interviewed for this project. As before, you can choose not to answer any questions if you don't want to. I'm about to ask a question about historic abuse; if you do decide to answer this, please be assured that I will not ask you to elaborate any further on this and won't ask any details, unless you mention anything that raises concerns about your current safety.

a. Did you experience sexual abuse, either as a child or an adult?
b. Did you experience any other adversities as a child (such as neglect, physical abuse, emotional abuse, bullying)?
OMIT THIS QUESTION IF TOPIC HAS SPONTANEOUSLY ARISEN DURING INTERVIEW

15) Would you be able to tell me about your relationship with mirrors?

Probe – Do you notice any difference in how you use mirrors when you feel self-disgust?
Probe – Do you notice any difference in how you use mirrors when you experience suicidal thoughts or feelings?

16) Would you be able to tell me about your relationship with food?

Probe – Do you notice any difference about your relationship with food when you feel self-disgust?
Probe – Do you notice any difference about your relationship with food when you experience suicidal thoughts or feelings?

Closure Questions to attempt to bring mood close to baseline

17) Is there something that you might not have thought about before that occurred to you during this interview?

18) What has it been like answering these questions?

19) Have you learned anything about yourself since your suicide attempt?

20) Is there something else you think I should know to understand self-disgust and suicide, or male suicide better?

Close, thank for time and move to debrief.

General prompts
In what way?
Can you tell me more?
What did you do then?
Can you explain a bit more about that?"
"can you explain what you mean?"
Is there anything else about…?
Are you able to give me an example?
what thoughts were you having then/now?
What were you feeling then/now?
What is it you are feeling?
What is the…[e.g. missing ingredient]
What feelings are attached to these thoughts?
Can you tell me more about those feelings of….
What are those feelings of….like?
Can you tell me in your own words?

Appendix S2. Audit trail for interview schedule

Interview schedule	When updated	Commonalities or gap identified in early data collection	Potential gaps in future interview	Changes to subsequent interview schedule
1.1	Updated after 1st Interview	Gap: Need to explore further whether participants usage of the word disgust matches on to conceptual understandings of disgust. Gap identified through interview memo, initial coding and supervision.	Future participants may use the word "disgust" however it is necessary to understand participants' usage of terminology and how they understand disgust.	Question added to interview schedule 1.2: *"what is your understanding of the word disgust/(Repulsion or other word)"?*
1.2	Updated after 2nd Interview	Both Rhys and Jacob expressed some difficulties in understanding their emotions, naming emotions and emotional literacy. However, there is no question to explore this further in interview schedule 1.1 or 1.2. Commonalities identified through interview memos, initial coding, supervision and early focused coding.	Participants may have had a history of difficulties in understanding their emotions. However, this would benefit from a specific question to identify any difficulties in emotional literacy in future interviews.	Question added to interview schedule 1.3 *How do you understand your emotions/feelings?* *Prompt – Do you find it easy to know what you're feeling?* *Prompt – Was this different during your attempt(s)?*
		Commonalities: Both Rhys and Jacob described differing relationships with mirrors and food. Rhys increased mirror use during suicidality and Jacob avoided it. Furthermore, Rhys stopped eating and Jacob described weight gain and disgust. Commonalities identified through early coding, interview memos and supervision.	Food and mirrors may both be related to disgust. Avoidance of food may be related to pathogen avoidance and increased mirror usage could relate to checking levels of disgust? These may be processes related to suicidality and disgust and would need further exploration as they may not be freely reported or perceived by participants as relevant.	Questions added to interview schedule 1.3 *Other participants have mentioned their relationships with mirrors. Would you be able to tell me about your relationship with mirrors?* *Other participants have mentioned their relationships with food. Would you be able to tell me about your relationship with food?* *Probe – Does this change when you experience suicidal thoughts/feelings?*

1.3	Updated after 3rd Interview	Gap: Unsure whether above question taps into emotional experiences sufficiently to explore emotional understanding. Unsure of behavioural and physical responses to participants' emotional experiences. Gap identified through interview memos, initial and focused coding, supervision and early category development of *struggling to understand*.	If alexithymia is present, then will need further questioning and differentiating of emotions. However, it is essential that questions are not leading in any way. Asking questions around behavioural and physical experiences may tap into and elicit affect states without leading participants.	Questions added to interview schedule 1.4 *Can you give me an example of a time when you've felt angry/sad/worried?* *Prompt: what do you do?* *Could you give me some examples about how your body reacts to certain feelings*
1.3	Updated after 3rd Interview	Gap: Similarly to above, individuals may describe disgust behaviour but unsure how this is delineated from similar emotions (e.g. shame). Gaps identified through early coding processes, focused codes (*self-disgust vs shame, situating self-disgust)* and supervision. Also identified in each individual interview memo.	Without differentiating and exploring these affect states further, participants may be describing "disgust" experiences that may be more related to other emotions (e.g. shame) and vice-versa.	Extra probes added to emotional differentiation questions on schedule 1.4: *Can you tell me of a time when you felt shame?* *Do you think, and In what way is shame different to self-disgust?* *Are you able to notice the difference between times when you feel ashamed and times when you feel self-disgust?* *What helps you to distinguish between these.*
			Adding a behavioural question may help to differentiate disgust further due to its distancing and repellent properties, compared to shames hiding properties.	*What do you do when you find something disgusting?* *Probe – Can you give me an example of a time you've felt disgusted with something or someone?* *Probe – What did you do?* *Probe – What did you notice going on in your body when you thought of that?*

1.3	Updated after 3rd Interview	Commonalities: All of the first three participants used substances to manage experiences of disgust. Identified during early coding processes, supervision and interview memos.	Substance use may be an emerging process in the way individuals manage their disgust and suicidal experiences. Without asking a question on this it may not be spontaneously reported.	Question added as a prompt to interview schedule 1.4: *Some people interviewed for this project mentioned that they drank alcohol or used drugs to manage feelings of self-disgust. Has this ever applied to you?*
1.3	Updated after 3rd Interview	Commonalities: Early traumas and adversities were prevalent across the early interviews. This included childhood sexual, physical emotional abuse and neglect.	Participants may not spontaneously disclose abuse during interview. It may be an important process in the development of disgust/suicidality. Question would benefit from being added, however, with an explanation around why asking, reminder of right to decline to answer and telling participants that no probing or follow-up will be asked.	Questions added to Interview schedule 1.4 with a caveat around reminding that participants don't have to answer and will not have to go into details: *Did you experience sexual abuse, either as a child or an adult?* *Did you experience any other adversities as a child (such as neglect, physical abuse, emotional abuse, bullying)?*
1.4	Interview schedule 4 was used for the remainder of the interviews.			

Appendix T. Examples of credibility, ethics and reflexivity

Appendix T1. Owning one's perspective

Exerts from research journal from first research meeting and exploring positioning of the researcher:

First research meeting (April 2018) – I was excited after this meeting as self-disgust has not been explored in suicidality before. However, I was slightly anxious about the disclosing of my personal experience of male suicide, including my uncle's death and the death of my best friend's father. However, it will be important to bear this in mind throughout the project. These are probably a significant reason why John's [Fox] project stood out to me amongst all the others. These experiences also shaped my decisions to work in this field, including my interest in working with adults who experience psychological difficulties. Therefore, it has the potential to influence me throughout the project and may increase a preoccupation with finding "something". Whilst the desire to discover new findings must be present for all researchers, this may be heightened for me, almost as a way to "make sense" of personal things which have happened. Therefore, it will be important for me to keep asking myself questions throughout the process, such as "why am I am doing this?", "what is the rationale for this?" and "what am I bringing to this?". Further on in the analysis journey I must also ask questions such as "is this person really saying this?" and "from who's perspective am I looking at this?"… I will need to use multiple methods (such as interrater reliability and reflexivity) to ensure that I am not imposing my view on the data… We discussed different research methods in the meeting. Grounded theory was one method that we talked about and I think this will be helpful to answer these questions, as you regularly compare data with your findings and, by its namesake, any findings must be "grounded" in the data… I'm also reflecting on how difficult this research project may be, both academically and personally. This will be tough data to spend a lot of time around. I'm hopeful that the experiences in the past will motivate me during periods when this project may be particularly challenging… Also, my gender as a male may result in me taking certain things for granted or assuming certain gender rules without questioning them (or even being aware of them). It will be important for me to keep these things in mind when approaching the data and the project.

Research journal experts after interviews and interview memos

Diary exert after Jacob interview (24/07/2019) – At times during this interview I found myself being pulled between my "therapist" role and my researcher role. This is understandable as the interview can seem like a therapy assessment at times (i.e. what happened, what were you thinking and feeling) and the interview took place [information redacted to ensure anonymity]. It felt, at times, that this participant may have been pulling me towards a therapy session too. I found the interview guide so helpful to manage this and the offering of breaks. I'm glad that I put the groundwork in now for all the structures during the planning phase, as I'm able to check in with field supervisors and the semi-structured interview design really helped to manage this interview… During this interview the participant became agitated and he related this to "not wanting to go there" regarding thinking about disgust. This really made me reflect about the research process and what I am asking of participants. Whilst useful for my research (e.g. it

makes sense that people want to distance themselves from disgust – this is the nature of disgust!), I must not probe and question participants to the point where it becomes uncomfortable. I feel like I handled this situation ethically, but it has made me reflect on the power dynamics between researcher and participant and how participant safety is always paramount. I was mindful to stop the interview completely, although after a break, Jacob was hopeful that he could continue (and agitation had decreased). It was useful to finish the interview, albeit within an edited format. This is definitely something to continue to utilise supervision for.

Diary exert after Richard interview (11/11/2019) - … I was mindful of how a lot of what Richard had said resonated with my personal experiences. I caught myself thinking of questions and probes to ask which weren't on my interview guide. Thankfully, I picked up on these in my head and didn't ask them. Whilst all the prior interviews have been difficult and sad, this one was particularly so, and this may be because it resonated with me more than the others. This further demonstrated that a semi-structure interview approach is useful as I was so grateful for the interview guide to keep me focussed. I was able to clock my thoughts but bracket them out and not have them influence the data collection.

Appendix T. Examples of credibility, ethics and reflexivity

Appendix T2. Situating the sample

Research diary exert regarding thinking about risk whilst situating the sample

Risk meeting discussion (10th August 2018) – Supervision today was useful to explore my concerns around risk. Recruiting those who have attempted suicide and discussing suicide is inherently (and understandably) going to raise some questions around ethics and risk. I myself am really anxious around increasing suicide risk. It feels a delicate balance between risking distress for research, versus exploring an under-researcher area. Today's meeting was useful to set out parameters around risk, including not recruiting people whose suicide attempts was under six months ago, the decision to not go with crisis teams for recruitment and the importance of developing a risk assessment policy. This policy will have plans of how to manage any foreseeable risk disclosure and I think this will be useful and helpful to contain my worries about the project (whilst being grounded in risk assessment policy). However, this discussion did slightly increase my anxieties around recruitment – i.e. will the strict inclusion criteria limit my ability to recruit.

Research journal entry regarding recruitment, field supervisors and situating the sample:

Meeting with field supervisors (21st July 2019). I met with the field supervisors today to go through the recruitment process and get their feedback on some of the material and documents for the project. They both felt positive that they would be able to recruit for the project. This was good news although I need to be mindful. The CMHT staff and field supervisors are gatekeepers to the projects recruitment and this may bias my sample in a number of ways:

a) They are both clinical psychologists and therefore, any individuals which they directly refer may have accessed psychological therapy. This, potentially, may result in greater insight to their difficulties, increased emotional literacy and understanding of their suicidality. Whilst this may be useful for my research (e.g. if they can tease disgust out from other emotions), it may not be representative of all suicidal men.
b) The supervisors may choose participants who they believe may resonate with the research topic more (e.g. men who express self-disgust). However, we discussed this and we reflected on the importance of promoting the project to any men who fit the inclusion criteria.
c) Recruitment from CMHTs may bias my sample as I'll only be able to access individuals who have reached the inclusion criteria for secondary mental health services.
    a. Not all suicidal men may reach the inclusion criteria for these services.
    b. Not all suicidal men will approach services (including GP) – although it is then unlikely that they will engage in research (although I am assuming this).
d) Recruitment is open to the whole CMHT and it will be important for me to keep promoting the project to ensure that recruitment is not biased from psychology.
e) If I am only able to recruit from this health board, this may lack generalisability across other areas and populations.
f) I am hopeful to continue promoting the project through other avenues and charities. This may help address some of the limitations above, although unfortunately today I heard that [charity name redacted] have pulled out of the project due to "conflicts with other research".

Situating the sample – Reflecting on the recruitment from individual interview memo

> … It is interesting to note that Huw doesn't appear to experience as many difficulties in identifying his emotional experiences as some other participants. It is important to note that this individual has accessed a full DBT treatment and that this may account for his understanding of his emotions. This may be in part due to my recruitment process of using CMHT and having clinical psychologists help to access participants. This may bias my findings or may mean that my findings are not easily transferrable to participants who do not access psychotherapy or secondary mental health services. However, it is also important to note that these interventions are post suicide attempt and he did remark on difficulties in his understanding of emotions during that time. This is definitely something to think about in supervision and to convey in the write-up.

Appendix T. Examples of credibility, ethics and reflexivity

Appendix T3. Grounding in examples

Research journal exert and interview memo for Huw which situates the role of the researcher whilst also being mindful of where drawing examples from during the analysis/write-up process.

Diary exert after Huw interview (10/02/2020) - … Again, this interview was difficult (they all are!). However, this one in different ways. Huw's self-disgust and difficulties were heavily related to his experience as a sexual minority. I was aware of my positioning as a sexual minority and of a similar age to Huw. He explained how he grew up around the messages of Section 28 and how that significantly affected him. I was mindful of my experiences of Section 28 and how some of his early school descriptions resonated with my experience. Luckily, the interview schedule kept me on track and I was able to bracket out these ideas. However, it could have led me to focus on his development of self-disgust more than I had done with others. Also, after leaving the interview I remember thinking "he said some excellent quotes in there". I must be mindful not to privilege his data over other participants. It will also be important to take my coding of this interview to independent peer review with [name redacted] to ensure that I am remaining grounded in the data.

Appendix T. Examples of credibility, ethics and reflexivity

Appendix T4. Providing credibility checks

Coding – Independent peer review examples – Copies from NVivo annotations – used to memo some of the initial coding process.

During the initial coding process I coded this line "*And I thought, I'd just go up*" as 'suggesting had other plans'. This related to Luke's description of him going to his "place" [where he attempts suicide], although how he arrived there was through dissociation and he wasn't planning on going there. However, I have coded the line stating that there may have been other plans. As I was comparing this code with the data, I wondered whether I am being too interpretative here and whether I am imposing my judgements on the data. He may not have had intention to end his life, or even had other plans, he may just have wanted to "go up". This will benefit from discussing with peer review to ensure that I am remaining grounded.

Peer review discussion:

We discussed this code in full. The independent reviewer shared by views that I may be putting my own judgements on the data. This was useful in reminding myself of the initial coding process – to remain grounded to what the line is saying. We had some other ideas of what this line could mean and in the end, we came to a consensus on changing the code to 'Breaking things down'.

Credibility Checks – Coding memo for Lewis and supervision discussion which highlighted similarities across both stages of the LSRP.

Within Lewis' coding there are some interesting points here relating to feeling disconnected and isolated from society and the consequences of having a lack of opportunity to connect with society. For him, this appeared to worsen his distress. As I was exploring these initial codes and focused codes I was instantly reminded of my emerging findings from my meta-ethnography. I am finding similar processes during the synthesis and I'm mindful that I am not imposing these findings onto this data set. This supports the idea that in grounded theory you should not do the systematic review until after data analysis, however this is not possible within the remit of an LSRP. I have compared the initial codes and focused codes with the data and it does appear to be describing experiences of disconnection. However, due to the similarities with the meta-synthesis this will benefit from peer review and supervision.

This was followed by supervision with the project supervisor and independent peer review, during which the data and codes was explored. There was consensus that Lewis was describing experiences of disconnection and it does not appear that this was me placing my meta-synthesis results on this data. However, this has been good learning in the need to be mindful of this throughout the rest of the analysis.

Credibility checks and positioning of the researcher – memo the early theoretical process and emerging grounded theory.

…After completing categorisation of the data, what emerged were a wide range of interacting categories, including self-disgust, other affect states, worsening distress, a history of trauma and difficulties with potential alexithymia and experiences of disconnection. These appeared interwoven across individuals' lives and what emerged were the difficulties (?impossibility) of identifying one specific process in relation to male suicide and self-disgust. Initially, this was disheartening and made me confused about how, and if, self-disgust acts as a process in male suicide. It was definitely there, however it (at times) was lost amongst the other difficulties – and was further impacted by the individual's difficulties in identifying their emotions. For example, Luke describes how self-disgust was a significant part of his suicidality, associating it strongly with his attempt. But the "sickening" self-disgust made him feel "worthless". This made theoretical coding difficult – was **self-disgust** the cause of **worthlessness** and **worthlessness** was the condition for a **suicide point**? Or was worthlessness a covariance for **suicide** but the significant cause was self-disgust? Would worthlessness have arisen without self-disgust? And in a context of alexithymia and disconnection, how can the processes be teased apart at all? Was worthlessness actually self-disgust, or vice-versa? Did people feel worthless about themselves because they feel disgusted by themselves? Are these two separate processes. And similar discussions were going on with myself, research team and other qualitative researchers with other aspects of this complex emotional landscape, for example shame. I began to resonate with what Clarke (2005, cited in Birks & Mills, 2001) describes as analytic paralysis – "A condition where you feel totally overwhelmed by the data and your seeming inability to develop a theory from it" (Birks & Mills, 2001, p.89). I also began to understand why, despite the multiple theoretical accounts, suicide remains difficult to conceptualise. The impact of COVID-19 has also resulted in recruitment ending for my project. It could be that a couple more interviews could tease this out some more.

This initially made me disheartened, did self-disgust not explain the data the way I thought (or hoped!) it had. This was important to notice too and to think about whether I am looking for findings which may not be grounded in the data (for various reasons, personally and professionally). Whilst initially disheartened, by looking at the data, categories, codes and memos, what appeared to be present was overarching concepts, which whilst descriptive, contain theoretical categories which help to understand how self-disgust worsens distress. For example, Luke's details above relate to exposure of something he finds disgusting, and this makes him feel worthless. Therefore, the data suggests that self-disgust does factor in male suicide through various processes, but it has to be considered with the wider context of other emotions, worthlessness, disconnection and difficulties in understanding emotions – If I were to ignore these and solely focus on self-disgust I would run the risk of making leaps and drawing conclusions which were not grounded in my data. However, the opposite was also untrue! The data supports the role of self-disgust in suicide – so I could not ignore this and say that self-disgust doesn't factor – that too is not grounded in the data…

What followed on from this memo, constant comparative methods and supervision (with research supervisor and independent researcher) was the development of the interweaving nature of the concepts and categories that was presented in the final write up.