School of Psychology
Ysgol Seicoleg

A Study of Psychological Protective Factors and Psychological Processes in Those who are Acutely Suicidal

Thesis submitted in partial fulfilment of the requirement for the degree of:

Doctorate of Clinical Psychology (DClinPsy)

South Wales Doctoral Programme in Clinical Psychology

Cardiff University

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Supervised by: Professor John Fox and Dr Andrea Davies

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DECLARATION

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PREFACE

Suicide is a global health problem with many people dying by suicide each year. Much research has been conducted on the various risk and protective factors which both increase and decrease the likelihood of both suicidal thoughts and attempts. However, more research is needed to understand the psychological processes involved in suicide. This thesis explored the psychological components of suicidal thoughts and behaviours in adults who are acutely suicidal. This was done by firstly systematically reviewing the protective factors in those who were admitted to hospital following a suicide attempt or for suicidal thoughts. Secondly, this was done by conducting a Grounded Theory with eleven acutely suicidal individuals with an aim to understand the process linking suicidal thoughts to suicide attempts.

The aim of the systematic review was to identify the psychological factors which protect acutely suicidal individuals from suicidal thoughts and behaviours. Fifteen papers were identified which looked at a range of different factors in very different populations of suicidal individuals. The review found that when suicidal individuals feel more able to cope with suicidal thoughts or urges, then this protects them from further suicide attempts. Also, if a suicidal individual perceives themselves as someone who is able to achieve things in their life, then this will also protect them from suicidal thoughts and behaviours. This may be protective even when someone does not perceive themselves to have others to support them and when they do not feel able to obtain resources in their life. In addition, suicidal individuals may be protected from suicidal thoughts and behaviours when they have meaning in life and can think positively about the future. Feeling trapped has been found to increase the risk of suicide, though, when someone feels positively about the future, even if they are feeling trapped, they will be less suicidal.

However, this review does have its limitations. Many studies were in very specific populations i.e. the military, veterans and African American women who had experienced domestic violence. Additionally, some of the studies used cross-sectional data (studying people at one time point) rather than longitudinal (over time). This does not provide information about factors which may protect someone from a *further* attempt. Further research would benefit from exploring whether suicidal individuals improve over time when these protective factors are present. Implications for those working with suicidal individuals (i.e. crisis teams, inpatient wards and community mental health teams) are that protective factors should be routinely assessed. Questions that can be asked are: what someone's reasons to live are; what coping they have for the suicidal thoughts and behaviours; what meaning they have in life and how supported they feel by those around them.

The aim of the empirical paper was to identify any psychological processes linking thoughts about suicide to attempting suicide. Eleven participants were interviewed whilst they were either under the care of the crisis team or the inpatient ward. The results of this study showed that there were nine categories that emerged from the data as central to this process. The participants spoke of thoughts of events from their past which were intensifying and impacting on their present. They found these thoughts hard to deal with it and described it with words such as 'despair' and 'pain'. Each individual then thought about ways to block out this intensity, which was often unsuccessful. This often served to increase the building pressure even further. Participants came to think of suicide as something positive as it would bring an end to their pain and despair, solve their problems and stop them from affecting, and being a burden to, those around them. They began to weigh the options that they had. For those who made the decision, their focus then narrowed on suicide and this became the only option. Once

this focus was narrowed, they attempted to end their lives. For those who chose not to, they were found to still hold some hope, whereas those who attempted were completely devoid of hope.

This study highlights the importance of various psychological processes which may be considered when mental health professionals assess the risk in someone who presents to hospital or to their GP with suicidal thoughts and/or an attempt. This means that mental health professionals could ask about their views on what death would bring them, whether they are feeling ‘numb’ or ‘shut off’ and whether they feel in control of their lives. Some brief psychological interventions may be useful in addressing these processes within mental health services. These interventions should focus on moving people towards acceptance. Further research is needed to see whether these processes are found in other patient samples.

Psychological Factors that Protect Against Suicidal Thoughts and Behaviours: A Systematic Review in the Acutely Suicidal

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ABSTRACT

Purpose: Suicide is a leading cause of death in the United Kingdom. Although we know some of the risk factors, protective factors have been less widely researched in those who are acutely suicidal. The aim of this systematic review is to identify the psychological factors that protect suicidal individuals from suicidal thoughts and behaviours. **Method:** PsycINFO, Web of Science and Medline were searched. Papers were quality assessed using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD). **Results:** Fifteen papers were identified which fit the inclusion criteria for the review. These papers identified 12 different protective factors. **Conclusion:** Reasons for living and coping show mixed results, with some studies showing certain coping styles correlate with lower suicide risk, and others not showing this relationship. Those who had a weaker sense of meaning in life conveyed more suicide risk. Self-efficacy and positive future thinking may mediate the relationship between known risk variables (partner violence and feeling trapped) or other protective factors and suicidality. Methodological limitations constrain the generalisability of these results. These factors can tentatively be included in interventions to prevent suicide but require further study.

PRACTITIONER POINTS

- Specific protective factors should be assessed in those who are acutely suicidal.
- Important factors which need more empirical enquiry are: coping style (specifically coping with suicidal urges); meaning in life; self-efficacy; effectiveness of obtaining resources; problem-solving confidence; positive affect and positive future thinking.

- Interventions should focus on increasing these protective factors by building skills and using cognitive and behavioural techniques to increase protective factors. The timing of these interventions is paramount and therefore where individuals are discharged from services soon after a suicide attempt, this may be a missed opportunity for intervention.
- More research is needed on protective factors, their potential interaction and applicability to the general clinical population.

Keywords: Protective factors, resilience, psychological factors, suicide, suicide ideation, suicide attempt, suicidal behaviour.

INTRODUCTION

Suicide is a major health concern across the United Kingdom (UK), with many people dying by suicide every year (National Confidential Inquiry into Suicide and Safety in Mental Health, 2018). In 2019, there were 5691 suicides registered in England and Wales, at a rate of 11.0 per 100,000 people (Office for National Statistics, 2020). Research into the factors which increase the risk of suicide has been comprehensively studied. This has covered psychiatric and socio-economic risk (Li et al., 2011) and the role of specific diagnoses on risk, such as post-traumatic stress disorder (PTSD; Krysinska & Lester, 2010), bipolar disorder (Hawton et al., 2005; da Silva Costa et al., 2015), schizophrenia (Hawton et al., 2005; Hor & Taylor, 2010; Popovic et al., 2014), depression (Hawton et al., 2013), personality disorders (Black et al., 2004) and multiple sclerosis (MS; Pompili et al., 2012). In addition, studies have looked at whether we can predict the increase in risk from those who self-harm (Chan et al., 2016). The risk factors identified are prior suicidal thoughts or behaviours, previous attempts, intent to die, lethal methods, a family history of suicide, social isolation, unemployment, increased stressful life events, hopelessness, and access to lethal means (Ribeiro et al, 2016; van Orden et al., 2010). Despite this research, many people still die by suicide each year. One promising area of research has been the study into factors which may protect someone from suicide. Protective factors are defined as factors which 'promote resilience and healthy survival among people who are exposed to known suicidal risk conditions' (McLean et al., 2008, p.5). Therefore, they are not merely the inverse of risk factors, or the absence of them (Moody & Grant-Smith, 2013). Further research is needed to identify these factors so that specific interventions can be designed for suicidal individuals, both to decrease risk and increase protective factors.

In the existing literature, McLean et al. (2008) conducted a review of both risk and protective factors on behalf of the Scottish government and differentiated between social factors and individual-level (psychological) factors. They summarised these individual-level factors as: problem-solving skills; self-control; hopefulness; reasons for living; optimism and perceptions of positive health. Although this review was comprehensive, the populations studied were varied (inmates, adolescents, American Indians, abused women and adolescents). This makes the findings hard to generalise to the clinical population (those who are acutely suicidal and accessing health services for suicidality), which makes it difficult to apply to clinical practice. Looking specifically at the concept of resilience (defined as factors which mediate the relationship between risk and suicidality), Johnson et al. (2011) found that the strongest moderators were positive attributional styles and higher levels of agency. Again, this review studied various populations, with two thirds in undergraduate samples (20 out of 32 studies), which limits the generalisability to clinical samples.

In addition to these two broad reviews, some systematic reviews have focused on individual protective factors. Bakhiri et al. (2016) looking specifically at reasons for living (RFL), a term coined by Linehan et al. (1983). This refers to the reasons that people have for staying alive even in the face of emotional distress. Bakhiri et al. (2016) found that, overall, having reasons for living was protective against both suicide ideation (SI) and suicide attempts (SA). However, it was not clear from this review *how* RFL impacted on this relationship. More recently, Cleare, Gumley and O'Connor (2019) completed a review of studies looking at the role of self-compassion in suicide. They defined self-compassion using Gilbert and Choden's (2013) definition: 'sensitive to the suffering of self and others with a deep commitment to try and prevent and relieve it' (p.2). They found that self-compassion and self-forgiveness were negatively correlated with self-harm, SA or SI in a number of studies.

Two criticisms of these reviews are that they have not focused solely on those who are acutely suicidal and there has not been attention on the potential *psychological* factors. Firstly, reviews have not focused on those who are acutely suicidal, yet clinical populations (those with current or recent suicide ideation and/or attempts) make up 28% of those who attempt suicide within the general population (National Confidential Inquiry, 2018). In order for research to be clinically relevant, it must study those groups who are the highest risk of suicide i.e. those who are acutely suicidal and involved with health care services as a result of that suicidality. Secondly, there has not been a focus on the potential *psychological* factors that could protect against suicide. In 2016 the British Psychological Society (BPS) published a report on suicide, highlighting the need for further research into the psychological factors that protect against suicide (BPS; 2016).

Throughout the research literature, psychological factors are defined as the combination of personality traits, temperament, cognitive-affective states (such as impulsiveness, aggression and hopelessness) and executive functions (such as decision-making, problem-solving and cognitive control) (Nock et al., 2013; O'Connor & Nock, 2014). For ease, this is the definition adopted by this review (see Appendix 1.1). The focus on psychological factors is not to negate the influence of socio-cultural factors and negative life events however, as it is clear that it is a combination of these which contribute to suicide (Beautrais, 2000). Psychological variables are the crucial mediating variables between social difficulties and suicide intent. For example, an individual may be extremely anxious and ruminating constantly (psychological), because they are in financial difficulty (social), caused by an economic downturn (political). It is how the individual makes sense of these social factors that results in suicide ideation.

To date, there has been no systematic review of the protective factors relating to SI and SA in the clinical population (those presenting to emergency departments, inpatient and outpatient departments due to suicidal thoughts and/or behaviours). It is important that we know what the specific protective factors are for this group of people because they are the individuals who convey the most risk, and therefore preventative interventions and strategies can then focus on enhancing these protective factors. As Donald et al. (2006) state, 'it is most cost-effective to target those high-risk groups with interventions that aim to improve levels of protective factors' (p.94). Therefore, the question posed by this review is: what are the *psychological* factors that *protect* against *suicidal thoughts and behaviours* in the *clinical* population?

METHOD

SEARCH STRATEGY

Definitions

There is a comprehensive account of the definitions of SI and SA included within the suicide research literature. SA is clearly defined by Van Orden et al. (2010) who state that suicidal attempts are those actions that are self-initiated and are accompanied by an intent to die (the absence of intent classifies the behaviour as self-harm). The author uses a broad definition of SI to include individuals who state that they feel life was not worth living, those wishing they were dead, those who had thoughts about taking their life and those who had seriously considered it (Silverman & Berman, 2014). This broad definition is used because all elements are incorporated into the Beck Scale for Suicide Ideation (SSI; Beck et al., 1979), a measure still used within clinical practice (Baertschi et al., 2018; Gutierrez et al., 2019). Protective

factors are defined as those factors which moderate the response to stress and adversity (Rutter, 1987). Psychological factors are again defined in a broad way in accordance with the British Psychological Society (BPS, 2016) to include personality and individual differences, cognitive factors, social factors, and negative life events which impact on the individual's thinking. Finally, a clinical population is defined as individuals under the care of a clinical team i.e. within an outpatient or inpatient service within accident and emergency departments, hospital wards, crisis and home treatment teams and community mental health teams *for suicidality*.

The review was conducted in line with Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA; Moher et al., 2009). A literature search of three electronic databases (OVID PsycINFO, Web of Science and OVID Medline) was conducted from all years until April 2020. For those papers which were quality assessed, a full search of the references was conducted to capture additional papers which may be included in the review. The search strategy included the terms relating to all four parts of the research question: protective factors; suicide ideation or attempts; psychological or cognitive factors and clinical population (see Table 1.1 and Appendix 1.2 for the search strategy). Search terms were derived from previous systematic reviews in this area and through wider reading within the research literature, in consultation with the University Librarian.

Protective Factors	Suicidal Behaviour	Psychological	Clinical
Protective factor (OR)	Suicid* (OR)	Psycholog* (OR)	Clinical (OR)
Resilien* (OR)	(Suicid* adj1 ideation) (OR)	Cogniti* (OR)	Patients (OR)
Prevent* (OR)	(Suicid* adj1 thought*) (OR)	Individual (OR)	Hospital (OR)
Risk reduc* (OR)	(Suicid* adj1 thinking) (OR)	Personality (OR)	Inpatient (OR)
Buffer* (OR)	(Suicid* adj1 attempt) (OR)	Distress (OR)	Outpatient
Protect* (OR)	(Suicid* adj1 behavio&r)	Resilien*	
Positive*			
AND	AND	AND	

Table 1.1: Search Terms

INCLUSION CRITERIA

Studies were included if they:

- Were primary research studies.
- Studied clinical populations (as defined above) who have experienced suicide ideation or suicide attempts (as defined above) at the time of inclusion in the study or within the last 12 months (in line with the definitions given by the National Confidential Inquiry).
- Had populations of adults (aged 18+).
- Were cohort or case control studies that were either prospective or retrospective in design. Randomised control trials (RCTs) were included if they gave data on the cohort as a whole as it pertained to protective factors.
- Were published in peer-reviewed journals.

Studies were excluded if they:

- Had no mention in the introduction, aims, results or discussion of these factors being protective.
- Were not primary research studies i.e. were meta-analyses or systematic reviews.
- Studied self-harm (suicidal behaviour without the intent to kill oneself). This is also known as non-suicidal self-injury (NSSI).
- Were not in the English language as there was limited time for these papers to be translated into English.

SCREENING AND SELECTION PROCEDURES

Screening and selecting papers for the review was completed using Rayyan QCRI (Ouzzani et al., 2016). This was chosen as it was a freely available resource for automatically sorting papers into included and excluded categories and removes duplicated papers. After employing the search criteria, 5663 papers were screened using Rayyan. Seventy-three of these papers were then screened with the full-text, and fifteen papers were included in the current systematic review (see Fig. 1.1).

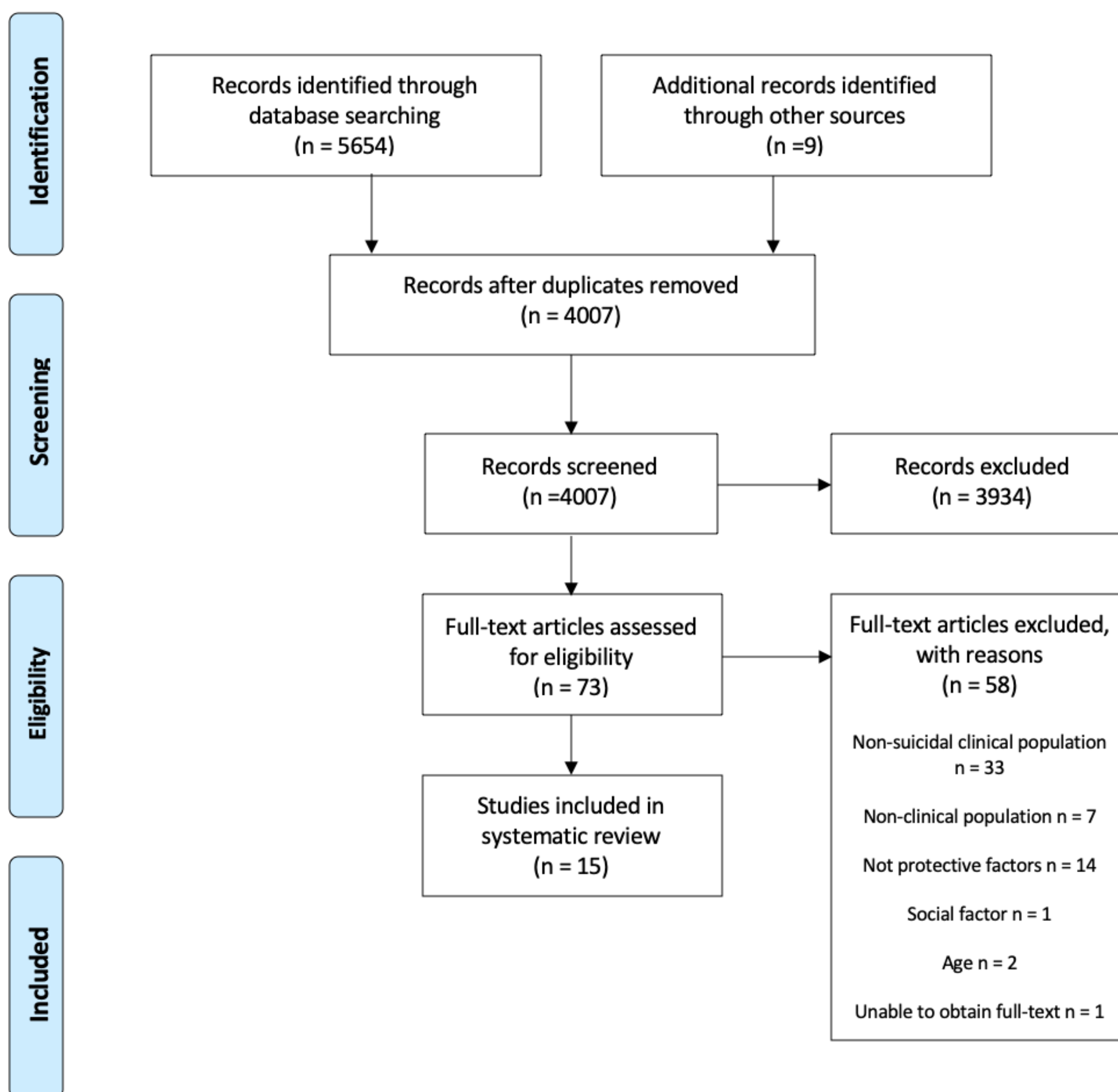

Figure 1.1: PRISMA diagram (Moher et al., 2009).

QUALITY ASSESSMENT

In order to assess the quality of the papers, the Quality Assessment Tool for Studies with Diverse Designs (QATSDD; Sirriyeh et al., 2012) was used. This tool was chosen as it shows good reliability and validity for a diverse set of studies (Sirriyeh et al., 2012) and has been used in other similar reviews (Gkika, Wittkowski & Wells, 2017; Searle, Hare & Davies, 2019). The QATSDD gives a total quality score on 16 items which were not used to exclude studies from the review, rather the scores were used to critically appraise the findings of each paper, in line

with the Centre for Reviews and Dissemination guidance (CRD; 2008). As the number of papers that fit the inclusion criteria for this review were limited, the quality scores were not used to exclude studies from the review, however, they were used in order to guide the interpretation of the results, as other studies have also done (Baess, 2018; Searle et al., 2019). The items of the QATSDD were operationalised for these studies in order to aid assessment by multiple reviewers (see Appendix 1.3). Four papers (27% of the sample) were independently assessed by a colleague and discussions were then conducted to come to a consensus on scores. The consensus scores were then used for the quality assessment.

RESULTS

Fifteen papers were eligible for the review (see Table 1.3) with 12 independent data sets. Of these papers, the protective factors studied were as follows: coping (n=4); self-efficacy (n=4); reasons for living (n=3); perceived social support (n=3); effectiveness of obtaining material resources (n=3); problem-solving (n=2); positive mental health (n=1); meaning in life (n=1); optimism (n=1); locus of control (n=1); positive affect (n=1) and positive future thinking (n=1). A narrative analysis of these protective factors will be conducted in this review.

Fifty-eight papers were excluded from the review (see Figure 1.1). Thirty-three papers were excluded as they were not actively suicidal individuals i.e. where lifetime suicidality was the measure and current suicidality was not present, or where it was not clear whether the participants were recruited to the study due to suicidality (stated as ‘psychiatric’ or ‘mental disorder’ and not suicidal). Seven papers were excluded because on further investigation, the participants were found to be non-clinical i.e. students, military personnel, veterans and community-residing older adults. Fourteen papers were excluded as they did not address

protective factors. These papers failed to mention protective factors throughout their paper and therefore were deemed to be talking solely of risk factors. Although it could be argued that certain risk factors, when found to be reduced in a non-suicidal sample in comparison to a suicidal sample, could be construed as protective factors, this is not in keeping with the definition given in the introduction. Protective factors are not just the absence of risk factors, they are factors which are independently known to reduce risk or buffer against known risk factors. One paper was excluded as it did not relate to psychological factors, rather the focus was on social factors (having children is protective against suicide). Two papers were excluded as their sample was not solely over the age of 18. This was an important exclusion criterion as it was not possible to independently look at the adults within the sample, and therefore the results would be less generalisable to current clinical practice (where adults services are separate from child and adolescent services). Finally, one paper was excluded due to being unable to obtain the full-text. A full list of the included and excluded papers is in Appendix 1.4.

QUALITY ASSESSMENT

The results from the quality assessment are presented in Table 1.2. The results are given as a percentage of the maximum score (42) as other studies have done. Two questions are omitted (number 11 and 14) as these relate only to qualitative studies. There was 61% inter-rater agreement and 8 item scores were changed after discussions. The range in quality ratings were between 48% and 83%. For those papers which had lower quality ratings, the scores were particularly low for evidence of sample size considered for the analysis, the rationale for choice of data collection tools, giving detailed recruitment data and evidence of service user involvement in the design. For those papers which had higher quality ratings, the scores were higher for having an explicit theoretical framework, stating the aims and objectives within the report, fitting between the research question and the method of data collection, fitting between the research question and the method of analysis, and for having good justification for the analytical method selected. Across all studies, Table 1.2 shows those questions which were not addressed well by any of the studies. These were evidence of the sample size being considered in the analysis and evidence of user involvement in the design of the study. Therefore, further studies in this area could improve on the reporting of the consideration of sample size, utilising service users in designing research, giving detailed recruitment data (such as the number of individuals approached to join the study and how many were lost to follow-up), and giving a clear rationale for why outcome measures are used.

	Item on QATSDD													
Paper	1	2	3	4	5	6	7	8	9	10	12	13	15	16
Brailovskaia et al. (2019)	3	2	2	3	0	0	0	1	2	3	3	3	0	2
Brüdern et al. (2018)	3	3	3	0	0	2	2	2	2	3	3	3	0	3
Bryan et al. (2019)	1	3	3	0	0	2	0	0	0	3	3	3	0	2
Bryan et al. (2018)	3	3	3	1	0	3	3	0	3	3	3	3	0	2
Daruwala et al. (2018)	3	3	2	1	3	2	3	3	2	3	3	3	0	2
Donald et al. (2006)	0	1	3	0	2	3	2	3	0	1	1	1	0	3
Flowers et al. (2014)	3	3	3	0	3	2	3	0	3	3	3	3	0	2
Horesh et al. (1996)	3	3	3	0	3	2	0	0	3	3	3	1	0	0
Interian et al. (2019)	3	3	2	0	1	3	2	2	2	3	3	3	0	2
Joiner et al. (2001)	3	2	3	0	3	3	2	1	1	1	3	1	0	3
Kaslow et al. (1998)	3	3	3	0	0	3	2	3	3	3	3	0	0	2
Kaslow et al. (2002)	2	3	3	0	2	3	1	3	2	3	3	3	0	2
Meadows et al. (2005)	3	3	3	0	3	3	1	3	2	3	3	3	0	2
Rasmussen et al. (2010)	3	3	3	3	2	2	3	2	3	3	3	3	0	2
Thompson et al. (2002)	3	3	3	0	0	3	1	3	3	3	2	2	0	3

Key:

Item No.	*Criteria*
1	Explicit theoretical framework
2	Statement of aims/objectives in the main body of the report
3	Clear description of research setting
4	Evidence of sample size considered in terms of analysis
5	Representative sample of target group of a reasonable size
6	Description of procedure for data collection
7	Rationale for choice of data collection tools
8	Detailed recruitment data
9	Statistical assessment of reliability and validity of measurement tools
10	Fit between stated research question and method of data collection
11	Fit between stated research question and format and content of data collection (Qualitative)
12	Fit between research question and method of analysis
13	Good justification for analytical method selected
14	Assessment of reliability of analytical process (Qualitative)
15	Evidence of user involvement in design
16	Strengths and limitations critically discussed

Table 1.2: Quality Assessment Results by Question Number

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Brailovskaia et al. (2019)	n = 199	Inpatients being treated for severe suicide ideation or a recent suicide attempt who reported lifetime suicide attempts. Germany	Positive Mental Health (PMH; high levels of subjective and psychological well-being).	Cross-sectional Retrospective	SITB interview (Nock et al., 2007) Positive Mental Health Scale (Lukat et al., 2016).	N/A	PMH negatively correlated with frequency of lifetime suicide ideation and number of lifetime suicide attempts. PMH buffers the impact of lifetime SI on lifetime SA.	57
Brüdern et al. (2018)	n = 60	Patients presenting to ED. Admitted following a suicide attempt. Switzerland	Reasons for Living (RFL)	Prospective	DEMO: Frequency of SI and SH in last 6 months. Lifetime and last 6 months SA (Gysin-Maillart, 2013). Beck Depression Inventory (BDI; Beck & Steer, 1987) Beck Scale for Suicide Ideation (SSI; Beck & Steer, 1991) 5 Reasons for Living (RFL) and 5 Reasons for Dying (RFD; Jobes, 2006)	6 months, 12 months, 24 months.	More RFL than reasons for dying reported at baseline. Number of RFL was not associated with the degree of SI at baseline and re-attempts during 2 year follow-up. RFL may have a protective effect on suicide ideation, not suicide attempts.	69
Bryan et al. (2019)	n=97	US Army personnel all reporting suicide ideation in last week, half had attempted suicide. United States of America	Meaning in Life	RCT (Crisis Response Plan)	SSI Meaning in Life Questionnaire (Steger et al., 2006)	1, 3, 6 month post-baseline	Meaning in life influenced reductions in suicide risk (as shown by SSI) in acutely suicidal US soldiers.	71

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Bryan, Oakey & Harris (2018)	n = 97	Army personnel attending clinic for suicidal thoughts and attempts in the US. United States of America	Reasons for Living Meaning in Life and Optimism and Religiosity	RCT	Brief RFL Inventory (BRFLI; Osman et al., 1998) Depression Severity Inventory Suicidality Subscale – frequency of suicide ideation (Metalsky & Joiner, 1997) Suicide Cognitions Scale (Bryan et al., 2014) Meaning in Life Questionnaire Life Orientation Test – Revised (Scheier et al., 1994) Suicide Attempt Self-Injury Interview (Linehan et al., 2006)	1,3,6 month post-baseline	Lifetime SA; recent 2 week SI. Survival and coping beliefs, responsibility to family both negatively correlated to suicide ideation and suicide cognitions scale. Responsibility to family significantly predicted follow-up suicide attempt.	48
Daruwala et al. (2018)	n = 139	Military personnel who are hospitalised for a recent suicide attempt or suicide ideation. United States of America	Self-efficacy	Cross-sectional	SSI Self-Assessed Expectations of Suicide Risk Scale (SAESA) Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011)	N/A	More severe SI at the worst time point was significantly associated with lower levels of self-efficacy.	79
Donald et al. (2006)	n = 95 attempters	18-24 year olds presenting to ED Australia	Feeling they could confide in family and friends; problem-	Case-control (hospital and	Their own questionnaire based on literature search	N/A	PSC and an internal LOC were protective against a suicide attempt.	48

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Donald et al. (2006) (continued)	n = 380 matched controls	Population-based sample matched	solving confidence (PSC) and locus of control (LOC).	population-based sample)	of risk and protective factors.			
Flowers et al. (2014)	n = 150	18-61 year old African American women presenting to ED. United States of America	Reasons for Living	Cross-sectional	Reasons for Living Inventory (Linehan, 1983). Suicide Intent Scale (SIS; Beck et al. 1974) Lethality Scale (Beck et al., 1975)	N/A	More RFL associated with less suicidal intent. More SI associated with less survival and coping beliefs. RFL not significantly associated with lethality of suicide attempt. RFL associated with SI above spiritual well-being and symptoms of depression.	74
Horesh et al. (1996)	n = 92 (30 suicidal, 30 non-suicidal and 32 controls)	Inpatients due to suicide attempt or overt SI with a plan to act. Israel	Coping styles	Cross-sectional	Albert Einstein College of Medicine (AECOM) Coping Styles Scale	N/A	Replacement coping styles more in controls. Coping styles of replacement, reversal, minimization and mapping were negatively correlated with suicide risk.	57
Interian et al. (2019)	n = 64	Veterans in acute inpatient psychiatric facilities due to SA or SI. United States of America	Coping with suicidal urges	Prospective (Control group of RCT)	Columbia Suicide Severity Rating Scale (C-SSRS) SSI Suicide-Related Coping Scale (SRCS; Stanley et al., 2017)	3 months	SCRS significantly lower in those participants who had a suicidal event within the 90 days follow-up. Lower SCRS score sig. predicted suicidal event in 90 days.	69
Joiner et al. (2001)	n = 113	Suicidal young adults in the military (age 18-31). United States of America	Problem-Solving and positive affect.	RCT	Problem-Solving Inventory (Heppner, 1988)	6 months, 12 months	All patients improved on problem-solving attitudes from baseline to follow-up, however, those high in positive affectivity tended to improve more.	62

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Joiner et al. (2001) (continued)					Modified Scale for Suicidal Ideation (Miller et al., 1986) Suicide Probability Scale (Cull & Gill, 1989) Positive affect (PA) as measured by the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983)		All patients improved on suicidal measures, however, those with higher PA tended to improve more than other patients. Evidence for a mediation effect of PS ability on the relationship between high PA and suicide measures.	
Kaslow et al. (1998)	n = 285 (n = 148 attempters; n = 137 non-attempters)	African American women aged 18-64 all of whom had experienced intimate partner violence, recruited from a US hospital. United States of America	Coping, views on family strengths and perceived social support.	Case-control	Index of Spouse Abuse (Hudson & McIntosh, 1981) Preliminary Strategic Approach to Coping Scale (Hobfoll et al., 1994) Perceived Family Support (Cohen & Hoberman, 1983)	N/A	Attempters reported higher levels of partner abuse than controls. Abused women who reported higher levels of perceived social support were less likely to engage in suicidal behaviour. Neither coping skills nor perceived family strengths moderated the partner abuse-suicidal behaviour link.	67
Kaslow et al. (2002)	n = 200 (100 = non-fatal SA; 100 = no history)	African American women aged 18-59 all of whom had experienced intimate partner violence, recruited from a US hospital. United States of America	Hope Self-efficacy Coping Effectiveness of Obtaining Resources (perceptions) Spiritual well-being	Case-control	Risk-rescue ratio (Weissman & Worden, 1972) Herth Hope Index (Herth, 1992) Self-Efficacy Scale for Battered Women (SES-BW; Varvaro & Palmer, 1993)	None	Attempters reported lower levels than non-attempters on all measures.	71

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Kaslow et al. (2002) (continued)					Preliminary Strategic Approach to Coping Scale Social Support Behaviors Scale (Vaux et al., 1987) Effectiveness of Obtaining Resources scale (Sullivan et al., 1992)			
Meadows et al. (2005)	n = 200 (100 attempters; 100 non-attempters)	African American women aged 18-59 recruited from a US hospital. United States of America	As above (Kaslow et al., 2002)	Case-control	As above (Kaslow et al., 2002)	None	Scores on all 7 protective factors predicted non-attempter status. After controlling for other protective factors, both hope and social support remained associated with non-attempter status. Those who endorsed more protective factors were less likely to have attempted suicide than those endorsing no protective factors.	76
Rasmussen et al. (2010)	n = 103 patients 37 controls	Admitted to general hospitals in Scotland following SH. United Kingdom	Rescue factors – positive future thinking	Cross-sectional	Defeat and Entrapment Scales (Gilbert & Allan, 1998) Future Thinking Task (MacLeod et al., 1998) Suicide Probability Scale	None	SI negatively correlated with social support and positive future thinking. PFT moderated the relationship between total entrapment/internal entrapment and SI.	83
Thompson et al. (2002)	n = 200	African American women aged 18-59		Case control	Risk-Rescue Ratio	None	Perceived friend and family support and perceived effectiveness of	69

Author and Year	Sample Size	Sample & Country	Protective Factor	Type of Study	Outcome Measures	Follow-up	Result	Quality Score (%)
Thompson et al. (2002) (continued)	(100 non-fatal SA; 100 = no history)	from a hospital in the US United States of America			Self-efficacy scale for Battered Women Social Support Behaviors Scale Effectiveness of Obtaining Resources scale		obtaining resources mediated the relationship between self-efficacy and suicide attempt status.	

Table 1.3: Summary of included studies in the review

Key: ED (Emergency Departments); RCT (Randomised Controlled Trial); SI (Suicide Ideation); SA (Suicide Attempt); SH (Self-harm); SITB (Self-Injurious Thoughts and Behaviour); US (United States).

COPING

Coping is defined as 'the cognitive and behavioural efforts used to master, tolerate and reduce demands that tax or exceed a person's resources' (Cohen & Lazarus, 1979). Coping is reported in five papers (Horesh et al., 1996; Interian et al., 2019; Kaslow et al., 1998; Kaslow et al., 2002; Meadows et al., 2005). There are a number of proposed coping styles, some of which are thought to be protective against suicidal behaviour. Horesh et al. (1996) found that the coping styles of mapping, minimisation and reversal were negatively correlated with suicide risk in their sample of inpatients and controls. This means that those individuals who minimise the severity of the problem, look for alternative ways to solve the problem and try to make the best of it, will have decreased suicide risk. However, Kaslow et al. (1998) found that coping skills (as measured by the Preliminary Strategic Approach to Coping Scale; Hobfoll et al., 1994) did not moderate the relationship between partner abuse and suicidal behaviour, and therefore was not considered to be a protective factor in this sample. In a different sample, women who had experienced partner abuse and who had attempted suicide were found to have lower scores on coping measures than non-attempters which indicates this as a protective factor (Kaslow et al., 2002).

Interian et al. (2019) studied a slightly different element of coping as they looked specifically at coping with suicidal urges. Part of coping with suicidal urges is utilising mechanisms such as talking with another individual, turning to spirituality and engaging in positive thinking. In their sample of veterans, they found lower scores on suicide-related coping in those who went on to make a further attempt within 90 days. They concluded that those participants who were high risk for suicide (i.e. they had already had a suicide attempt) were less likely to attempt suicide again if they had a greater ability to use suicide-related coping.

As coping was studied very differently across the papers, with multiple different measures used, this may account for the mixed results. The papers were also across different populations of participants (veterans, inpatients and African American women). Different results were found across two samples of African American women which indicates that more research is needed to study this specific population, as well as more general populations of suicidal individuals, in order to get a clear picture of this potential protective factor. In further research it would be useful to use the same measures of coping.

SELF-EFFICACY (SE)

This is defined as 'one's perception of being able to succeed in particular situations or behaviours' (Daruwala et al., 2018, p.1131). Four papers in the review reported on this protective factor (Daruwala et al., 2018; Kaslow et al., 2002; Meadows et al., 2005; Thompson et al., 2002). Three of these papers use the same sample and the same measures (Kaslow et al., 2002; Meadows et al., 2005; Thompson et al., 2002) and therefore SE is only reported in two separate datasets. Again, the results come from specific populations (military personnel and African American women). In the military sample, they found that more severe SI was significantly associated with lower levels of SE, and that those with a history of multiple attempts, had lower SE than those with a single attempt (Daruwala et al., 2018). This study also found that African-American participants had significantly higher SE scores than white participants. This may have a bearing on the results from the other studies. In African American women they found that those who had made a suicide attempt had lower SE than non-attempters (Kaslow et al., 2002), but Meadows et al. (2005) found that this was not predictive of a suicide attempt over and above the other protective factors (hope, social support, coping

and effectiveness of obtaining resources). Thompson et al. (2002) found that perceived family support and effectiveness of obtaining resources mediated the relationship between SE and suicide attempt status.

REASONS FOR LIVING (RFL)

RFL was reported in three papers (Brüdern et al., 2018; Bryan, Oakey & Harris, 2018; Flowers et al., 2014). It is described as one side of the 'internal debate hypothesis' (Kovacs & Beck, 1977) which states that individuals have both reasons for living and reasons for dying, which are 'weighed' cognitively. However, they are considered to be two separate constructs (Bryan et al., 2018). The results from the included papers are heterogeneous. Brüdern et al. (2018) concluded that having fewer RFL was not associated with suicide risk at follow-up and that there was no influence on suicidal behaviour in the 12 months after the index attempt. Contrarily, Bryan et al. (2018) found that, in particular, survival and coping beliefs (a sub-scale of the Reasons for Living Inventory) were important within their military population and were negatively correlated with SI. Flowers et al. (2014) had a similar result to Bryan et al. (2018) in their sample of African American women and found that more RFL was associated with less suicidal intent, but not associated with suicide lethality. This association remained when they controlled for spiritual well-being and depression. However, Flowers et al. (2014) did not find the same difference in the sub-scales as Bryan et al. (2018).

Bryan et al. (2018) had one of the lowest quality assessment scores. In addition, both Bryan et al. (2018) and Flowers et al. (2014) recognise their limitation of studying specific populations and therefore questioning the generalisability to the wider population of suicidal individuals. Brüdern et al. (2018) did not have this limitation, however their sample size was

small (and power was not commented upon). Overall, it may be that these mixed results are due to the different populations studied within the papers and further research is needed to identify whether RFL are an important protective factor for the clinical population.

PERCEIVED SOCIAL SUPPORT (PSS)

This was found to be a moderating factor in Kaslow et al.'s (1998) study, as abused women who reported higher levels of PSS were found to be less likely to engage in suicidal behaviour. They concluded that as long as women perceive themselves to have a confidant and close relationships, this will be protective against suicidal behaviour in those who are victims of domestic violence. The same result was found in Kaslow et al. (2002)'s study. In Meadows et al. (2005) they found PSS to be uniquely associated with non-attempter status when other protective factors were controlled for. Thompson et al. (2002) found that PSS was one variable which mediated the relationship between SE and suicide attempt status. Although another paper (Donald et al., 2006) did look at PSS, their measure also included an objective measure of social support and therefore is not deemed to be a psychological factor and so was excluded from the analysis.

These papers are cross-sectional studies which looked at cases compared to controls. This means that we cannot conclude whether PSS is something which can protect an individual who has already experienced a SA from suicidal behaviour in the future. These results are also all from one dataset and therefore need other studies to corroborate the findings. An interesting finding from this research is that PSS was found to mediate the effect of SE on suicidal behaviour. This may indicate that individuals feel able to succeed when they feel they are supported to do so. It would be beneficial for future research to explore this relationship further.

EFFECTIVENESS OF OBTAINING RESOURCES (EOR)

EOR relates to the perception an individual has in how successful they have been at providing for themselves in a number of areas (housing, material goods, education, employment, healthcare, childcare, parenting skills, transportation, social support, finances and legal resources). This variable was studied only in women who had experienced partner violence. It was found to be significantly lower in attempters compared to non-attempters (Kaslow et al., 2002) but it did not distinguish between the two groups in Meadows et al.'s (2005) study. The perception of being able to obtain resources was found to mediate the relationship between SE and suicide attempt status (Thompson et al., 2002). EOR may be a factor which is uniquely associated with women who have experienced domestic violence as Kaslow et al. (2002) mention that abusive relationships can leave women feeling powerless when choices and capability are taken away from them. Therefore, this makes the finding hard to generalise to the wider suicidal population. EOR was found to mediate the relationship between SE and suicidal behaviour. Again, this relationship needs more investigation and in longitudinal studies.

HOPE

Hope is defined as 'positive expectations about the future and positive ways of assigning causality to events' (Meadows et al., 2005, p. 110). It is reported on in two papers with the same dataset (Kaslow et al., 2002; Meadows et al., 2005).They found that hope was higher in non-attempters and that hope (along with SE, PSS and coping) predicted suicide attempt status in the future. However, this is not a concept which is clearly defined.

MEANING IN LIFE (MIL)

This was explicitly studied in one paper (Bryan et al., 2019). They distinguish between the presence of meaning (how much an individual believes their lives are meaningful and/or full of purpose) and the search for meaning (the degree to which individuals are seeking to find meaning and purpose in their lives) using the Meaning in Life Questionnaire (Steger et al., 2006). Those with more severe suicide risk reported a weaker sense of MIL and less interest in finding a sense of purpose and meaning. They found that having MIL reduced the risk in actively suicidal soldiers. Dissecting this a little further, Bryan, Oakey and Harris (2018) found that feeling a responsibility to family and fear of suicide was positively correlated with MIL. Suicide risk within this study was defined by a score on the Scale for Suicide Ideation (SSI), with higher scores indicating more severe suicide risk. This is a controversial claim as clinical suicide risk is not purely defined by the presence and level of SI (Silverman & Berman, 2014).

POSITIVE AFFECT (PA)

Joiner et al. (2010) define PA as the ability to experience positive moods, which they posit allows an individual to temporarily broaden their cognitive ability and therefore acquire skills resulting in better outcomes. They found that having high PA meant an improvement in suicidal symptoms over six months. However, they note that this is a provisional study of this construct due to the poor measure of PA that was used. This was reflected in the quality assessment which showed poor statistical assessment of the reliability and validity of this measure.

PROBLEM-SOLVING CONFIDENCE (PSC)

This is defined as the cognitive component of problem-solving which means that an individual has confidence, and not necessarily ability or style, to solve problems (Donald et al., 2006). Donald et al. (2006) found that PSC is a protective factor when comparing suicide attempts with a community sample of non-attempters, however, this paper was the lowest scoring on the quality assessment and also used a case-control design. This paper scored lowest in the theoretical framework being explicit which means that it was not clear why PSC might be an interesting protective factor to study. It also scored low on the reliability and validity of measurement tools as this was an idiosyncratic measure of PSC which was not clearly explained within the paper. This makes it difficult to understand the role of PSC as a protective factor. Joiner et al. (2001) similarly looked at problem-solving attitudes and found that problem-solving ability improved over time more in those patients with high PA. They found a mediating effect of problem-solving ability on PA and suicidality.

INTERNAL LOCUS OF CONTROL (LOC)

Having an internal LOC means that an individual believes that the effect of their actions is attributed to them and not some external source, therefore they have a sense of control and mastery (Pearce & Martin, 1993). Donald et al. (2006) found that having an internal LOC was protective for young people against suicide. However, the quality assessment findings (as noted above in *Problem Solving Confidence*) make it difficult to understand the role of locus of control as a potential protective factor in suicidal individuals.

POSITIVE FUTURE THINKING (PFT)

This was reported on by one paper (Rasmussen et al., 2010). It is hypothesised that there are a number of 'rescue' factors which moderate the relationship between someone feeling trapped (entrapment) and suicidality (Rasmussen et al., 2010). PFT is one of these factors as measured by the Future Thinking Task (FTT; MacLeod et al., 1997). In this task, individuals are asked to generate any positive things which will happen to them in the future. They found that those who had repeat SA had significantly fewer positive future thoughts than the hospital controls and that there was a negative correlation between suicide ideation and PFT. They found that it did moderate the relationship between entrapment and SA. This was the highest scoring paper on the quality assessment as it clearly linked theory to the study and used reliable and valid measures which fitted the research question.

POSITIVE MENTAL HEALTH (PMH)

One paper looked at PMH (Brailovskaia et al., 2019). They state that this is a variable which confers resilience to suicide ideation. It is defined as 'high levels of subjective and psychological well-being' (p. 246). It is measured in this study using the PMH scale (Lukat et al., 2016) which comprises of nine items looking at being in 'good spirits', having satisfaction and confidence in life, enjoying life, being equipped to fulfil needs and deal with difficulties, being in good physical condition and finding joy in things. Brailovskaia et al. (2019) found that PMH negatively correlated with frequency of lifetime SI and number of lifetime SA, and that PMH buffers the impact of lifetime SI in lifetime attempts. Having recruited actively suicidal participants and then studied lifetime suicidality, the results show that for inpatients who are acutely suicidal, having PMH buffers against making a suicide attempt. However, PMH is very

scarcely studied within the suicide literature, in fact, most of the published studies in this area come from this research group. In addition, PMH is poorly defined and therefore has very little clinical utility. Without a clear definition, it would be difficult to incorporate this potential protective factor into an intervention.

DISCUSSION

Factors that protect individuals from suicidal thoughts and behaviour have been studied in addition to those factors which increase the risk of suicide. The aim of this systematic review was to identify the psychological factors that protect against suicidal thoughts and attempts in those who are acutely suicidal. Fifteen papers fulfilled the inclusion criteria and were included in this review. A number of protective factors were identified: coping; self-efficacy; reasons for living; perceived social support; effectiveness of obtaining resources; hope; meaning in life; positive affect; problem-solving confidence; internal locus of control; positive future thinking and positive mental health. This review found that there were mixed results in RFL and coping, however, suicide attempts are found to be reduced in those who express a greater ability to use suicide-related coping. Another factor that was found to be protective against future suicide attempts was self-efficacy, the perception that one is able to achieve in life. Effectiveness of obtaining resources and perceived social support may mediated the relationship between self-efficacy and suicidal behaviour and thoughts. Further promising results were found in meaning in life and positive future thinking. Meaning in life was found to be lower in those more at risk of suicide, and PFT was found to mediate the relationship between entrapment and suicidality.

These results should be considered in light of the various limitations that are both highlighted by the papers themselves and by this review. One of these limitations is the research

design. Although case-control studies are useful in understanding potential protective factors, it is an assumption that these protective factors are obtainable within those who are acutely suicidal. For example, if we find that in comparison to attempters, non-attempters have high levels of PFT, we assume that PFT can be increased within those who are suicidal. Further research is needed to know whether this is the case by studying those who are acutely suicidal over time when PFT has been targeted by an intervention. Therefore, more information can be gathered from longitudinal designs where one protective factor is measured over time. If this factor is found to increase in individuals as suicidal behaviour decreases, then this gives more information in identifying protective factors within acutely suicidal individuals. Papers which followed this design and were of a higher quality were Brüdern et al. (2018), Bryan et al. (2019) and Interian et al. (2019).

Those factors which were studied longitudinally were reasons for living, meaning in life, problem-solving and positive affect. It was found that the risk of suicidal behaviour reduces if there is meaning in life, and that if someone has confidence to solve problems, this mediates the relationship between thinking positively about things and suicidal behaviour. Another moderator to suicidal behaviour, this time from feelings of entrapment, is having positive future thinking. In addition, having an internal locus of control is protective against suicidal behaviour. For the majority of these potential protective factors, they are only reported on within one dataset and therefore more research is needed before concluding that these are important protective factors. In addition, as the majority of papers do not comment upon their power, it is not clear whether they were powered enough to reveal statistically significant results (see Table 1.2). Only two papers reported on whether their sample size fit the calculations for analytical requirements (Brailovskaia et al., 2018; Rasmussen et al., 2010).

The results highlight that coping with suicidal urges is an important factor in preventing suicide attempts in the future. This is extremely important when thinking about effective interventions. Learning skills to cope is vital to those who suffer with suicidal thoughts on a regular and prolonged basis (Linehan, 1987). Interventions such as Dialectical Behaviour Therapy (DBT; Linehan, 2015) would be particularly appropriate for this skill-building. Other factors which are studied by only one paper within this review will need further investigation. However, they show some promising results for understanding more about protective factors. EOR is one such factor which may be related specifically to domestic violence survivors; however, higher levels were found to relate to non-attempters in comparison to attempters. Further research would benefit from focusing on how EOR in the general suicidal population may be important. It may be a factor related to helplessness and this relationship would need some investigation.

In the papers there are preliminary results on the mediating effect of some protective factors on the strength of relationship between SI or SA and another protective factor. Thompson et al. (2002) found that hope and social support mediated the association between self-efficacy and SA. This highlights that the interaction of these identified protective factors needs more empirical investigation. This again is vital for designing appropriate interventions as the focus may need to be on the mediating variables rather than on factors such as self-efficacy.

In relation to the previous systematic reviews mentioned above, Bryan et al.'s (2018) findings were in keeping with the results from Bakhiri et al.'s (2016) systematic review which found that high RFL correlated with low levels of suicide ideation. Brüdern et al. (2018) did not corroborate this finding. The difference may be related to the distinction between suicide ideation and suicide attempts. Those in Bryan et al.'s study were recruited due to SI, and those

in Brüdern's study were recruited after a SA. There is a possibility that RFL are lower in those with SI and temporarily higher in those with SA (suggesting evidence for the 'suicidal mode' as the paper explains). This is an important point as it is vital within research to consider the ideation-to-action framework (Klonsky & May, 2013) which highlights the importance of treating these as separate processes. Interian's (2019) findings may be important to consider in light of this framework. They found that feeling able to cope with suicidal thoughts protected against future SA. This may indicate that it is a vital factor in protecting individuals from moving from SI to SA and would warrant further research.

STRENGTHS AND LIMITATIONS

There are a number of limitations to this review which must be considered in light of these findings. Firstly, as there were not a high number of published papers that address this research question, the results came from a diverse range of very specific populations i.e. veterans, military populations and African American women. This limits the generalisability of the findings to those populations of individuals presenting to hospitals for suicide ideation and attempts. Joiner et al. (2001) state that their gender distribution of 82% males was 'common'. This is not the gender distribution of the general population. In addition, some military samples had a high numbers of adjustment disorders and lower levels of depression, which was at odds with the other clinical samples. Therefore, more research is needed on protective psychological factors within these general populations in the future in order to reflect the demographics of the wider population. In addition, ten out of 15 studies were from the United States (US), three from Western Europe, one from Australia and one from Israel. These countries may have similar cultural attitudes towards suicide which may limit the generalisability of findings to countries across the world where suicide may be viewed differently. Suicide attitudes in

different cultures may bias the reporting of suicidal behaviour. For example, Pritchard (1996) found that male suicides in China were under-reported due to stigma within that country at the time. This would in turn impact on the results given in a study on protective factors within different cultures.

Secondly, the study designs included in this review were also diverse due to the small numbers of papers published in this area. Some papers used a case-control design, others used a correlational design and some used a longitudinal design. This has implications for the results as certain study designs have more scientific rigour in answering the question posed by this review. It would be beneficial for future research to employ longitudinal designs so we can ascertain what psychological factors are protective for individuals over time. Thirdly, due to this diverse nature of the papers, this review used a narrative analysis and could not include a meta-analysis. If there were more papers which employed the same outcome measures, or same designs, then a meta-analysis on the individual data could be conducted.

Fourthly, this review looked specifically at a clinical population of individuals presenting to hospitals because of their suicidal thoughts and behaviours. Although this is beneficial when looking at those who are at the most risk, and is the most relevant to healthcare provision, nevertheless, it excludes those individuals who are suicidal but do not present to services. It is important to study suicidality across the range of individuals for whom it exists, both in the community and within hospitals. As mentioned in the introduction, a number of systematic reviews have already been conducted across these settings but focusing on one specific protective factor at a time. It would be beneficial for research in the future to synthesise this information and bring together all protective psychological factors in order to understand which are most pertinent to protecting individuals from suicidal thoughts and behaviour. Fifthly, the

quality appraisal tool shows good reliability and validity (Sirreyeh et al., 2012), and is useful for increasing understanding of each included paper (Fenton, Lauckner & Gilbert, 2015), however the items are open to interpretation which may affect the agreement between raters in this review. Fenton et al. (2015) have called for further definition of the language used in the items.

Given these limitations, the review also has a number of strengths to be considered. Firstly, this review focuses on psychological factors. One criticism offered by Thompson et al. (2002) with regards to their variable of perceived social support, was that this only identified someone's perception and not their actual social support. However, this review would argue that it is the perception which is paramount to protecting an individual from suicide, not the actual support that they have. If we know that someone who perceives themselves to have more support, even if this is not achieved in reality, is more protected, then it is the perception that becomes the focus on the intervention and not attempting to link them with more support. Secondly, although the quality assessment tool was discussed above within the limitations, the very presence of a quality assessment tool in this study allows for a deeper understanding of the results. Many systematic reviews published to date do not conduct a quality assessment, and therefore this is a strength of the current review. Lastly, this is the only review to synthesise those psychological risk factors for a group of acutely suicidal individuals. This is important because in clinical services, these are the individuals in need of the most support and intervention. If we are able to understand more clearly which psychological protective factors are important, then we can devise appropriate interventions to prevent suicide.

CLINICAL IMPLICATIONS

Although more research in this area is needed, we can make several conclusions from this review that will aid interventions for suicidal individuals. Firstly, these results show that it is important to assess for protective factors and to ask questions related to the factors in this review: what someone's reason to live is; their coping styles; their confidence to solve problems; what meaning they have in life; what hope they have; how able they are to have positive thoughts about the future; how good they feel they are at getting what they need and how much they feel supported by those around them. Secondly, we can then direct interventions to focus on enhancing these psychological factors i.e. helping individuals to generate reasons to live, to utilise other effective ways of coping, to increase their confidence to problem-solve, to instil hope, to generate positive thoughts about the future and to change their perceptions of the support network they have and how good they are at gaining resources. Brüdern et al.'s (2018) paper is important to recognise when thinking of interventions as they note that their participants were able to generate more RFL after an attempt than RFD after the suicide attempt. They argue for a 'suicidal mode' whereby individuals feel relief and have renewed goals following a suicide attempt. This highlights the need to target interventions at the right time, which may be after this 'suicidal mode' has dissipated. This has implications for clinical services who discharge suicidal individuals quickly following attempts. This may need consideration in order for services to intervene appropriately with suicidal behaviour.

One way to do this would be to use the specific areas of those factors which are studied within these papers. For example, instead of trying to increase general coping, it would be beneficial to focus on how one copes with suicidal thoughts specifically. Interian et al. (2019) talk about using internal coping strategies and external resources. This is akin to those skills taught in Dialectical Behaviour Therapy (DBT) which teach a suicidal individual to tolerate distress and accept difficult intense emotions (Linehan, 2015). Therefore, using DBT with

suicidal individuals within crisis teams and inpatient wards could be trialled (where it is not being used already). This may also have the effect of increasing one's self-efficacy, although this would need to be studied further. Joiner et al.'s (2001) paper shows that increasing positive affect would have the effect of 'broadening cognition' so as to optimise the skill-learning of DBT. In addition to addressing coping, self-efficacy and positive affect, promising results were found in positive future thinking. Interventions could focus on increasing positive thoughts about the future as a way of mediating the effect of needing to escape. Various cognitive techniques could be used here such as being supported to problem-solve and generate alternatives. Other behavioural techniques could also be used to increase positive experiences in the present which may impact on the ability to think positively about the future.

Another specific intervention which could be applied given these results is in increasing the perception for an individual that their life is meaningful. Bryan et al.'s (2019) paper tests the efficacy of an intervention to address this (the Crisis Response Planning (CRP) intervention). Speaking with suicidal individuals about the presence of meaning in their lives, and how they search for meaning would mean that interventions could focus on these specific cognitions and plan for how to achieve this meaning. Drawing all of this information together means that the multitude of factors that may protect someone from suicidal behaviour are known. Although studying individual factors in isolation can be beneficial, it is important to see that a number of factors may be involved in reducing the risk of suicide. It would be beneficial for further research to bring these protective factors together and investigate whether some are more protective against suicide.

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Study into Thoughts within Extreme Distress (STED): A Grounded Theory Study into the Processes Linking Suicide Ideation to Suicide Attempts

Paper 2

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ABSTRACT

Objective: Suicide is a leading cause of death across the world. Researchers have attempted to study the 'suicidal mind' to understand when the risk for suicide increases. More recently, understanding how individuals move from thinking about suicide to making an attempt has been studied and psychological models have been developed to draw these risk factors and processes together. However, these models are narrow in focus, drawing on retrospective data and leave psychological factors ill-defined. Therefore, more research is needed to look at all potential psychological processes involved in suicidal thoughts and behaviour. **Methods:** Eleven participants completed individual research interviews at a major hospital in the UK. **Design:** Grounded Theory was used to analyse the interview data. **Results:** Nine categories emerged from the data: Building Pressure; Blocking out the Intensity; Re-framing Death Positively; Narrowing Focus; Weighing up Options; Planning to Die; Acting; Revealing the Internal World and Improving. **Conclusions:** The theory highlights a narrowing focus on suicide as key to the process from thinking to acting. Other findings were that those who attempted noted a total loss of hope, with perceptions that dying would benefit themselves and others around them. Clinical implications for these findings are discussed. Risk assessment in crisis teams and inpatient wards may benefit from addressing these findings after further investigation.

Keywords: Suicide; Suicide ideation; Suicide Attempt; Suicidal Behaviour; Psychological Processes; Grounded Theory.

Practitioner Points

- Risk assessment within CRHTs and inpatient wards should include exploration of additional psychological processes which may put individuals at a higher risk of attempted suicide i.e. a narrowing focus on suicide with no alternative perspective. Individuals may present at peace, with clarity and relieved in their decision.
- Brief psychological therapeutic approaches could be adopted within acute mental health services to address these psychological processes such as Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT).

INTRODUCTION

Suicide is preventable (World Health Organisation, 2004), yet many people die by suicide each year (National Confidential Inquiry into Suicide and Homicide, 2018). Between 2006 and 2016 in Wales there were 3496 deaths, 22% of whom were known to mental health services in the 12 months prior to their death (National Confidential Inquiry, 2018). Despite continued research into the prevention of suicide, we still cannot accurately predict suicides (O'Connor & Kirtley, 2018). Vital to suicide prevention is the discovery of the factors that elevate someone's suicide risk. The British Psychological Society (BPS) categorises these risk factors into social factors, negative life events, cognitive and psychological factors (BPS, 2016). Social factors found to increase suicide risk are: family history of suicide; access to lethal means (Ribeiro et al., 2016); unemployment and social isolation (van Orden et al., 2010). Negative life events found to increase suicide risk are: previous suicide attempts (Ribeiro et al., 2016); physical illness, and family conflict (van Orden et al., 2010). In addition, there has been research into psychological factors, with an interest in 'getting inside the suicidal mind' in order to understand why people desire, and try, to hurt themselves' (Cha et al., 2018, p.98). Williams (2014) argues that this is because social factors are not sufficient for suicide death, as it is the sense that people make of these social factors and changed circumstances that is key. Psychological factors are defined as the perceptions, attitudes, beliefs, appraisals and interpretations that are made of social and interpersonal situations. This means that the suicidal mind is critical for understanding risk.

THE 'SUICIDAL MIND'

Shneidman (1996) wrote about the 'suicidal mind', positing that nearly all suicides are a result of psychological 'pain' which comes from thwarted psychological needs. Shneidman's work forms the basis of many current suicide models (Barzilay & Apter, 2014). However, Barzilay and Apter (2014) state that there is very little empirical evidence for his ideas, and that psychological pain is not clearly defined meaning it may be overlapping with concepts such as hopelessness. Since Shneidman's work, research has focused on a variety of risk factors contributing to suicidal thoughts and attempts.

Hopelessness and Future Thinking

Following the work of Beck (1979), hopelessness has become a key psychological construct which has received a significant amount of research. It is defined as having pessimistic expectations (Beck et al., 1974). Dixon, Heppner & Rudd, 1994 found that hopelessness had a mediating effect between problem-solving ability and suicide ideation. Future thinking is another concept which has been researched. MacLeod et al. (1993) found that when completing a verbal fluency task, people who were suicidal could think of fewer future positive events than controls, but there was no difference in the number of negative events they expected in the future.

Defeat and Entrapment

In early conceptualisations of the suicidal process, Baumeister (1990) states that ultimately suicide is about escape from the self and the world around the individual due to initial failures. In addition to Baumeister (1990), Shneidman (1996) talks of 'constriction' which means that in the person's mind, suicide becomes the *only* way of escaping. More recently, Williams'

(2014) ‘Cry of Pain’ model states, using Schotte and Clum’s (1982) stress-diathesis model, that certain life events in addition to personality features will leave a person vulnerable to experiencing shame and humiliation. These emotions mean that one feels trapped and suicide becomes a way of escaping. Defeat and entrapment have been found to mediate the relationship between negative appraisals of social support and problem-solving ability on suicide ideation in University students (Taylor et al., 2010), and it mediates the relationship between rumination and suicide ideation (Teismann & Forkmann, 2017). It has also been found to mediate the relationship between rumination, panic and fear of dying with suicide ideation (Li et al., 2018).

Psychological Pain and Rumination

Klonsky and May (2015) see pain as central to the formation of suicide ideation within their Three-Step Theory (3ST). However, they state themselves that they use the term ‘pain’ in the broadest of senses to mean *any* form of pain which results in a desire to die. However, it is still unclear, even in the broadest of senses, what is meant by the term pain when people use it or define it when answering questionnaires related to their suicidal thoughts or attempts. Another factor which has been studied is rumination. Rumination refers to the continuous focus on the distress and pain that the individual is experiencing (O’Connor & Nock, 2014), without a move to problem-solving (Morrison & O’Connor, 2008). In a systematic review, Morrison and O’Connor (2008) found that ten out of eleven studies found a positive association between ruminating and suicide ideation. A recent meta-analysis found that global rumination and brooding were associated with suicide ideation and attempts (Rogers & Joiner, 2017). Brooding is defined as dwelling on the negative consequences of distress (Treynor et al., 2003).

Even though psychological factors are well established within the research literature, the critique of Shneidman's work is still valid: psychological factors are still not well defined. Without clearly defined concepts it is difficult to apply quantitative methods to research. To give a further example, if someone responds positively to a questionnaire regarding rumination, it is still unclear *what* they are ruminating about, or *how* this process of rumination leads to suicidal thoughts and/or attempts. Another critique of this literature is that the focus of research is often narrow, yet suicidal behaviour is complex and multi-factorial (Kral, Links & Bergmans, 2011). This can make it difficult for those working within suicide prevention and mental health services to know which are the most pertinent psychological factors. This is where psychological models of suicide are useful as they draw upon multiple risk factors.

PSYCHOLOGICAL MODELS OF SUICIDE

The Interpersonal Theory of Suicide (ITP; Joiner, 2005)

Joiner identified two main factors that are involved in someone thinking about suicide: thwarted belongingness and perceived burdensomeness. These factors together create a desire to die within the individual. He then posited that an individual will go on to attempt suicide when they have acquired the capability to end their life. He stated that this capability usually becomes acquired through the exposure to 'painful and provocative' events. This accounted for risk factors such as previous self-harm and suicide attempts, experiencing childhood sexual and/or physical abuse, having a high pain tolerance and also getting tattoos and piercings.

Integrated Motivational-Volitional Model (IMV; O'Connor, 2011)

O’Connor (2011) developed his IMV model in addition to Joiner’s ITP model and to further the ideas around acquired capability. The aim of this model was to be able to predict suicide attempts and it states that a good predictor of behaviour is the intention to act (based on the Theory of Planned Behaviour; Ajzen, 1991). Therefore, the IMV model attempts to explain how intentions are formed. O’Connor also draws largely upon Williams’ (2014) ideas of defeat and entrapment. O’Connor (2011) expands on this to introduce ‘threat-to-self moderators’ which increase or decrease the likelihood that someone who is feeling defeated, will then also feel trapped. He draws upon the literature regarding poor problem-solving, autobiographical memory biases and rumination to explain this process. O’Connor then talks of ‘motivational moderators’ which increase the likelihood of someone who is feeling both defeated and trapped, to then think of suicide as the way out of this situation. Joiner’s ideas of belongingness and burdensomeness are important here, along with the ability to think of the future, thwarted goals, depleted resilience, lack of social support and positive attitudes around death and dying. O’Connor then argues that a person will go on to attempt suicide when they have not only the capability to do so, but access to means, impulsivity, high pain tolerance, fearlessness around death and previous suicidal attempts. Some of these factors, such as the exposure to suicide (either through family and friends or through glamorisation in the media), may contribute to their feeling of capability.

Therefore, there are a number of risk factors implicated in suicidal thoughts and attempts. These risk factors can be categorised into social factors, negative life events, cognitive and psychological factors. The importance of psychological factors is clear, as it is often the sense that people make, or the beliefs they hold as a result, of social circumstances or negative life events that leads to suicide attempts. Therefore, these factors must continue to be studied. The various psychological factors which have been implicated in playing a central role in suicidal

behaviour are: psychological ‘pain’; problem-solving ability; deficits in attention; deficits in autobiographical memory; attention to suicide-related or death-related stimuli; feelings of entrapment; perceived burdensomeness; thwarted belongingness and hopelessness. In order to make sense of the many and varied factors, psychological models of suicide have been developed. In early models there was no distinction between suicidal thoughts and suicidal behaviour. However, as many people who think about suicide do not go on to attempt to end their lives, it has been argued that these processes should be separated out (Klonsky & May, 2013). Therefore, there are now psychological models of suicide which attempt to explain the process of moving from thinking to acting (the ‘ideation-to-action’ framework).

It is proposed that there are two issues with these existing psychological models of suicide. The first is that they often draw on retrospective data to test their aims and hypotheses. It is argued here that in order to fully understand the process by which an individual makes a suicide attempt, the participants need to be currently suicidal in order to access those thoughts and processes. The second is that these models rely on previous theories and the study of risk factors, in order to know which factors are the most appropriate to include within their models (van Orden et al., 2010). However, we still experience large numbers of suicides in the UK every year (National Confidential Enquiry into Suicide and Homicide, 2018). Therefore, we suggest that there may be other factors that are missing from these existing models. As the focus of these existing models can be seen as narrow (Barzilay & Apter, 2014), we need further research to know whether the risk factors that we are studying are the most important factors. One way of exploring risk factors in a way which does not continue to empirically test those *known* risk factors, is to use a grounded theory method with interviews conducted with suicidal individuals at the time of distress.

AIMS OF THE PRESENT STUDY

The aims of this present study are:

1. To recruit from an actively suicidal clinical sample to elicit the psychological processes at the time that they occur (Glaser & Strauss, 1967, as cited in Starks & Brown Trinidad, 2007). It is vital to elicit these processes at the time because cognitions are thought to only occur for 'brief periods of time' (Beck, 2001).
2. To determine *any* psychological processes linking thinking about suicide to acting on these thoughts.

METHOD

PARTICIPANTS

Eleven participants were recruited from the Crisis Resolution Home Treatment Team (CRHTT) and inpatient mental health ward in a district general hospital within South Wales, United Kingdom (UK). Demographic details are given in Table 2.1.

Age Range	19-54
Gender	
Male	6
Female	5
Referral Source	
CRHTT	6
Inpatient	5 (4 informal; 1 Section 2)
Diagnosis	
Depression	3
Emotionally Unstable Personality Disorder	3
PTSD	1
No diagnosis	4
Suicide Ideation/Suicide Attempt	
Suicide ideation alone	3
Suicide attempt	5
Current suicide ideation with historic attempt	3

Table 2.1: Demographic details of participants

Inclusion Criteria

Participants were included in the study if they:

- Were under the care of the CRHTT or ward due to significant suicide ideation with risk of an attempt, or a suicide attempt.
- Were adults aged 18 and above.

Exclusion Criteria

Participants were excluded if they:

- Were unable to give informed consent (as determined by the mental health practitioners within the teams or by the researcher upon initiation of the research interview). Reasons for being unable to consent include active psychosis; cognitive deficit impacting on capacity or being under the influence of substances at the time of the interview.

- Were discharged from the CRHTT or ward before the time of the interview
- Had verbally expressed that they had accidentally harmed themselves.

Informed consent was obtained prior to the research interviews (see Appendix 2.1).

INTERVIEWS

Semi-structured interviews were conducted, recorded and transcribed by the author (see Appendix 2.3 for the initial questions asked). The initial interview schedule was devised using Charmaz (2014) as a guide, and in consultation with one supervisor. Initial questions were open-ended, following questions were specific to the research question, and the final questions allowed for any other data to be gathered. The questions were designed to elicit the psychological and thinking process of how one goes from thinking about suicide to acting on those thoughts. Follow-up questions were used for constant comparison i.e. digging deeper into concepts which were mentioned in earlier interviews, and for concepts which were novel i.e. 'could you tell me a bit more about that', or 'explain it to me'. Nine interviews were conducted in the hospital grounds and two were conducted over the phone due to Covid-19. The interviews ranged from 34 to 69 minutes.

Theoretical Sampling

Due to time restrictions and the impact of Covid-19 on recruitment, there were limited opportunities for theoretical sampling as the sampling was predominantly convenient. However, once categories began to emerge within the data, new research questions were developed to 'examine these ideas through further empirical enquiry' (Charmaz, 2014, p.199).

The interview schedule was adapted in keeping with grounded theory methodology as a response to the aims of the research, introducing additional questions based on the emerging categories of the initial interviews and to facilitate constant comparison of the data (see Appendix 2.4). For example, the category of 'Being a Burden' was beginning to emerge from the data and therefore the question was developed: 'what impact do you think the suicidal thoughts and attempts have had on your relationships with other people?' If there were more time to expand this research, theoretical sampling could be used.

DATA ANALYSIS

The aims of this research were to explore in detail the process involved in starting to think of suicide and in making a suicide attempt. Grounded theory methodology offers the researcher a way of organising transcribed data and a structured process in which to develop themes and theory from within. As Charmaz (2014) states, the methodology consisted of:

1. Initial line-by-line coding: Coding each line by using gerunds.
2. Focused coding: Subsuming initial codes into wider focused codes; re-naming larger sections of data to improve accuracy. This was done by constant comparison both within each transcript and between participants.
3. Memo-writing: This process allowed for relationships between codes to be considered and therefore focused the next stage of raising focused codes to conceptual categories. Memos allowed for hypotheses about the data to be made and where the process was not clear, further questions were added to the interview schedule.
4. Conceptual categories: Focused codes were raised to conceptual categories. Diagramming was used to aid this process.

5. Theoretical coding was used to examine the relationships between the conceptual categories. Memo-writing captured the relationships between the categories in relation to the context, causes, consequences, covariances, contingencies and conditions (Glaser, 1978).

Data saturation was not reached due to time constraints. Reliability checks were conducted with one supervisor and with two colleagues. Examples of the data analysis can be found in Appendix 2.6. Quality of the grounded theory method was considered using a checklist (Charmaz & Thornberg, 2019; see Appendix 2.9).

ETHICAL CONSIDERATIONS

Ethical approval for the study was obtained through Health and Care Research Wales (HCRW; see Appendix 2.5). In line with this approval, participants were first presented with an information sheet (see Appendix 2.2) and given at least 24 hours to consider taking part. The information sheet and consent form were developed with a service user. Participants were free to withdraw from the study at any point (see Appendix 2.2). The participants were still receiving care from the CRHTT or inpatient ward at the time the interview was conducted. One interview was terminated early due to the level of distress that the person was experiencing. Clinical support was given to the participant via the clinical team immediately after the interview ended.

REFLEXIVITY

The author is a final year trainee clinical psychologist. One supervisor is a clinical psychologist working with the teams involved in the study, and the second supervisor is also a

clinical psychologist working in another CRHTT, and a supervisor as part of clinical training. Supervisors were there as experienced clinicians to help develop questions, codes, and in the reflective process. Discussions with supervisors allowed the author to reflect on her position and experiences so as to give transparency and authenticity to the data analysis. The author is aware of her position as someone who had not experienced suicide ideation or made an attempt herself, but as someone who had experienced suicide personally. The author is someone who had worked in suicide risk assessment and intervention as both as assistant psychologist and trainee clinical psychologist over the last seven years. The previous experience of the trainee meant that the coding and analysis of interviews were seen through the lens of psychological models into suicide and risk factor research. Another lens which was also present was that of existing psychological literature and clinical practice. The author sometimes found herself labelling behaviour, emotions and thoughts as described in the literature. To guard against these issues a reflective diary was used (see Appendix 2.7) to identify these existing pre-conceptions and assumptions made of the research participants, and to notice this in order to continue to be grounded in the data (reflexive bracketing; Ahern, 1999).

RESULTS

From the analysis, nine categories emerged which were central to the process addressed by the research question (the full process can be seen in Figure 2.1): Building Pressure; Blocking out the Intensity; Re-framing Death Positively; Narrowing Focus; Weighing up Options; Planning; Acting; Revealing the Internal World and Improving. There were a number of sub-categories which relate to each of these categories, which will be presented within this section. Focused codes relating to these sub-categories are presented in italics.

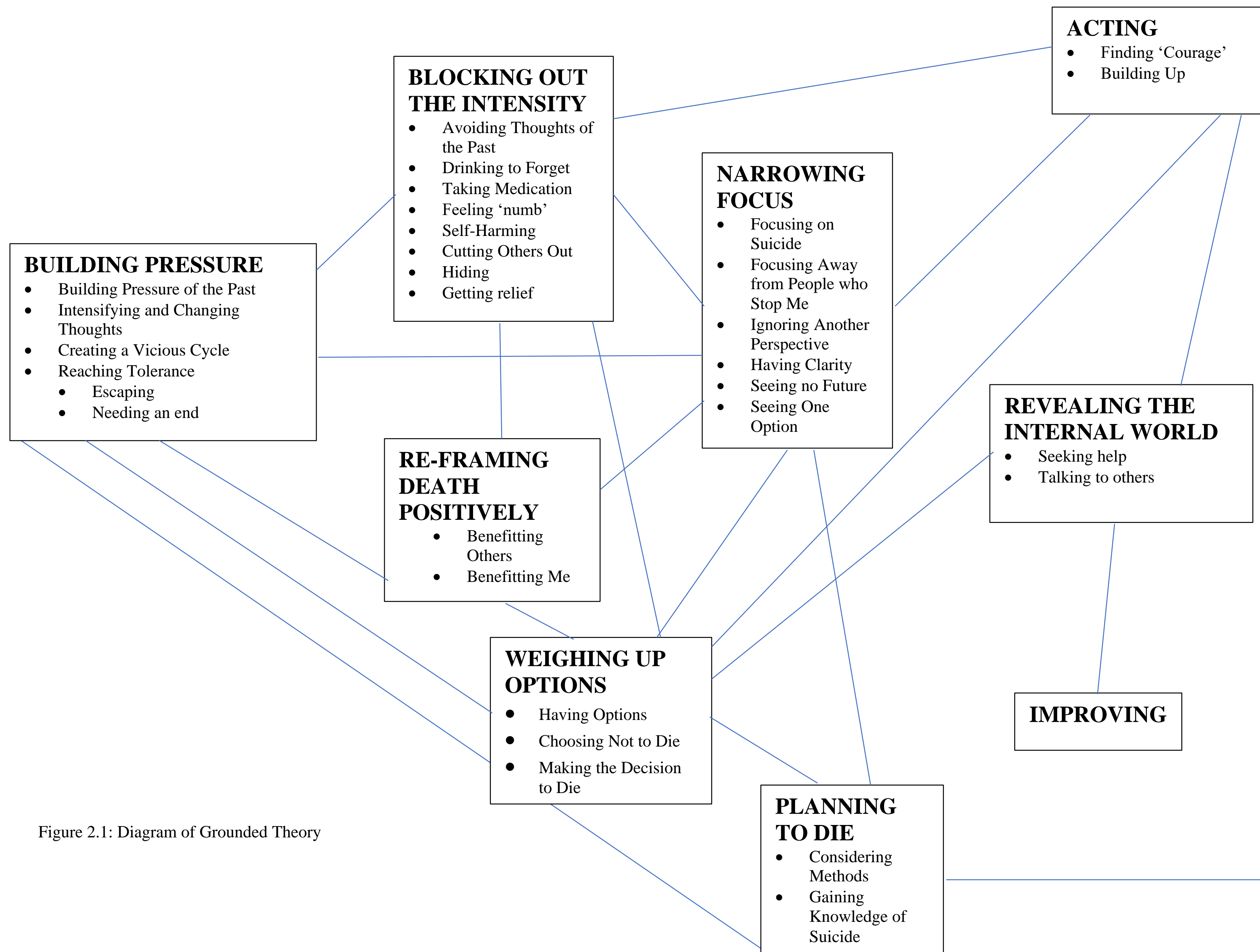

Figure 2.1: Diagram of Grounded Theory

CATEGORY: BUILDING PRESSURE

Included in this category are the sub-categories of Building Pressure of the Past (the content of the thoughts), Intensifying and Changing Thoughts (the nature of the thoughts), Creating a Vicious Cycle (how this is maintained), and Reaching Tolerance.

Sub-Category: Building Pressure of the Past

> *"It's just a bit of everything really. It's a build up from like, going back to my childhood. I've had a tough upbringing with my Dad. My Mum had left. She had a mental breakdown. So, it's just a build-up of everything"* (Participant 7).

Ten participants were able to recall many difficult life experiences from their past that were impacting their present. These thoughts were not merely there in the background, but were 'building up' to become something which was *Intensifying* and *Overwhelming*. The content of the events which emerged in the interviews were many and varied. The psychological processes involved in this category were *Being Certain* that adversity was going to return, *Feeling Unsafe* because of a sense of threat that remained (due to constant reminders of the past in the environment and others being present). Additionally, *Feeling Abandoned* and *Feeling Unloved* were patterns that continued into their current relationships. In addition, four participants found themselves *Attributing Blame* and therefore felt responsible for traumatic events. This blame and responsibility results in a belief that others would benefit from their death.

Sub-Category: Intensifying and Changing Thoughts

The thoughts from the past were intensifying over time. The thoughts became *Overwhelming* and their *Thinking is Disordered* meaning that they lost concentration, focus and an ability to engage with others.

> *"It is like a literal fog in your brain, you go to do something for example, and then you forget what you're going to do and then you…the thoughts are just jumping around, continuously. I'm thinking one thing, all of a sudden thinking another…*(Participant 3).

These intense and changing thoughts were *Unceasing* and therefore there was no escape from them. As a result of the loss that participants have experienced they evaluate themselves as *Feeling a Failure* and *Feeling Worthless.* One participant described this as a 'negative noise'. For other participants, the content of these thoughts was *Feeling incapable, Undeserving, Feeling Unloved, Feeling Useless,* and *Criticising Myself* in terms of their own behaviour and ideas, which further exacerbated the feeling of being a failure. Part of this intensity was the addition of other difficulties, such as *Panicking*. For some participants this is where the suicidal thoughts began:

> "*It was the anxiety that really brought on the [suicidal thoughts]…because it was the sheer panic. The depression alone I could talk myself around, but when it's the mind and the body working against you, you're almost fighting everything you've got"* (Participant 4).

Sub-Category: Creating a Vicious Cycle

Making Comparisons with who they were before the intense thoughts, or making comparisons with others, reinforces ideas that they are incapable and worthless. The problems created in their relationship with others then means *Navigating Difficult Relationships*. This leaves one with exacerbated feelings of worthlessness, failure and incompetence. Also central to this process is that of *Losing My Normality*. As these intensifying thoughts take control of them (*Being Controlled*), they feel as if they are losing their essence. They also lose who they are because of life experiences such as *Losing Relationship, Losing a Job* and *Experiencing Death.* These losses leave participants yearning for their competent, functioning selves to return, and contribute to the pain and despair they experience.

Sub-Category: Reaching Tolerance

Nine participants spoke about reaching a point where they realised they could no longer cope (*Experiencing the 'Final Straw'*) with the intensity of the thoughts. They perceived that they were *Losing Control* of their own minds and ability to function as they were before.

> *"And they just keep coming back and back. It's exhausting. It's just that feeling that everything is just going to come collapsing down and you're powerless really to stop it"* (Participant 2).

Losing Control also leads to *Experiencing Fear* and it is this combination of the mental and the physical which pushes the participants to the point of *Needing an End* and *Escaping* this despair and pain. Part of *Needing an End* is *Desiring Death*. Death becomes a focus as one of the ways to escape their own minds and situations.

As a result of the building pressure, one must find a way to block this intensity out. Planning to die is a consequence of this building pressure, as is *Re-framing Death Positively.*

CATEGORY: BLOCKING OUT THE INTENSITY

Blocking out the intensity was described as *Avoiding Thoughts of the Past* and *'Shutting off' Emotions.* This occurred as an attempt to protect both themselves and others from the consequences of the intensity e.g. *Being Irritable.* The result of blocking out intensity was that the building pressure was exacerbated. They attempted to block out the intensity by: *Taking Medication; Drinking to Forget, Self-harming* or *Cutting Others Out.* These were wilful decisions which rarely worked to block out the emotions. However, two participants spoke about *Switching off Emotions* which was not wilful and was successful. These two female participants had made serious attempts on their lives and they spoke of *Feeling Numb.* This was pivotal in the process of attempting suicide as it served to reduce all other intense thoughts and allow the individual to focus solely on suicide. Therefore, *Narrowing Focus* can be seen as an intermediary between *Blocking out the Intensity* and *Acting. Blocking out the Intensity* was also the consequence of *Making a Decision* as participants found relief, peace and calm from their thoughts.

CATEGORY: RE-FRAMING DEATH POSITIVELY

Re-framing death positively means that participants saw death as something which would benefit others. Those who had attempted either in the past or currently also spoke of death bringing benefit to them. Both will be explored in this category.

Sub-Category: Benefitting Others

All participants talked about *Being a Burden* to those around them. For some, this was due to their emotions and mood, for others it was due to a physical illness. Being a burden was defined by the participants as having an imbalance in their lives (i.e. others doing more for them than they are able to do for others). Part of this is taking others' time and also relying on them. Death becomes an option to bring an end to this:

"*Just to, you know, put them out of my misery I suppose"* (Participant 3).

Sub-Category: Benefitting me

Those who attempted suicide spoke of thoughts that death would be beneficial to them as it would mean *Solving all Problems*, give them something to achieve (*Achieving with Suicide*) and would reunite them with their loved ones. Also, suicide attempts provide a way of *Regaining Control* when it has been lost. These thoughts occur as a result of the difficult life experiences they have had. For those participants that thought in this way, they talked of *Lacking Purpose* before the thought of suicide and being consumed by all of their problems. Suicide provides something which life cannot give at this point (*Gaining Purpose).*

The context in which *Re-framing Death Positively* happens is when the intensifying thoughts impact on others. The consequence of re-framing death positively is that it lessens the intensity (*Blocking out the Intensity*) and creates a *Narrowing Focus* on suicide.

CATEGORY: NARROWING FOCUS

This category highlights that individuals are *Focusing on Suicide* and *Focusing Away from People Who Stop Them*. They become *Determined* and are *Ignoring Another Perspective*. The result is *Seeing No Future* and *Seeing One Option* to get away from the intensity. These feelings mean that the uncertainty is now gone (*Having Clarity*). This is vital to those who have attempted suicide as they all experience this benefit of a narrowed focus and some peace when previously there has been despair.

"And all of a sudden there was the clarity back again" (Participant 3).

This narrowing focus occurs in the context of *Making a Decision* and a resulting *Blocking out the Intensity.* The consequence is *Acting* when the focus is narrowed completely and an outside perspective is missing. The conditions needed for this to occur are *Building Pressure* and *Re-framing Death Positively.*

CATEGORY: WEIGHING UP OPTIONS

"I think it was just weighing up the options. Again, almost in a black and white pragmatic way. Was that, well, you've got two choices here. That's how it felt at the time, with the two choices. You carry on as you are. Or take the second option, and it all stops, it all ends" (Participant 11).

All participants talked of considering what their options were to change their situation and internal experiences due to *Needing an End*. All spoke of *Having Options*: to carry on as they are; to try something different, or to die by suicide. The options can both be painful:

> *"It was like I was in a burning building and I didn't want to jump, but I was getting burned and I didn't want to get burned…jumping just the lesser of two evils"* (Participant 4).

This is crucial to noticing the difference between those who think of suicide and then decide against it, and those who decide to act on those thoughts. It is worth noting that participants made different decisions at different points in their life and it is this which will be explored within this category.

Sub-Category: Choosing not to die

Choosing not to die involves a combination of factors: thinking of relationships with others and being aware of the impact that it would have on them; having some hope for change in the future; still having some purpose (in life in general and in relationships), and still fearing death. Also important to the decision to not die is one's previous experience (*Acting Before)*. When there is hope experienced by a previous attempt then there is a firm decision to not try again. Conditions whereby this happened were when others were directly reminded of their loved ones when they were seriously considering (or even about to attempt) suicide. The consequences are that participants sought help and therefore revealed their internal world to others.

Sub-Category: Making the Decision to Die

Those who made the decision to die were those who talked of an inevitability of suicide (*Going to Happen*) as they predict that the worst is going to happen, or that there will be no hope in the future (*Predicting the Future*). There needed to be something which happened in order for the decision to be made, and participants talked about needing this ‘push’. The context in which participants make this decision to die is when the other options will be ineffective and the issues will not be solved. The consequences are a narrowing of focus, specifically a relief that this is going to be over. The conditions needed for this decision are in the loss that participants experienced close to the suicidal attempt (*Building Pressure)* and the compounding of the idea that death is the only option.

CATEGORY: PLANNING TO DIE

Out of the 11 participants, 10 had made explicit plans on how to die by suicide and eight of these included details of where, when and how they were going to die. One acted with things that he saw around him in his environment and had never planned to die by suicide with any detail. Five participants had a plan before they were going to act (two of whom went on to act with that plan). Five participants acted first and then developed plans over time after this attempt). This shows that there is variation in when the plans are developed, which highlights that having a plan does not necessarily put someone at greater risk of an attempt.

Sub-Category: Considering Methods

One part of the planning process is the consideration of how to die. For some, *Leaving Others Out* was very important, including in *Considering the Aftermath*. The participants had

clearly imagined what the aftermath would look like and were able to put themselves in the shoes of their loved ones, or even strangers. Some methods were chosen by one participant because it left uncertainty as to whether they would be effective or not. This appeared to reflect her general ambivalence to death. For all others, *Finding Effective Ways to Die* was vital. For all participants, *Using Available Methods* was considered, dependent on *Experiencing Illness* and considering their location. Deciding against a method occurred for those who had experienced suicide in another and witnessed the aftermath.

Sub-Category: Gaining knowledge on suicide

Knowledge on methods was gathered through watching television and through searching the internet (for two out of the 11 participants). Others had not researched it but felt a sense of certainty that their method would be successful. Others gained some knowledge, but only through acting in the past. This knowledge was built upon for next time.

Planning to die happens in the context of the *Building Pressure* of the past. A consequence is a *Narrowing Focus* because spending time *Considering Methods* means that the focus further narrows on suicide. Narrowing focus is a mediator to *Acting* as having a plan in and of itself does not result in an attempt in this sample.

CATEGORY: ACTING

Sub-Category: Finding 'Courage'

"I think I would have done it…it's finding the courage. And at the moment, I think I can't find the courage…And if adversity comes in the way I think it might do this year then I feel I might find the courage then to go through with it properly" (Participant 2).

An important aspect to being able to act, is for the fear of dying and killing oneself, to disappear. When this fear is gone, the person feels able (*Being Courageous, Feeling Powerful, Having Confidence, Having Power*) to die by suicide. This courage could be gained through *Drinking* Alcohol and *Taking Medication* which allowed the participants to forget and to feel capable.

Sub-Category: Building up to an Attempt

Four participants spoke about *Testing out Methods* to see if they would work and to test their capability. One participant was taking increasing amounts of medication to see how much would kill her. She linked this *Being Unsure of Suicide* as she then was resigned to death if it worked, but couldn't work out whether she really wanted to die. Another action involved in building up to the attempt is *Collecting Medication* which was planned in four of the 11 participants.

Acting occurs in the context of making a decision, even when that is a quick decision (*Acting on impulse*). The cause of acting is when the individual is *Blocking out the Intensity* and a *Narrowing Focus.* Acting is contingent on the individual experiencing *Dissipating Fear.* The consequence is that they are *Revealing the Internal World* as mentioned above. The consequence is also that the participants learn what to do for next time if they still desire to die (*Planning to Die*).

CATEGORY: REVEALING THE INTERNAL WORLD

The participants spoke of revealing their distress and despair in two different ways: before or after the attempt. Those who revealed their internal world before an attempt did so in the context of *Reaching Tolerance*, caused by the need to block out the intensity they were experiencing. This group chose to seek help with either professionals or with friends and family instead of acting on those thoughts. They had others who they were willing to share with (*Having a Close Friend; Letting Others In)* and also hoped that this might change things. The consequences of this however were that they felt as if they were further burdening them but also that the intensity had lessened. Therefore, there is a link between revealing the internal world and *Improving* for those who did not act.

The second group did not reveal their internal world before acting, but rather revealed it in the context of acting i.e. because they came into contact with services, their internal worlds were revealed. Those who did not share their distress either did not have loved ones or were afraid of the repercussions (*Being Rejected; Being Misunderstood; Worrying About Others Leaving).* This was the result of previous experiences where this had happened and had made their problems worse. This is also related to other categories because hiding the truth is to avoid *Being a Burden* and *Losing Control:*

> "*I don't know, so then if I tell someone, then they have control again, and I don't like that*" (Participant 9*).*

Those who did not seek help had weighed out the options and had made a decision to die with a covarying desire to die.

CATEGORY: IMPROVING

Although the focus of the research is on how individuals think about suicide and the process of making an attempt, most participants spoke of having moments of improvement in their distress. These moments are important when considering the attempts and what prohibits someone from acting. Participants noticed an improvement when they were *Achieving in Life* again, *Being Supported* by others (whether that was mental health professionals, work colleagues or family), *Enjoying Things Again, Engaging in Activities, Noticing Positives, Regaining Control* and *Returning to Normality.* This category helps distinguish between those individuals who expressed that they were going to attempt again with those who had attempted and then decided against it. Those who want to act again are those who have no hope of improvement and who still feel that there is no escape. Those who have acted and then seen that their lives can improve, are those who have made decisions not to act again. Therefore, improving is contingent on *Having Hope.* Improving occurs in the context of being able to reveal the internal world to others.

DISCUSSION

The aim of this research was to identify any psychological process that links suicide ideation to attempts in acutely suicidal individuals. Its purpose is to expand our knowledge on the 'suicidal mind' in order to better assess risk in those who are suicidal and to provide appropriate

intervention. Using grounded theory, there were nine identified categories which emerged as central to this process. This theory posits that suicide ideation starts when individuals have experienced a building of pressure from their past and their thoughts and emotions intensify. This building pressure needs to be blocked out. Suicide is an option that can solve current problems, end the pain and despair, and make death something that is beneficial for both them and others around them. Those who attempt suicide cannot see the future. They see no purpose, achievement or hope and they think that nothing will change. They make the decision to die as it will solve these problems. It is this narrowing focus on suicide which is vital to the process of making a suicide attempt, as well as when there is no emotion (blocking out the intensity). The attempt itself can then further add to the building pressure for some. For others who are able to repair relationships and regain some hope, there is an improvement in their mood and thoughts.

Existing Research

Some of the categories and sub-categories confirm what we already know about suicidal behaviour: that individuals perceive themselves to be a burden to those around them (Joiner, 2005); that individuals are looking to escape from the pain that they are experiencing (Williams, 2014); that individuals feel hopeless (Klonsky & May, 2013) and that there is a narrowed focus on suicide (similar to Shneidman's (1996) idea of 'constriction'). Shneidman's ideas are often thought of as outdated by further research, however, this was shown to be important here. *Blocking out the Intensity, Re-framing Death Positively* and *Building Pressure* all contribute to *Narrowing Focus* in this theory. However, this leads to *Acting* when individuals can see no other perspective at all. Some participants had this narrowing but then

were able to consider the perspectives of their loved ones. Therefore, it is the degree of narrowing that is important in this process.

The sub-category of *Intensifying and Changing Thoughts* which focuses on the *Unceasing* nature of thoughts may well be considered to be the same, or close to, the concept of rumination. Another sub-category which may be considered to be equivalent to previous research on the capability for suicide (Joiner, 2005), is that of *Finding Courage.* The participants here found courage in *Drinking Alcohol* and *Taking Medication,* but also the key for those who attempted was this description of *Dissipating Fear*. Their fear was gone when they made the decision to die and they gained confidence, power, relief and peace. This echoes O'Connor's (2011) idea of fearlessness around death.

However, this theory also offers additional information that may be used to understand these existing concepts. For example, *Being a Burden* is a well-known element to these models and is used in clinical risk formulation, however, *Re-framing Death Positively* subsumes this category. Participants did not just speak of being a burden, but went further to say that they would benefit from their death in that they would achieve purpose, control, and their problems would be solved. This served to block out the intensity of the thoughts and to further narrow their focus on suicide.

This theory calls into question some of the existing research on hopelessness. Klonsky and May (2013) state that hopelessness does not differentiate ideators from attempters. However, in this sample, those who were completely devoid of hope were those who acted. Those who chose not to die had some degree of hope for change. This means that although hopelessness may be present in both groups, having some degree of hope can delineate the process.

Therefore, the key to clinical risk assessment would be to ascertain the *degree* of hopelessness, not just it’s presence.

Novel Findings

This theory also presents novel findings to the area of suicide research. One such finding is the process of *Narrowing Focus* and its interaction with *Blocking out Intensity* and *Making a Decision.* Participants spoke of getting relief from making a decision to die as they gained clarity, peace and purpose. This reinforced the view that suicide is the only option, as it brings a perceived benefit to the individual in that moment. This has clinical implications for risk assessment as individuals may present as calm, at ease, and at peace. They may be feeling numb and the fear surrounding death may be gone. Therefore, clinicians working with suicidal individuals would benefit from asking questions relating to fear of death and an absence of feelings in a risk assessment.

Another novel finding is that of *Losing Control.* The idea of control permeates a number of categories in the theory presented here. All participants perceived a loss of control or being controlled by another entity in their lives and this was contributing to the maintenance of their suicidal thoughts (*Creating a Vicious Cycle)*. The perception that one is *Losing Control* is vital to the process of *Reaching Tolerance* and seeking ways to escape. This also impacts on how able one feels to *Reveal the Internal World* as that control may be further removed by letting others know of the distress. Control is a concept which warrants further research. However, one potential link with existing research is Linehan’s (1991) intervention with suicidal individuals whereby skills can be learned to control their emotions (emotional regulation) and control the effects of others on their distress (interpersonal effectiveness) (as cited by Joiner et

al. 2002). Dialectical Behaviour Therapy (DBT) would address these difficulties, yet many health services within Wales do not use a DBT approach within CRHTs and inpatient wards.

Strengths of the study

This study is unique in asking suicidal adults at the time of being actively suicidal, what their processes are in moving from thinking about suicide to attempting. This also gives a voice within research literature to those with lived experience of suicidal behaviour. The strength of a grounded theory approach is that it allows for existing understanding to be subject to 'empirical and analytical scrutiny' (Charmaz, 2014, p.32). Therefore, the existing research can be scrutinised and possible processes which have not been empirically studied can come into the foreground. This is vital when translating to clinical settings in how professionals intervene and manage risk.

Limitations of the study

Although it is a strength of the study that individuals were interviewed at the time that they were actively suicidal, this also means that for some individuals, trying to access their cognitive processes was hampered by their emotional state. For one participant the interview was shortened in order to accommodate the distress. It could also have been the case that due to their involvement with health services, the individuals may have been 'motivated to deny or conceal such thoughts to avoid intervention or hospitalisation' (Nock et al., 2010, p.512). In a study of inpatients who died by suicide, Busch, Fawcett and Jacobs (2003) found that 78% of those who died did not state they were suicidal in their last communication with the ward. This may have been further impacted by the limits of confidentiality being explained to participants

before taking part. This potential concealment may have had an impact on the data collection due to the depth and insight not being present for all participants. Nevertheless, the categories were well developed and so it is unclear whether this occurred or not. The limits of confidentiality are a vital part of the research in order to keep the participant (and others) safe whilst they participate. Studying individuals at the time they are acutely suicidal also means that these results, and the model, are likely to be applicable only to similar samples of individuals.

Another limitation to the study is the potential for the suicide research and wider societal ideas about suicide to influence both the way the participant labels processes, and the way this is heard by the researcher. For example, some participants used terminology which is prevalent within mental health services and research i.e. 'rumination'. By using this term, an idea of what this means was already influencing the researcher making sense of it. This then may have impacted the initial coding and the way that these codes became part of the final theory as it is impossible for the researcher to be a 'tabula rasa'. However, the benefit of using grounded theory, and reflexive bracketing, is that concepts and terms are not thought of as theoretical because of their place in existing literature, but because they are grounded in the data collected.

Clinical Implications

Given these findings, there are a number of clinical implications which should be considered. The theory presented here highlights the importance of social factors on suicide attempts through the cognitive processes that result from these experiences. Especially for men within the sample, suicide attempts came as a result of feeling inadequate, a failure, and worthless as a result of relationship breakdowns and job loss. These thoughts then led to relief

when the focus narrowed on suicide. Therefore, it is imperative to consider these social factors when assessing suicide risk within CRHTs, psychiatric liaison teams and inpatient wards.

This theory also identifies other factors to consider when assessing risk within suicidal individuals. It is vital that mental health professionals ask about the potential benefits that death will bring to the individual, whether emotions have been 'numbed' or 'shut off' and whether the individual is feeling in control of their emotions and of others around them. Risk assessment would benefit from further research into these areas with consideration for these concepts to be included in psychological models of suicide if they are validated. If these factors are substantiated then it would be beneficial to look at brief psychological therapeutic approaches for CRHTs and wards to be able to intervene with these psychological processes. These processes give some indication of potential therapeutic interventions which could be offered to acutely suicidal individuals. Given the finding that blocking out the intensity can add to the building pressure, then approaches such as Acceptance and Commitment Therapy (ACT) may help an individual to accept the strong emotions and then defuse those intense thoughts (Harris, 2009). DBT, which has already been referred to, would be another approach which would also address this issue of acceptance. Other non-psychological interventions are also implicated by this theory. Those who chose not die did so because they were physically reminded of their loved ones. Where this is the case, individuals may benefit from keeping reminders of their loved ones visible in places where they may turn for methods to end their life.

FUTURE RESEARCH

This theory provides further direction for research into the psychological processes of those who are actively suicidal. Research would benefit from exploring these categories further, such

as perceived control over one's life, the perceived benefits of death to the individual and the absence of emotions in the decision to die by suicide. These categories may offer more understanding to suicidal behaviour and therefore improve risk assessment and psychological intervention for these individuals.

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APPENDIX 1.1: DEFINITION OF PSYCHOLOGICAL FACTORS

Personality and Individual Differences	Cognitive Factors
Hopelessness Impulsivity Perfectionism Neuroticism and extroversion Optimism Resilience	Cognitive rigidity Rumination Thought suppression Autobiographical memory biases Belongingness and burdensomeness Fearlessness about injury and death Pain insensitivity Problem solving and coping Agitation Implicit associations Attentional biases Future thinking Goal adjustment Reasons for living Defeat and entrapment

Taken from O'Connor & Nock (2014): The psychology of suicidal behaviour

APPENDIX 1.2: SEARCH STRATEGY

What are the psychological factors that protect against suicidal thoughts and behaviour in the clinical population?

Protective Factors	Suicide/Suicide Ideation/Suicide Behaviour	Psychological factors	Clinical Population
Protective factor*	Suicid*	Psycholog*	Clinical
Resilien*	(Suicid*) adj1 (ideation)	Cogniti*	Patients
Prevent*	(Suicid*) adj1 (thought*)	Individual	Hospital
Risk reduc* (adj3)	(Suicid*) adj3 (risk)	Emoti*	Inpatient
Buffer*	(Suicid*) adj1 (attempt*)	Personality	Outpatient
Protect*	(Suicid*) adj1 (behaviour)	Affect	
Positive	(Suicid*) adj3 (thinking)	Distress	

OR was used between items in the same column.
AND was used between the 4 different columns.

APPENDIX 1.3: OPERATIONALISATION OF THE QATSDD CRITERIA FOR QUALITY ASSESSMENT

Criteria	0	1	2	3
1. Explicit theoretical framework	No mention at all	Reference to broad theoretical basis Reference to research	Reference to a specific theoretical basis Reference to research and models	Explicit statement of theoretical framework and/or constructs applied to the research How the theoretical context relates to the specific aims and question of the research is stated
2. Statement of aims and objectives	No mention at all	General reference to aim/objective at some point in the report including abstract Reference in abstract	Reference to broad aims/objectives in the main body of the report Reference to broad aims (hypothesis without aims) in introduction or discussion	Explicit statement of aims/objectives in main body of report Explicit statement of the aims in the introduction
3. Clear description of research setting	No mention at all	General description of research area and background Research area i.e. suicidal behaviour and thoughts	General description of research problem in the target population Suicidal people in hospitals	Specific description of the research problem and target population in the context of the study Suicidal people in hospitals with location in the world
4. Evidence of sample size considered in terms of analysis	No mention at all	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements Sample size calculations are given and final number is above this.

5. **Representative sample of target group**	No mention at all	Sample is limited but represents some of the target group or representative but very small Demographic details given	Sample is somewhat diverse but not entirely representative Mentions who the target population should be and the demographics, but this is stated that it is not representative	Sample includes individuals to represent a cross-section of the target population, considering factors such as experience, age and workplace As 2 but concludes that it is a representative sample
6. Description of procedure for data collection	No mention at all	Very basic and brief outline of data collection procedure Mentions the measures	States each stage of data collection procedure but with limited detail, or states some stages in detail, but omits others Does 1 or 2 out of the 3 mentioned in 3.	Detailed description of each stage of the data collection procedure, including when, where and how data were collected Goes through when data was collected, where, and by whom.
7. Rationale for data collection tools	No mention at all	Very limited explanation for choice of data collection Mentions why some tools were used	Basic explanation of rationale for choice of data collection tools States that they were used in a previous study	Detailed explanation of rationale for choice of data collection tools Relates 1 and 2 to the research question
8. Detailed recruitment data	No mention at all	Minimal recruitment data Number of people seen	Some recruitment information but not complete account of the recruitment process Number of people seen and number in analysis	Complete data regarding number approached, number recruited, attrition data where relevant, method of recruitment Number approaches, number seen, attrition levels and final numbers in analysis. Explanations for drop-out.
9. Statistical assessment of reliability and validity of measurement tools	No mention at all	Reliability and validity of measurement tools discussed, but not statistically assessed	Some attempt to assess reliability and validity of measures tools, but insufficient	Suitable and thorough assessment of reliability and validity of measurement tools with reference to the

		Mentions the reliability and validity but no statistics given.	Reliability and validity scores given but only in general, not in relation to their study.	quality of evidence as a result of the measures used Reliable and valid measure within this study.
10. Fit between stated research question and method of data collection	No research question stated	Method of data collection can only address some aspects of the research question	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition	Method of data collection selected is the most suitable approach to attempt to answer the research question
12. Fit between research Q and method of analysis	No mention at all	Method of analysis can only address the research question basically or broadly	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail	Method of analysis selected is the most suitable approach to attempt answer the research question in detail
13. Good justification for analytical method selected	No mention at all	Basic explanation for choice of analytic method Basic explanation of what method was	Fairly detailed explanation of choice of analytical method Talks about analytic method and why it was chosen, but not related to question	Detailed explanation of why analytic method was used, in reference to the question
15. Evidence of user involvement in design	No mention at all	Use of pilot study but no involvement in planning stages of study design	Pilot study with feedback from users informing changes to the design	Explicit consultation with steering group or statement or formal consultation with users in planning the study design
16. Strengths and limitations discussed	No mention at all	Very limited mention of strengths and limitations with omissions of many key issues	Discussion of some of the key strengths and weaknesses of the study but not complete	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample and analysis

		Mentions 1 or 2 limitations	Mentions key strengths and/or limitations but not all	Mentions strengths and limitations related to: study design; measures used; procedure; sample; and analysis.

APPENDIX 1.4: INCLUDED AND EXCLUDED STUDIES

<table>
<tr><th colspan="2">Suicide
Clinical
(National Confidential Inquiry)</th><th colspan="2">Protective
(McLean et al. 2008)</th><th colspan="2">Psychological
(O'Connor & Nock, 2014)</th></tr>
<tr><th>Inclusion</th><th>Exclusion</th><th>Inclusion</th><th>Exclusion</th><th>Inclusion</th><th>Exclusion</th></tr>
<tr><td>Anyone entering the study because they are suicidal (ideation, attempts). They must be in A&E/ED, an inpatient or an outpatient because of their suicidality, or suicide ideation/attempt in last 12 months.

SI/SA dependent variable.</td><td>NSSI
Inpatient or outpatient because of schizophrenia, PTSD, depression, anxiety or any other physical health condition e.g. heart failure, psoriasis.

Psychiatric patients where suicidality is not specified.

Another factor is dependent variable i.e. SI/SA not in results.</td><td>It must be reported that it is protective somewhere in the study

Any variable that lessens the likelihood that an individual will engage in suicidal behaviour.

A negative correlation between that variable and suicide ideation/attempts.

Any variable that mediates the relationship between suicidal ideation/attempts and a risk factor.</td><td>Risk factors (those that increase the likelihood of suicidal behaviour).

No mention of protective factors throughout.</td><td>Personality and individual differences

Cognitive factors

Psychosocial – how an individual makes sense of things in their social world I.e. if negative life events lead to rumination, that would be included.</td><td>Social factors.

Environmental.

Neural/brain structure.

Genetic.</td></tr>
<tr><td></td><td></td><th colspan="2">Types of Study</th><td></td><td></td></tr>
<tr><td>Prospective: Study watches for outcomes during the study period.</td><td>Correlational: What relationships naturally occur with one another?</td><td>Correlational

Case-control

Prospective/Retrospective

RCT (where results are reported overall, not just by arm of intervention)</td><td>RCTs (where results can't be gleaned overall)</td><td>Case control study: Observational study in which two existing groups differing in outcome are identified and compared on the basis of one attribute.</td><td></td></tr>
</table>

No.	Paper	Reason for Exclusion						
		Suicide/ Clinical	Study Design	Protective	Psychological	Age	Full-text	English
1	Allan et al. (2015)	Anxiety clinic						
2	Allbaugh et al. (2017)	Suicide historical not current						
3	Bakhiyi et al. (2017)	Lifetime history						
4	Benjaminsen et al. (1990)			All negative				
5	Berlim et al. (2003)	Depression						
6	Bi et al. (2010)			All negative				
7	Brailovskaia et al. (2019)	Y	Retrospective	Y	Positive mental health	Y	Y	Y
8	Brüdern et al. (2018)	Y	Prospective Cohort study	Y	Reasons for Living	Y	Y	Y
9	Bryan, Oakey & Harris (2018)	ED for active military	Longitudinal	Y	Reasons for Living	Y	Y	Y
10	Bryan et al. (2013a)	MH outpatient						
11	Bryan et al. (2013b)	As above						
12	Bryan et al. (2019)	ED for active military	Prospective RCT	Y	Meaning in Life	Y	Y	Y
13	Choi et al. (2013)			Global assessment functioning – severity of MH problem				
14	Daruwala et al. (2018)	Y	Cross-sectional	? Self-efficacy – lower when SI is high	Yes – self-efficacy	Y	Y	Y
15	Davidson & Wingate (2013)	Outpatients seeking therapy						
16	Davidson et al. (2010)	Students						
17	Donald et al. (2006)	Y	Case-control	Y	Internal locus of control	18-24	Y	Y

					Problem-solving confidence			
18	Flowers et al. (2014)	Y Suicide attempt reason for admission	Cross-sectional	Y	Reasons for Living	18-61	Y	Y
19	Garza et al. (2010)	Outpatients referred for therapy						
20	Heisel & Flett (2004)	Psychiatric inpatients – not clearly stated that they are suicidal						
21	Heisel et al. (2016)	Community older adults						
22	Hirsch et al. (2007)	Primary care patients						
23	Hirsch et al. (2014)	Suicide in last year, not reason for admission to hospital ('medical or psychiatric')						
24	Hirsch, Webb & Kaslow (2014)	As above						
25	Holden et al. (1989)	Y (Study 1) 97 patients in acute emotional distress Study 2 – unclear what the results are – they are amalgamated with study 2 – non-clinical	Cross-sectional	N Not a protective factor- looking at questionnaire reliability	Y Social desirability (personality factor)	Y	Y	Y
26	Horesh et al. (1996)	30 inpatients suicidal behaviour 30 non-suicidal 32 healthy controls		Y replacement a useful coping style	Coping styles	Y	Y	Y
27	Hunter & O'Connor (2003)	65 participants: 22 DSH; 22 hospital controls and 21 controls	Cross-sectional	No mention of protective factors in the intro	Y PFT	Y	Y	Y

28	Interian et al. (2019)	Y	Control condition only	Y	Y Suicide-related coping	Y	Y	Y
29	Johnson et al. (2010)	Schizophrenia outpatients						
30	Joiner et al. (2001)	Larger trial of suicidal individuals	Longitudinal	Mediational	Problem-solving attitudes Positive affect	Y	Y	Y
31	Jollant et al. (2017)	Mood disorder or Bipolar disorder						
32	Kannan et al. (2010)	Y		Coping skills and responsibility	Coping and reasons for living	46% in age 21-30, however there are 13 year olds in it	Y	Y
33	Kapoor et al. (2018)	Self-identified, not suicidal at the time						
34	Kaslow et al. (1998)	Non-fatal suicide attempt n = 148 and controls n = 137	Case-control	Coping, family strengths and perceived social support	Perceptions, coping	Y	Y	Y
35	Kaslow et al. (2002)	Non-fatal suicide attempt n=100 Abused women	Case-control	Compared to non-attempters	Hope, self-efficacy, coping, spiritual well-being	Y	Y	Y
36	Kochanski et al. (2018)	Y Suicidal patients		Risk factors - what makes it worse?	Y Wish to Live index??	Y	Y	Y
37	Kovacs et al. (1977)	Y		No reporting of WTL index	Y Wish to Live (intro)	Y	Y	Y
38	Lin et al. (2020)	MDD patients, not suicide						

39	MacLeod & Conway (2007)	Y Suicidal vs. controls		No mention of protective factors throughout	Y Future thinking and coping	Y	Y	Y
40	Marco et al. (2016)	Mental disorder not suicide						
41	Meadows et al. (2005)	Y Suicide attempters vs. non-attempters	Case-control	Y	Y Hope, self-efficacy, coping, resources	Y 18-59	Y	Y
42	Nsamenang et al. (2013)	Primary care clinic – not suicide						
43	O'Connor et al. (2006)	DSH – suicide attempters		All factors in introduction which increased risk of future SB, therefore, risk factors	Self-efficacy, instrumental and affective attitudes	Y	Y	Y
44	O'Connor et al. (2007)	NSSI in with SI and SA			Positive future thinking	Y	Y	Y
45	O'Connor et al. (2008)	Y – suicidal injury with intent		N Did not mention any protective factor	Positive expectancies	Y	Y	Y
46	O'Connor, Smyth & Williams (2015)	Following suicide attempt		Talks about risk, not protective	Positive future thinking	Y	Y	Y
47	Pennings et al. (2015)	Military personnel presenting to training centre						
48	Petrie & Chamberlain (1983)	Y – attempted suicide patients		Factor relating to questionnaires, not protective	Social Desirability	Y	Y	Y
49	Pfeffer et al. (1995)					Children who were		

						adolescents at follow-up		
50	Polanco-Roman et al. (2014)	Undergraduates						
51	Pollock & Williams (2002)	Y Suicidal vs. psychiatric controls vs. controls		Aims are in relation to risk, not protective	Problem-solving and autobiographical memory	Y	Y	Y
52	Pompili et al. (2008)	Bipolar and Major Affective disorders						
53	Rabon et al. (2019)	Primary care						
54	Ram et al. (2020)	Suicidal patients	Cross-sectional Dependent variable is not suicidality	Y	Cognitive resilience, cognitive flexibility	Y	Y	Y
55	Rasmussen et al. (2010)	Suicidal patients		Negatively correlated	Positive future thinking	Y	Y	Y
56	Rasmussen et al. (2011)	Undergraduate students						
57	Roy et al. (2011)	Substance misuse – not hospitalised for suicide						
58	Rudd et al. (1996)	Not clear whether they are suicidal		Not the focus of the study – RCT of intervention	Problem-solving	Y	Y	Y
59	Siegmann et al. (2019)	Inpatient – not suicide						
60	Stefa-Missagli et al. (2019)	Inpatients with a mental health diagnosis – not suicide						
61	Straus et al. (2019)	Nationally representative sample of veterans						
62	Street et al. (2012)	Previous year – not current suicide ideation						
63	Sun et al. (2017)	No attempt in last 6 months						

64	Teismann & Forkmann (2017)	Outpatient – not suicide						
65	Teismann et al. (2018)	Inpatients – not suicide						
66	Teismann et al. (2019)	Outpatient – not suicide						
67	Thompson et al. (2002)	Y Same as Kaslow et al. (1998)	Case-control	Y	Perceived social support and resources	Y	Y	Y
68	Tillman et al. (2017)	Psychiatric disorders – not suicide						
69	Tsoh et al. (2005)	Attempted suicide		Y reported on	Only report on protective being children, not personality	Y	Y	Y
70	Tucker et al. (2013)	Undergraduates						
71	Vasudeva et al. (2017)	Unable to get full-text					N	
72	Walker et al. (2017)	Primary care clinic						
73	Zhang et al. (2018)	Suicide attempt in last year, not suicide reason for hospital stay						

APPENDIX 2.1: CONSENT FORM

IRAS ID: 259863

Participant Identification Number for this trial:

CONSENT FORM

Study into Suicidal Thoughts within Extreme Distress (STED)

Name of Researcher: **Charlotte Davies**

Please initial box

1. I confirm that I have read the information sheet dated 28.08.2019 (version 1.4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that the information collected about me will be used to support other research in the future, and will be shared anonymously with other researchers within the study team. ☐

4. I understand that the interview will be audio recorded and direct quotes will be used in the write-up of the study. ☐

5. I understand that the information held and maintained by XXXX Health Board may be used to help contact me during the course of this study and with the results when they are published. ☐

6. I understand that if there is anything in the interview that is a concern for my safety, or for the safety of others, this information may be shared with my clinical team and information will be added to my health records as a result of this. ☐

7. I agree to take part in the above study. ☐

______________________	______________________	______________________
Name of Participant	Date	Signature

______________________	______________________	______________________
Name of Person taking consent	Date	Signature

APPENDIX 2.2: PARTICIPANT INFORMATION SHEET

Study into Suicidal Thoughts within Extreme Distress (STED)

We would like to invite you to take part in our study. Before you decide, it is important for you to understand why the study is being done and what it will involve for you. Please take time to read the following information carefully and discuss it with others if you wish.

Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Although there has been a lot of research to help prevent suicide, there is still not enough known about what the difference is between those who think about suicide, and those who act on these thoughts. Psychologists have tried to explain this by saying there are different factors that mean someone goes from thinking about suicide, to attempting suicide. These theories have been tested, but that has not included asking about people's own views on their thinking processes. This study aims to find out what people's experience is to see whether psychological theory is helpful in the real world. The longer-term aim is to be able to notice who might be at the most risk of suicide, and work with them in order to prevent this in the future.

Why have I been chosen?

You have been asked to take part because you are under the care of either the Crisis Resolution and Home Treatment Team (CRHTT) or the inpatient ward at XXXX Hospital at this time. Your usual health care will continue and will not be affected by taking part in this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

If you agree to take part, you will be contacted by our researcher Charlotte Davies (Trainee Clinical Psychologist). You will then have an interview with Charlotte at XXXX hospital. This interview will ask you about what was happening for you leading up to your admission to hospital, or your visit to Accident and Emergency (A&E). This will involve talking about what was going through your mind at the time. The interview should last around 1 hour. Once the interview is completed you will be given a £10 shopping voucher to thank you for your time.

Please note:

If at any point during the interview, the researcher is concerned for your safety, or for the safety of others, the interview may stop, and this information will need to be shared with your clinical team. In some cases, this information may need to be shared with others such as the police or social services. If this is the case, you will be told about this at the time. If any information is shared with your clinical team, then this information will go into your health records.

What are the possible benefits of taking part?

There are no specific treatment benefits for you as an individual. However, the aim of the research is to add to what we know about suicide attempts and suicidal thoughts, so that we might work to prevent suicide in the future. This research aims to identify ways we can talk to others in the future who might be feeling the same way as you have.

What are the possible disadvantages of taking part?

This may well be a very distressing time for you. Sometimes when people talk about this in more detail it can mean that they continue to be distressed. However, for other people, talking can be a way of starting to make sense of what you are thinking and feeling.

You are still under the care of the CRHTT or ward and therefore we encourage you to talk to someone who is involved in your care if you are feeling particularly distressed. Please tell the researcher if this is the case and we can arrange for someone to come and talk with you.

What happens if I don't want to carry on with the study?

You are free to withdraw from the study at *any* time. You should speak with the researcher if you would like to withdraw and you do not have to give a reason. You can then talk about whether you would like your interview to be included in the results or not (depending on how far along the research you have got when you withdraw).

What will happen to my personal information?

Any personal identifiable information will be held within the CRHTT or on the ward within the hospital. All interviews will be recorded on a portable voice recorder (property of the South Wales Doctoral Programme in Clinical Psychology). No identifiable information will be on the voice recorder as all participants will be given their own number.

Once the interview has taken place it will be transcribed by the researcher (this means that the recording will be put onto paper, word for word). The transcribed data will be held on an encrypted USB stick. Once the interview is completely transcribed, the original voice recording will be permanently deleted.

What will happen to the results of the study?

The results will be part of the large scale research project required in order to qualify as a Clinical Psychologist on the South Wales Doctoral Programme. The results will be written up for publication in a scientific journal. The research will also be presented at a conference. No participants will be identified in any of the write-up and no-one will be able to identify the hospital where you have been treated.

Results of the study will be put into a newsletter for all of those who have taken part. If you would **not** like to receive this, then please let the researcher know.

How will my data be managed?

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: www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection or by contacting the University's Data Protection Officer: inforequest@cardiff.ac.uk

XXXX (HB) will use your name and contact details to contact you about the research study, and 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. XXXX HB 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 the researchers conducting the study or staff who may need to audit the data collection process.

XXXX HB will keep identifiable information about you from this study for one year after the study has finished.

Who is organising and funding the study?

The study is part of a doctoral research project at the South Wales Doctoral Programme in Clinical Psychology and therefore funding is provided by this programme. The study is sponsored by Cardiff University and supported by XXXX Health Board and has been reviewed by XXXX Research & Development Department.

Study Contacts

Researcher Charlotte Davies	South Wales Doctoral Programme in Clinical Psychology 11th Floor Tower Building Park Place Cardiff CF10 3AT 02920 870582 Daviesc102@cardiff.ac.uk
Chief Investigator (South Wales Doctoral Programme in Clinical Psychology) Dr John Fox	South Wales Doctoral Programme in Clinical Psychology 11th Floor Tower Building Park Place Cardiff CF10 3AT 02920 870582
Chief Investigator Dr Andrea Davies	Dr Andrea Davies
Cardiff University Independent Contact (if you would like to raise any concerns or ask any questions to someone independent of the research team) Dr Dougal Hare	South Wales Doctoral Programme in Clinical Psychology 11th Floor Tower Building Park Place Cardiff CF10 3AT 02920 870582

How do I make a complaint?

If at any point during your involvement with the study you feel dissatisfied with the study process or members of the staff team, then you have the right to raise a concern or make a complaint. If you wish to make a complaint you can contact the concerns team on XXXX. If you wish to seek support in this you can contact the Patient Advice and Liaison Service (PALS) on XXXX or alternatively you can email them at XXXX.

What happens next?

If you **do not** want to take part then you do not need to do anything.

If you **would like** to take part in the study then please let a member of the ward staff or CRHTT know and they will contact the researcher. The researcher will be in contact within the next 3 days to arrange an interview. You will be asked to sign a consent form before taking part in the interview. This is just to make sure that you understand what is written on this document. There will be an opportunity before this for you to ask any questions that you have. If you have any questions, please feel free to write them down ready for the researcher.

APPENDIX 2.3: INITIAL INTERVIEW SCHEDULE

1. Can you tell me a bit about what has brought you to this point of being [with the CRHT] [on the ward]?

2. What was going through your mind just before you [harmed yourself] [were admitted]?

3. How do you think you went from not thinking, to thinking about suicide?

4. How do you think you went from thinking about suicide, to harming yourself?

5. What thoughts did you have?
    a. Have those thoughts changed over time?

6. Did you plan to harm yourself?
    a. What was it like making a plan?
    b. Why did you not go ahead with it? / Why did you go ahead with it?

APPENDIX 2.4: ADAPTED INTERVIEW SCHEDULE

7. What stopped you from acting?

8. Have you had any episodes in the past where you have tried to harm yourself?

9. Could you tell me about how you came to think about *how* you would end your life? (002, 008)

10. What impact do you think the suicidal thoughts and attempts have had on your relationships with other people?

11. Do you think your view of yourself has changed since being suicidal?

12. Did you let anyone know about your suicidal thoughts/plans/attempt?
    a. What response did you get?
    b. What did that mean for your thoughts?

13. Would death have done anything for you, or brought you anything?

14. Have you experienced the suicide or suicide attempts of others in your life?
    a. Has this affected your thinking?

15. Is there anything else I should know to understand your thoughts around suicide any better?

16. Is there anything I've missed that you think would be really important for me to know?

17. Have you got any questions or anything you'd like to ask me?

APPENDIX 2.5: ETHICAL APPROVAL

This appendix has been removed for the purpose of maintaining confidentiality for the research participants.

APPENDIX 2.6: EXAMPLE OF INITIAL CODING, FOCUSED CODING AND CATEGORIES (WITH MEMOS)

Below is a selection of parts of the transcripts with the associated initial code, focused code and category to give an idea of the process of Grounded Theory. Below these examples are Memos relating to that category.

Text	Initial Code	Focused Code	Category
Participant 3 And all of a sudden there was the clarity back again, you know, there was a purpose, there was an end result, something I could actually achieve.	Having Purpose Achieving	Benefitting Me	Re-framing death positively
Participant 9 Like, if you're…I don't know. I just feel like it's better to be not here, so it'd be a better way to be, I don't know, like in the grave.	Better off Dead		
Participant 3 And that gave me a little bit of comfort that there was going to be an end in sight.	Bringing an End		
Participant 6 You know, happy days. All my problems solved. Yeah, it's kind of like, before doing it, you know, I was thinking, it's going to solve all my problems.	Solving all Problems		
Participant 9 I'm going to get that control back. Make my own decisions. Because right now I can't do that.	Regaining Control		
Participant 7 And then, because I'd had an abortion at sixteen, I felt like I needed to be with my baby.	Reuniting with Loved Ones		
Participant 2 I feel like I'm burdening an awful lot of people around me. I'm very lucky to have quite a lot of love around me. And I feel that I try to be up for those people, but I just can't be. And that's making me feel quite guilty.	Being a Burden Affecting Others Feeling Guilty	Benefitting Others	

Participant 4 I didn't…because we…because I saw what my brother went through. Well, not so much my brother but what his family went through with it, I didn't want to do that to my family. And it was the fear of being a burden on them.	(Experiencing illness) Being a Burden		
Participant 9 And I just feel like, you know, it's just taking their time out of the day, like, travelling back and forth. And…they just text me all the time. I feel like they…I'm wasting their time because they're spending too much time worrying about me, and I don't like the thought that they're worrying about me. So, then I can stop them from worrying about me if I just took my [pills].	Wasting Others' Time Worrying Others Ending Worry		
Participant 1 I had that message then from [wife] and I'd, I'd convinced myself that there was no good for them, no good for her, and that she was better off without me.	Benefitting Others Through Death		
Participant 1 Just lots of feelings of inadequacy. And erm, again, panic of what to do with the family. I've let my family down.	Letting Others Down		
Participant 2 And if it did then I wouldn't have any control over what I was saying or doing and I might hurt my Dad. I might hurt myself. I was ready to. To run into a mirror.	Protecting Family		

Memo
RE-FRAMING DEATH POSITIVELY The participants spoke of not just desiring death but that they actually came to see death as something which would bring about positive change for not just those around them, but for themselves.

"And I was failing as a person. The one thing that I had left was my job and I couldn't do that because it was taken away from me. And that's the point where I started to think, well, do you know what, it would be easier on everyone. Relief for me. But I thought that it would make life easier for those around me. For work, they could replace me. And then everyone could just carry on and there would be no bother from me anymore. That's…that was my, that was my mindset for the whole thing" (Participant 2).

BENEFITTING OTHERS

Impacting on others

At first I thought that this was too similar to *Being a Burden* and that actually it might just be describing the same thing. However, when I looked again at the quotes, there definitely seems to be something in how the low mood, the 'misery' impacts on everyone else. The participants spoke about their actions, mistakes and feelings were so severe that they were impacting on people and therefore people would actually be better off without him. Their loved ones would benefit and their lives would be better if they were not in them. This appears to be linked to B*eing a Burden* because some of those actions, mistakes and feelings meant that the participants thought of themselves as a burden.

There is of course the worry from some that their death will impact too negatively on those around them. They recognise that this also will affect the people they love. It is the thinking through of this which is quite different for the different participants. This is why I have split it into two sections: affecting others through attempting/thinking, and affecting people prior to all of this which sparks the suicide ideation.

All participants feel this. 5 prior to suicide and 8 because they are suicidal.

Burdening others

There seems to be so much wrapped up in these statements of being a burden i.e. an imbalance that means others do more for the person, than the person can do for others; taking other people's time, almost with the judgement that it is 'wasting it'. Trying to explore what these are is necessary to truly understand what burden means for different people, or does it mean the same thing for everyone? It would seem that there is an almost shared understanding of what being a burden means, but this is unsaid.

Being a burden is about having to rely on others for things: for care; for board; for money; for lifts; for emotional support. There is something about the roles being reversed in some cases, where the thought of children having to provide care or emotional support due to either a physical illness or emotional state, is too much for the adult to bear. It is enough to think about ending their life to stop that burden on everyone else.

There is also something about an imbalance in that love cannot be reciprocated and because of the person's situation (employment status and emotional state), there is nothing for the person left to offer someone else. Therefore, the relationship is unbalanced. The person becomes a centre of attention rather

than the balanced relationship that they expect. This 'nothing left to offer' is a result of the loss of thinking that is occurring i.e. loss of concentration, focus, memory - that fogginess that comes. This means that the person as a result, thinks of themselves as not worthy of love because it cannot be reciprocated.

Being a burden is about others having to do more because of the incapacitation caused by intense emotions and also by those who experienced illness. It is this incapacitation which appears to create these feelings of being a burden. There is a fear in some of the participants that these intense emotions will 'rub off' on others and their lives will be worse for the individual being in them.

Therefore, it seems that incapacitation comes first (either through a physical illness or intense emotional state), and then the perception that they are a burden on those around them.

Falling out with others

The participants spoke of falling out with others, either prior to the suicidal behaviour, or after it. Those who fell out with others prior to the suicide attempt were those who then began to think of themselves as worthless and inadequate as a result of this. This also left participants with a feeling of not being in control. Those who fell out with others because of the suicide attempt was because they let others know how they were feeling and others responded in an angry way. Therefore, this further exacerbates the original problem.

Benefitting others through death

This is the idea that others would be 'better off without me' because of the arguments that were caused and because of the burden that is placed on others through that individual being alive. The benefit comes when others would have more freedom than they do currently, or a better life that the individual is not able to provide. They also wouldn't have the worry and the thinking time that is caused by that individual. Therefore, when others are benefitted, it becomes a real option. This is a convincing process - the person is thinking of all the reasons why someone might be better off.

BENEFITTING ME

Achieving and Having a purpose

Some participants were able to see a future and the things that they wanted to achieve in their lives. However, for others, suicide becomes the goal and the thing to achieve. This is true for those who have attempted, but not for those who did not attempt.

"When I made the decision, the final decision to do it. So, I had been thinking about it for a few weeks beforehand. And that gave me a little bit of comfort that it was going to be an end in sight. When I made that decision on the Saturday to go and purchase the alcohol, I thought 'this is it, this is great, I'm going to do this'. And all of a sudden there was the clarity back again, you know, there was a purpose, there was an end result, something I could actually achieve" (Participant 3).

Included in this idea of achieving is that some participants did not feel that their lives were where they wanted them to be i.e. their quality of life was poor both physically and psychologically. For participant 11 this seems to relate to a sense of worthlessness and also not having a purpose.

Bringing an end

There was the decision that death would bring about an end to the despair, pain and suffering that these participants were experiencing. For those who attempted, this was because they had no other hope for change. Therefore, death would be something which would benefit them because that pain would be gone.

Solving all problems

All the problems from the past and from the present would be gone if they were to die. It becomes the only option to make things 'right' or 'better' with those around them.

Regaining Control

Participant 9 talks about regaining control by choosing a method (overdose) whereby she can stop if she needs to. She is using an overdose as a way of taking control. This is vastly different to participant 4 who seems to not want to die (shown overall in the interview), yet participant 9 is ambivalent to death and therefore more willing to use overdoses as a way of controlling the mind, and circumstances.

I'm wondering whether suicide is a way of taking back control of all the things that have gone out of control. This is making me think about what I don't know. I don't know whether death would provide anything for people? The participants have talked about 'bringing an end' - but do they want an end that brings silence, or an end which brings control, power over others in death, a slap in the face to people in their lives. What does it bring? Is this related to control or not?

Text	Initial Code	Focused Code	Category
Participant 3 and I was determined to see it through.	Being determined	Being determined	Narrowing Focus
Participant 9 Like…and then…you just…I don't know. In terms of actually taking them, I feel like, you're just so determined you're going to do it.			
Participant 9 But I don't think that puts me off. It doesn't.	Sticking to the plan		
Participant 8 I don't…it doesn't make me think, or any concern for how they may feel.	Not thinking of others	Focusing away from people who stop me	
Participant 9 Because I'm just not in a position to think about how they may feel.	Not thinking of others		
Participant 3 I couldn't get it out of my head, the suicide.	Having a 'one track mind'	Focusing on suicide	
Participant 5 They weren't even in my head. It was just the hurt			
Participant 6 It's literally, suicide, suicide, suicide. That's all that is there.			
Participant 6 The only thing that I wanted to achieve was the suicide.	Achieving suicide		
Participant 3 It was going to be a defined end result.			
Participant 3 And I was on a mission.	Focusing on the goal		
Participant 6 I couldn't let them get in the way.	Staying on track		
Participant 3 And all of a sudden there was this clarity back again.	Having clarity	Having clarity	
Participant 6 I kind of woke up from the dream.			
Participant 6 There is no outside viewpoint…unless you've got someone with you.	Being unable to see another perspective	Ignoring another perspective	

Participant 6 But then, there's no outside viewpoint where I could have gone, 'the drugs are making me want to commit suicide'.	Being unable to see another perspective	Ignoring another perspective	
Participant 1 I kept using the words that, I don't have a future.	Seeing no future	Seeing no future	
Participant 11 You don't see a future.			
Participant 8 There's only one way out of it, usually. And that's when I usually do something to take my own life, you know?	Seeing one option	Seeing one option	
Participant 8 It was just…on that actual day, yeah…it was just, "right, hang on, that is the only way".	Coming to a decision	Seeing one option	Narrowing Focus
Participant 7 And I don't know how else to do it.	Having no other options		
Participant 8 You know, ways to, well, most of the time it only seems like there's only one way to be able to stop all that feeling.	Having one idea		

MEMO
NARROWING FOCUS The focus in the person's life turns away from things that might have made them unsure before (having children and being needed, caring for their children, having a future) and focusing solely on suicide. This is not a wilful thing, but is something which is described as 'just happening'. The narrowed focus on suicide means that it becomes the only option (see separate memo) as the person can only see negatives, cannot see positives, and finds solace in suicide as a way to get away from the pain and struggles of this life. The narrowed focus on suicide is also beneficial because it turns attention away from that difficult past and focuses on something else: *"Suppose it's just like you think more about, taking the tablets than you do about thinking about the stuff that's happened, maybe?"* (Participant 9). It continues to be beneficial because it sorts out the disordered thinking and gives clarity. *"There was no scattered ideas, there was just one core idea of suicide"* (Participant 6).

Again, it is beneficial because it becomes the solution to all the problems remaining in this life.

As well as a narrowed focus and one option being seen, the person becomes determined on doing this. That determination is present in P1, 3 and 9. These are three participants who have had serious attempts. Two were sure that they wanted to die by suicide, whereas P9 is ambivalent. That determination means that they can then execute their plan. Those with a plan which has steps, they are the ones who go ahead and start focusing on those steps. For each one of those, they go ahead and do it (P1, P3, P8, P9). The person who has attempted but is missing from this is P6, although he sets his sights on achieving suicide, which for him may be the same way of describing that he is determined.

In order to have that narrowed focus, another perspective has to be ruled out, whether this is the perspective of another person, or the perspective of the individual from another time. P6 talks about how medication narrowed this focus for him and the other ideas were just not there.

Seeing one option

People get to the stage where they have been looking for a way out, looking for escape and an end to the suffering and struggling that they are going through. The focus narrows to see just the one option to achieve what they want to: for an end to come; for others to benefit from it and stop being impacted.

The option can be seen as the better of the two because one option is all that noisy negativity, the intensifying emotions, and the other option is death:

"But it'd be like I'm getting burnt, and jumping just the lesser of two evils" (Participant 4).

This is slightly different for P9 because she is ambivalent, and so she chooses this and wants to act because it is unpredictable. Given all the reasons that she states for being suicidal and attempting, I think this is to end the thoughts and the constant fear of being abused or coming to harm.

"It's just…there's only one route, there's not…you know, there's no margins, no bartering. It's just when that thought's there, it's just I've got to act on it" (Participant 8).

This seeing one option is clearly linked to making a decision. That focus is narrowed and it has got to be completed. The making a decision is enough to see the act through.

Text	Initial Code	Focused Code	Category
Participant 11 You know, I really didn't want a second.	Avoiding another attempt	Choosing not to die	Weighing Up Options
Participant 10 And I thought, if I don't phone this doctor today, I will not be around by Monday.	Changing actions		
Participant 2 Because it just doesn't solve anything	Deciding it doesn't solve anything		
Participant 2 All this could be about nothing. All this panic, and all this worry, and all this concern, and all this depression could be about…things are going to be okay.	Having hope		
Participant 11 Just, I suppose from the life experience of knowing that yeah, this does have a negative impact on others.	Impacting others negatively		
Participant 5 Thought of my children, and what it would do to them.			
Participant 11 You know, there's got to be a way out of this. Rather than, you know, the option of suicide.	Looking for another option		
Participant 4 Just keep going.	Persevering		
Participant 1 But the main thing that stops me is my wife, first and foremost. The thought of my wife being hurt.	Restraining myself Impacting others negatively		
Participant 10 And I don't want to die.	Wanting to live		
Participant 9 I feel like half the time I don't actually know what I want from stuff.	Being unsure what I want	Being unsure of suicide	
Participant 5 But, at the same time, it's, if I'm here, I'm here. If I'm not, I'm not.	Feeling apathetic		

Participant 6 You know, that’s why I took the overdose and everything first, before, just, ringing people and that. Because then it was out of my control. If I was dead, and you know the police turned up, then I was already dead and things.	Leaving things to chance	Being unsure of suicide	Weighing Up Options
Participant 10 You know, is that a road I really want to go down…to kill myself?	Questioning suicide		
Participant 9 Just in case I regret it…oh I don’t know.	Worrying about regret		
Participant 6 I’m sat looking at the table with all these different board games, you know. One board game is, convince all my friends…or tell all my friends the truth and try and convince them of what actually happened. And then the other one is kind of, convince…just go back to work and get on with it.	Having options Carrying on	Weighing up	
Participant 4 That if things got that bad, there’s an option. I think it was all about options.	Having options		
Participant 11 I think it was just weighing up the options. Again, almost in a black and white pragmatic way. Was that, well, you’ve got two choices here. That’s how it felt at the time, with the two choices. You carry on as you are. Or take the second option, and it all stops, it all ends.	Weighing up		
Participant 6 And that…all that, and even now, is what has pushed me.	Being ‘pushed’	Making a decision to die	
Participant 8 Yeah. I think that’s what pushed me that bit further then.	Being ‘pushed’		
Participant 11 That pushed me over the edge.			
Participant 9 Because it’s the better…it’s just a better option, do you know what I mean?	Choosing the ‘lesser of two evils’		

<table>
<tr><td>Participant 1
I felt happy that I’d made the decision. I was happy with the decision.</td><td rowspan="2">Making a decision</td><td rowspan="2">Making a decision to die</td><td rowspan="2">Weighing Up Options</td></tr>
<tr><td>Participant 3
And, you know, I made the decision on the Saturday morning with…I thought if I…if I I just sort of looked at the pills and thought, this has got to happen.</td></tr>
</table>

MEMO

WEIGHING UP OPTIONS

"I think it was just weighing up the options. Again, almost in a black and white pragmatic way. Was that, well, you’ve got two choices here. That’s how it felt at the time, with the two choices. You carry on as you are. Or take the second option, and it all stops, it all ends" (Participant 11).

This is about having to act, having to do something to change the situation and having the options to do that.

"It’s my security blanket almost. That if things got that bad, there’s an option. I think it was all about options" (Participant 4).

Choosing the 'lesser of two evils'/Choosing not to die

Reading through participant 4's transcript, the metaphor really struck me about being in a burning building and jumping (suicide) is just the lesser of two evils.

"It was like I was in a burning building and I didn’t want to jump, but I was getting burnt and I didn’t want to get burnt. It weren’t…when I went through the whole…got to the worst point, that was what I was telling my husband, it’s not I want to die, or I want to leave you in any way whatsoever, but it’d be like I’m getting burnt, and jumping just the lesser of two evils" (Participant 4).

Looking at this transcript, it made me realise that she had come to reach a point where she knew there was a decision to be made. Therefore, this relates to all the codes regarding having options i.e. to live or to die. To attempt suicide. This becomes the only option as a way of fleeing despair. Therefore, it seems that there is a process of:

Returning to normal <-- Reaching a choice point (because of despair, overwhelming ruminating thoughts) --> Choosing the 'lesser of two evils'.

Choosing the lesser of two evils is one way to stop despair. For some, it becomes the only way to end that despair and overwhelming thoughts. For others, they realise that this cannot be the option and there must be another way. This is true for participant 11 who had tried it before and did not want to go back there. However, he talks about having already made the decision not to try again, he still has that option there in the back of his mind. This means that even after the decision has been made, the options are still there.

"I suppose there's just something deep down in the psyche that says, no, it is an option, you know, it is an option, but, no" (Participant 11).

Participant 2 describes that point as 'going past the point of caring' i.e. you care up until the point where you choose the lesser of two evils and then you don't care whether you live or die. Participant 11 describes it as the point whereby the focus is beginning to narrow and there seems to be only one way to get out of this. He only stop because of his past experience and remembering all that had gone before.

Finding another way out/Carrying on

Rectifying things with people or letting it go. The push then to making the decision to die was taking medication which heightened all emotions around these issues. This means that there were three options here really, but death only became an option when the medication was seen to heighten the issues and create that courage.

"One board game is, convince all my friends…or tell all my friends the truth and try and convince them of what actually happened. And then the other one is kind of, convince…just go back to work and get on with it" (Participant 6).

Making a Decision to die

That decision to act appears to give peace and happiness. There seems to be something which happens to clear all of that noise, chaos and intensity so that a decision to die feels like a very good option at that point.

With the decision to die, comes a great sense of relief for participants. Relief that their internal struggles and intensifying emotions will be over, and that the decision has been made and it is seen as 'easy' (P6). The relief comes in thinking that it is going to be over, and that they have 'finally' acted after having thought about it.

APPENDIX 2.7: REFLEXIVE BRACKETING EXAMPLE (EXCERPTS FROM REFLECTIVE DIARY)

PARTICIPANT 2 Following Interview
I found myself getting very distracted by the research I already know about, and only picking up on words that are used within other research i.e. burden, hopelessness, powerlessness. This is something which may have clouded my ability to get to what those concepts mean within qualitative research. I need to watch this in the next interview.

PARTICIPANT 3 Following Interview
The research was still creeping into my thinking because I thought that I noticed more about concepts such as burden and courage/capability/previous history of suicide/family history etc. However, I also think that I paid more attention to other concepts such as loss of control and darkness. I managed to pick up and dig deeper into the things that he was speaking about rather than just notice what the previous research has said.

PARTICIPANT 5 Following Interview
I brought in some of the ideas of courage because I know that came up in interviews 3 and 4. I also followed up more on darkness because that was interesting from previous interviews. However, it wasn't just these things I followed up on i.e. coping – so don't think I'm being too biased and only narrowing my focus on the previous literature. Hurt and pain – this was his standard answer to a lot of questions. I was very aware of what I thought that 'hurt' and 'pain' mean in my own experience and how this was clouding how I asked the questions. I reflected in the moment that I was assuming what was being said about hurt and pain, and then managed to dig deeper to find out what it was for him. I thought I knew what this might be, but wanted to know what his experience was. This hurt for him was that he was questioning his own irritability and then feeling guilty about other people. It was all the thought of loss and then bottling it up (until it needs to spill out).

PARTICIPANT 7 Following Interview
Blame – she was blaming herself for all the difficult things that have happened in her life. It was very clear in this interview what her beliefs were around herself, others and the world. This cognitive model was very much in my mind when I was talking to her. 'Beating myself up' and blaming were the same thing in her mind. I knew that this was in my mind and so attempted to dig deeper until I understood what the process was for her. This was very difficult as there was so much emotion attached to these processes at the moment. She (understandably) became very distressed which affected how I thought about the questions I was asking and how I started to use summaries as a way of helping her deal with this distress. This did not strictly follow grounded theory methodology but was needed as a way of managing her distress in the room.

PARTICIPANT 11 Following Interview

He used a lot of psychological jargon and I think this is related to his experience of having undergone therapy before. He uses terms such as 'grounding, psychache, mindfulness' and I suppose knows that there is a shared understanding there. This means that my position as a Trainee Clinical Psychologist is something that changes the way that he communicates. If he were speaking to an undergraduate student, I wonder whether this would be different? This may also affect how I code this interview and therefore I need to bear this in mind when coding.

QUESTIONS AND COMMENTS RAISED BY CODING

- Are power and courage the same thing in the context of the interviews? Having the power to carry things out and having the courage to do it. I think they are.
- A few of the participants now have talked about having experience of suicide. This may be being picked up on because it is a known risk factor, however, it is interesting to explore maybe how this has impacted on the process.
- My coding may have been influenced by doing a talk this morning on the psychology of suicide and having those ideas of being stuck in our minds (also influenced by reading Shneidman this morning). This might then mean that I have coded based on existing research and have not really thought about what is coming from the data. I will need to go back and check on these codes.
- I also think about how I code is quite influenced by existing knowledge of mental health i.e. 'having a panic attack' I have coded as 'feeling frightened' – but are panic and feeling frightened the same thing? Have I imposed my language on this?
- I was coding one line: 'And that's…that's what I call my…danger zone'. I coded this as ***Noticing risk.*** I struggled with using this term because actually this is a term we use in clinical practice and therefore is bringing a framework to the coding. To me, this is what she is saying – that she notices when her risk increases. But maybe that takes away from what she is saying – that actually she is a danger to herself and she recognises this. Therefore, I am going to re-code it as ***Noticing I'm a danger to myself.***
- I found when coding for the section where he talks about not being a believer, then I immediately thought that he is talking about not having somewhere to go to (after death), not having a reason to speed the death process up I suppose. This might not be what he is getting at, I might have interpreted it like this because this is my thinking and my belief system because of being a Christian. I need to look at these codes again and attempt to see what he is saying and change my codes so that they reflect what he says.

APPENDIX 2.8: INITIAL CODING EXAMPLES

PARTICIPANT 3	
Transcript	**Initial Code**
And you mentioned that you had the medication assembled by the side of your bed. Was that a decision you made? Could you tell me more about that? So…after the suspension, that's when I started to think in those terms. And one night in particular, I managed to, sort of, go around the house and just pick up literally every single box of…and strip of medication I had. And it actually, it's quite a nice pile I had by the side of the bed. And I didn't quite have the guts to see it through, but that's when the thoughts started appearing in my head, that it would be so easy to do that. There was a little bit of a fear that it wouldn't work, and I might end up severely injuring myself. So, I started doing some research about some more potent medication that I could get my hands on. But…that information doesn't seem to be easily available (laughs). So, I was just, kind of, thinking along those lines for a few weeks. And then when that final day come I thought, oh, alcohol will probably give it the nudge that I need, and the confidence, the boost. The boost that I need to do it, and will add to the effect.	Initialising thoughts Gathering medication Feeling proud Lacking courage Thinking has control Worrying about injury Researching methods Lasting thoughts of suicide Feeling empowered Drinking alcohol Gaining confidence
What were the thoughts going through your mind when you were going around the house getting that medication? I suppose, thoughts…this is a good thing, this is going to be right. Although, I wasn't actually going to see it through on that particular day, but it was kind of, like, a bit of pre-planning. So, as I was gathering it up, it was kind of like, yeah, this is going to happen at some point. It's…you know, things like that.	Seeing death positively Deciding not to act Planning not acting Going to happen
What stopped you from doing it on that day? It was…as I said before, it was like is this really going to work? Am I going…I'm probably going to end up injuring myself. I was a bit worried, not a bit, quite a bit worried about that actually (laughs). That I was going to end up very sick, some permanent disability, in hospital for the rest of my life. Which would have been even worse. So, that, that was the kind of thing that was stopping me. But even so, they were there, and I had them this side of the bed, and I'd be looking at them, and I'd be like (gestures looking at the tablets)…just thinking about it quite a lot. Thinking about it every time I came into the bedroom, looking at the tablets. Yeah, at some point this is going to happen.	Questioning effectiveness Worrying about injury Worrying about illness Stopping the actions Being reminded Persisting thoughts Going to happen

So, you had an idea that it was going to happen at some point? Yep. **How did you go from thinking that to then doing it?** I think it was…it was my birthday that was the nudge I think. So, it was the anniversary of my brother's suicide on the fifteenth, and I just…it was hell. It was really, really bad. Normally I'm out doing something for my birthday, but it just didn't seem right. And, for the whole week then, I just…you know, I was feeling bad. And if there's a worse feeling than that (laughs), I was going down continuously. Until the Saturday when I thought, I can't take this anymore. I'm going to do this. And then all of a sudden I lifted up. So, it was kind of, yeah, like an anniversary event that, that, that triggered it all off. That kind of sent me down a bit, and then the decision brought me back up again.	Being 'nudged' Remembering deaths Living in 'hell' Having to change plans Experiencing the 'worst' Going down Reaching tolerance Going to happen Deciding brings elevated mood Noticing triggers Being controlled

PARTICIPANT 8	
Transcript	**Initial Code**
Can you tell me a bit about what has brought you to the point of being on the ward here? I don't know how to explain this one [laughs]. This time, is because I sort of, started to understand which way my thoughts were going. As in, previously, I'd get over emotional. Intensely emotional. And then I'd go from one extreme, to being numb, and not having no feeling. And that's…that's what I call my…danger zone. When I haven't got no feeling. And usually, I'd drop the kids to my mother's, a safe place, and I'd go off and I'd take my overdose, or whatever I'd usually do. But this time, I done things a bit different. I see my psychologist every week anyway, and she started to think that I was ready to come in. But I sort of had a bit of a break on the…over the weekend, before I came in, where I didn't have no feeling or nothing. I dropped the kids off as I normally would, but then I rung instead. So, it was like I was able to, sort of, reign myself in a bit.	Noticing direction of thoughts /Understanding the process Swinging between emotions Experiencing intense emotions Feeling 'numb' Noticing I'm a danger to myself Being without feeling Having a pattern Being advised by others Feeling nothing Seeking help/Changing patterns of behaviour Restraining myself
Okay. So, you start to feel numb, with no feeling. What's that like? There's just nothing. There's no hope. There's no…it's strange. Because I'm used to feeling things so intensely, and it's all just taken away. And it's like I can't cope because it's not…the chaos ain't there. The feelings and…yeah. It's just…it just makes me unsafe from myself, you know? It's…	Feeling nothing Being robbed of feelings Being without chaos Noticing I'm a danger to myself Feeling unsafe
And that having no hope, what's that like?	

I suppose it's just like I feel every day really. But it's just…you're lost. It's like…it is just literally existing. It's not…you don't feel love, you don't feel...even hurt, you're that numb, you can't…you can't feel anything. Yeah.	Repeating patterns Existing Being without feeling Feeling 'numb'
Okay. And the thought there, 'I can't cope' – what's that thought about? Just life in general. It's just…just can't get past that point, you know. It's…it's like the barrier goes up and you know, well, I know, that there's only…[laughs] there's only one way out of it, usually. And that's when I usually do something to take my own life, you know?	Generalising Hitting a barrier Wanting out of life
Can you tell me more about that process of 'there's one way out'? Like, it just becomes centred. That's the only thought that I can get in my head. I suppose looking at it, it can seem selfish. But, you know, like, my kids, my family, none of that even enters my head. Except for the fact that I drop them off beforehand. I don't…it doesn't make me think, or any concern about how they may feel. It just gets…yeah. I think it's the…my emotion gets so intense that everything just shuts off. It's a weird one to try and explain. But then the emptiness, the numbness, the nothing, that's just like the gateway, just to go. Because there is no feeling around it, if that makes sense? I might…when I'm feeling, like, the extreme feelings, the really intense upset, hurt, scared. When that gets so intense, I'm constantly thinking of ways to get out. You know, ways to, well, most of the time it only seems like there's only one way to be able to stop all that feeling, and that's just to…just to kill myself. But then when it goes numb. When I get that numb feeling then, which is usually when I get my impulse…you know, that's my impulsive time, because I can just act out. That's because I haven't got no worry about the kids, or no…there's no thought, there's no process. It's just normally, drop them off and do it. You know, there's nothing stopping me. There's nothing holding me back.	Having a 'one track mind' Judging actions as selfish Not thinking of others Protecting family Intensifying emotions 'Shutting off' emotions Having difficulty describing Feeling empty Gaining permission for suicide Feeling 'numb' Intensifying emotions Escaping intense emotions Having one idea Feeling 'numb' Repeating patterns Acting on impulse Having no reasons for stopping

PARTICIPANT 9	
Transcript	**Initial Code**
So, do you think you planned to harm yourself, to take the overdose? Yeah, I'm not going to lie…hmmm…I don't know. It's a mix. Yeah, I think so. The first time, no, definitely not. The second time, probably not, as well. But then the third and fourth time I knew what I was doing. And…	Being honest Noticing difference in attempts Developing knowledge

So, tell me about making that plan then. Making the plan? [Laughs]. You go to Tesco's…I think it's just in my head. It's impossible to say, but I think my plan was that. I was going to…like, my plan would be that I'd go to the shop, take the paracetamol and sleep it off. That's my plan. Most of the time. You know, I'm pretty good at doing that. I've done it a few times. There's only…I've done it more than four times yeah, but just, I've only been in four times. Because, the other times I did it…after the first overdose I was just in such a…I can't…not kind of like guilty, but then I didn't care. I was kind of glad I did it, if that makes sense. But, because I felt like I'd actually done something. And then…I don't know. You just kind of grab onto the fact that you've actually done something. So then, in the week between the first and the second one I did quite a lot of days where I just took them and just slept it off. But then, the time I got to a week later I was like, "right, this isn't a good…", well not a week later even, like a couple of weeks later I was like, "right, this isn't a good idea". But then, I still end up doing it. I thought, right, I'll stop doing it every day and sleeping it off. And then…it's just impossible to break the cycle as well. Because it just makes you feel good about yourself. I don't know…I suppose.	Planning the steps Repeating patterns Getting better at attempting Going to hospital Giving up caring Acting eventually Taking small amounts Taking medication Remembering timings Deciding to stop Acting contrary to thoughts Feeling good
Okay. So, that makes you feel good. Can you tell me a bit more about that then? Just the idea again, that you're kind of in control, and the fact that you've done something that…and you know you've kind of…it's not a goal, but you know you've kind of achieved a goal, do you know what I mean? If you're going to…my goal is to, like, I don't know, take thirty-two. If I took thirty-two then I've done well. So, that's kind of...it sounds really…it just…it just is. I could be like, right…you could have other goals as well, maybe the last one. But, I don't know, maybe you could have other goals like how much can I drink and take. Or like, how much can I take in a certain time. That stuff. I don't know…it's a way of…it's a bad way of challenging yourself. There's a good way of doing it.	Having control Achieving goals Challenging myself Having a goal Challenging myself
And why would you be challenging yourself? I don't know…it's just like [laughs]…oh god, it makes me sound so bad, but it's just…see how many you can do in a certain time, but also see how much you…I shouldn't say this, but see how much your body could take or something, do you know what I mean, before you felt like, I don't know. Like, for me, in the second week, it's seeing how many I can sleep off every day. Which obviously, that's kind of a stupid challenge, and a stupid…I should have gone, you know, I should have gone to A&E, but was still alive, so…I don't know. That was kind of a challenge for me. Seeing how many	Worrying what others think Challenging myself Testing tolerance Having a goal Taking on another perspective Regretting decisions

I could sleep off every day. It's not a good idea, but…I don't know. It just makes you feel better I suppose. But also…	Challenging myself Improving
In what way? It's better in the sense that no-one knows [laughs]. You could just go to sleep, no-one knows. Go and have a drink, no-one knows. Go to your flat, no-one knows. But then you still know you're doing it, so, you still feel good.	Hiding Feeling good

APPENDIX 2.9: QUALITY CHECKLIST FOR GROUNDED THEORY STUDIES (CHARMAZ & THORNBERG, 2020)

Item	Description
1	Strive to achieve methodological self-consciousness. Why have you chosen the specific topic, methodology and methods, and how do these fit with who you are and your research objectives and questions? What version of grounded theory have you adopted and why? What are the ontological and epistemological assumptions, and what do these mean for the research process, researcher position, findings, and quality issues, including transferability?
2	Learn everything you can about the type of qualitative inquiry you adopt, whether it's narrative inquiry, discourse analysis, or a version of grounded theory. If possible, work with a mentor who is knowledgeable about your approach.
3	Take an open, non-committal, critical, analytical view of the existing literature in the field. In contrast to Glaserian grounded theory but in line with Straussian and constructivist grounded theory, we recommend that you review the literature to establish a defensible rationale for the study, to avoid re-inventing the wheel, and to increase theoretical sensitivity. Treat the literature as provisional and fallible, not as the Truth.
4	Gather rich data. For psychologists, rich data usually means learning and collecting the stories of people who have had or are having a specific experience. Rich data means an openness to the empirical world and a willingness to try to understand the experiences of people who may be far different from you.
5	Be transparent. Describe how you conducted your study, obtained your sample and state how and why you have included the participants, and how you have used grounded theory and data collection methods. Include justifications of your choices.
6	Go back and forth between data and your developing analysis to focus your subsequent data collection and to fill out your emerging analytic categories.
7	Tolerate ambiguity while you struggle to gain intimate familiarity with the empirical world and to create an analytic handle to understand it.
8	As you proceed, ask progressively focused questions about the data that help you develop your emerging analysis.
9	Play with your data and your ideas about it. Look for all possible theoretical explanations of the data and check them.
10	Collect sufficient data to a) make useful comparisons, b) create robust analytic categories, and c) convince readers of the significance of your categories.
11	Ask questions about your categories. What are their properties? In which ways do they subsume minor categories? How are your main categories connected? How do they make a theoretical statement? What is the significance of this statement?
12	Always treat your codes, categories and theoretical outlines as provisional and open for revision and even rejection in the light of new data and further analysis.
13	After you have completed your analysis, compare it with relevant material from the literature, which may well include case studies and perspectives that you did not address during your earlier review. At this time, your review will be focused on the ideas that you have developed. This review gives you the opportunity to show how your analysis fits, extends, or challenges leading ideas in your field.

APPENDIX 3: SUBMISSION GUIDELINES FOR PSYCHOLOGY AND PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE

PAPTRAP submission guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

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

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Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.
Word limits for specific article types are as follows:

Research articles: 5000 words
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In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.
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For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

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Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

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

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Please provide appropriate keywords.
Acknowledgments

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

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

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

The main text file should be presented in the following order:
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As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.

The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the APA FAQ.

Reference examples follow:

Journal article
Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:10.1176/appi.ajp.159.3.483

Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document
Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from http://www.youtube.com/watch?v=Vja83KLQXZs

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