THE IMPACT OF MASCULINITY UPON MEN WITH A DIAGNOSIS OF PSYCHOSIS

Written by:

Robert John Searle

Supervised by:

Dr Dougal Julian Hare

Dr Bronwen Davies

Dr Sara Morgan

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This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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SECTION A: A SYSTEMATIC REVIEW OF HOW MEN WITH A DIAGNOSIS OF PSYCHOSIS PERCEIVE THEIR MASCULINITY

1.0 ABSTRACT

Background: Research indicates that men experiencing psychotic phenomena pursue forms of masculinity outside of conventional norms. Yet the question of how men with a diagnosis of psychosis consider their gender expression has received little attention.

Objective: This review questioned how adult males who have received a diagnosis of psychosis perceive their masculinity. The evidence base to date was systematically reviewed within this article.

Search strategy: Literature searches across the databases Cochrane Library, PsycINFO, Medline and Web of Science were conducted. In total, nine studies met full text criteria for the review.

Selection Criteria: Included studies were original, written in English, quantitative peer-reviewed articles which included one or more standardised outcome measurements used with adult participants.

Analysis: The studies were assessed for methodological quality, including biases via use of the Quality Assessment Tool for Studies with Diverse Designs (QATSDD).

Results: Of the nine identified studies, seven reported males either choosing less masculine roles or scoring lower on traditional masculine descriptive measures as compared to controls. One study showed that their male participants held a masculine disposition, and one study found no significant difference of role preference between either their experimental or control groups. Although this indicated that men with a diagnosis of psychosis are less likely to adhere to conventional masculine norms, the overall evidence lacked quality, particularly in regards to study design and statistical rigour.

Conclusions: The evidence base regarding how men with a diagnosis of psychosis experience their gender expression has significant limitations. Indications for future research include: more statistically rigorous designs, utilisation of more recently published masculinity inventories or the use of methodology which aims to understand individuals experiences in a collaborative manner.

Keywords: Masculinity, Schizophrenia, Psychosis, Systematic Review.

2.0 INTRODUCTION

Men identify with masculinity in numerous ways, and a range of multiple masculinities are displayed by individuals (Addis, Reigeluth, & Schwab, 2016). Some research suggests that to be adequately masculine, men must:

- *Be powerful, competitive and strive for power and dominance* (Kaufman, 1987).
- *Not show vulnerability, emotions or weakness* (Jansz, 2000).
- *Be successful in their work and be in control themselves, others, and their environments* (Möller-Leimkühler, 2003; Robinson & Watt, 2001).
- *Be sexually skilled* (Barker & Ricardo, 2005).

However, Mac an Ghaill and Haywood (2012) suggest that hyper-masculinity (an exaggerated form of masculinity) is associated with violence and aggression, whereas hypo-masculinity (a minimised form of masculinity) can lead to personal vulnerability and risk as well as the increased likelihood of group rejection and social isolation (Cialdini & Trost, 1999). Consequently, difficulties navigating and meeting the demands of masculinity may result in distress and unhealthy coping behaviour (Iwamoto, Cheng, Lee, Takamatsu, & Gordon, 2011).

Some men also experience psychotic phenomena. Although each individual is unique, there are experiences which are commonly thought of as being indicative of psychosis. These include:

- *Hearing voices* (‘hallucinations’).
- *Speaking in a way that others find hard to understand* (‘thought disorder’).

- *Believing things that others find strange* (‘delusions’).
- *Periods of confusion which appear out of touch with reality* (‘acute psychosis’).

Some people may also appear withdrawn or unmotivated which can often be a result of feeling helpless and overwhelmed by experiences, but this can also be the side-effects of medication. There is an ongoing debate about what creates the vulnerability to experience psychosis. However, it is strongly considered that life events and circumstances, inherited tendencies and the way in which events are perceived can all play a role (British Psychological Society, 2014).

Researchers have made efforts to clarify and measure the possible impact of masculinity on health and wellbeing (Connell, 1995). Yet the intersecting factors of being young, male and experiencing psychotic phenomena have received little attention (Harrop & Trower, 2001). For example, LaTorre (1984) proposed a diathesis-gender-stress model. He claimed that the stressors involved in gender identity (e.g. disturbed family dynamics and expectations of ideal gender identities that individuals may find objectionable), inhibit the perception of self in a sex-congruent gender identity. It was considered that this stress would increase the likelihood of an individual experiencing psychotic phenomena (Nasser, Walders, & Jenkins, 2002). The lack of empirical evidence to fully support this model when it was published was largely due to the poor state of gender identity assessment as opposed to an absence of the phenomena (LaTorre, 1984). However there has since been a number of published studies which highlight an apparent relationship between men’s conceptions of masculinity and psychosis.

For example, Hirschfeld, Smith, Trower, and Griffin (2005) interviewed a sample of young men with a diagnosis of psychosis. They found that their participants referred to difficulties becoming financially independent, belonging to a peer group, developing sexual relationships,

achieving at work and educational goals as explanations for their psychosis. Yet these are all factors linked with masculine norms emphasising independence, autonomy and self-sufficiency (Chu & Gilligan, 2014). This is supported by evidence which shows that recovery from psychosis rates are greater during periods of full employment as compared with periods of economic recession (Schrank, Bird, Rudnick, & Slade, 2012).

The dominant negative interpretation of men displaying effeminate behaviour in western cultures, has also led some men to fear displaying behaviour considered to be feminine (Wilkinson, 2004). Yet concern regarding gender expression can be prominent in an individual's experience of psychosis. For example, Mitropoulos et al. (2015) examined case histories of 174 inpatients with a diagnosis of psychosis in a retrospective cross-sectional analysis. They found that significantly more men (18.3%) than women (1.4%) experienced psychotic phenomena in relation to being accused of homosexuality or being forced to engage in homosexuality, with no other demographic characteristic besides sex predicting this.

Furthermore, research highlights that the use of psychotropic medication to alleviate difficulties associated with psychosis can result in impotency, resulting in men feeling emasculated (Mckeown, Robertson, Habte-Mariam & Stowell-Smith, 2008). Alternatively, grandiose delusions may represent exaggerated positive evaluations of self (Fowler et al. 1995), which may in turn galvanize a man's conception of his masculinity.

Empirical research also suggests that men can be reluctant to seek help from health professionals (Fraser, 2017; Lynch, Long, & Moorhead, 2016; Sheffield, 2016). This is often because seeking help may undermine a man's sense of masculinity, consequently leading to

feelings of inadequacy and shame (Courtenay, 2011). Alternatively, Safran (1990) claims that help-seeking could result in men believing that they will be perceived as being vulnerable by others, thereby increasing their likelihood of being at risk of harm.

Yet there have also been studies which document an association between avoidance of help-seeking and psychosis. For example, Dickerson, Sommerville, Origoni, Ringel, and Parente (2002) used a battery of psychometric assessment tools within their study of outpatients with a diagnosis of schizophrenia. They found that one of the most commonly reported experiences of stigma included avoidance of self-disclosure about mental illness due to worries about being viewed unfavourably by others. Furthermore, von Reventlow et al. (2014) found that their participants who were at high-risk of psychosis (and later made a transition to experiencing psychotic phenomena) had significantly longer delays between initial help-seeking and receiving appropriate intervention.

2.1 Aims

To date, there has been no systematic review of how masculinity is expressed in men with a diagnosis of psychosis. The current paper therefore aims to systematically review the available evidence, to determine how adult males who have received a diagnosis of psychosis perceive their masculinity.

3.0 METHOD

3.1 Data sources and search strategy

A systematic search of quantitative studies was conducted on 18th October 2016 using four electronic databases, namely Cochrane Library, PsycINFO (1806 – October week 2, 2016), Medline (1946 – October week 1, 2016) and Web of Science which all include research literature from social science, nursing and medical professions. Covering this range of disciplines was necessary as the variation in terminology which can be used in place of 'masculinity' and 'psychosis' necessitated a comprehensive and inclusive search approach. When searching the databases, groups of terms relevant to two specific elements of the question were combined, including the following search terms: "psychosis", "schizophreni*", "hallucinat*" in combination with "masculin*", "macho", "hegemonic" and "manliness" (Appendix A). Further manual searching of reference lists from identified studies were also undertaken. An overview of the search and screening process is displayed in Figure 1.

3.2 Inclusion/exclusion criteria

In order to meet the aims of the review, a priori inclusion and exclusion criteria were developed. Literature was included if it:

- Comprised of adult males (over 18 years).
- Included participants who had received a diagnosis of psychosis.
- Explored participant's conceptions of masculinity.
- Was quantitative research.
- Was published in a peer-reviewed journal.
- Was original research.
- Was written in English.

Literature was excluded if it:

- Comprised of only adult females (over 18 years).
- Included children (under 18 years).
- Only included indirect participants (e.g. staff groups, parents of adults with a diagnosis of psychosis etc).
- Was a symposium paper, forum paper, editorial, dissertation or case study.
- Was not research (e.g. book chapter, protocol).
- Was a duplication.
- Was not an article length representation of the study (required to assess quality).

3.3 Abstract/full text review

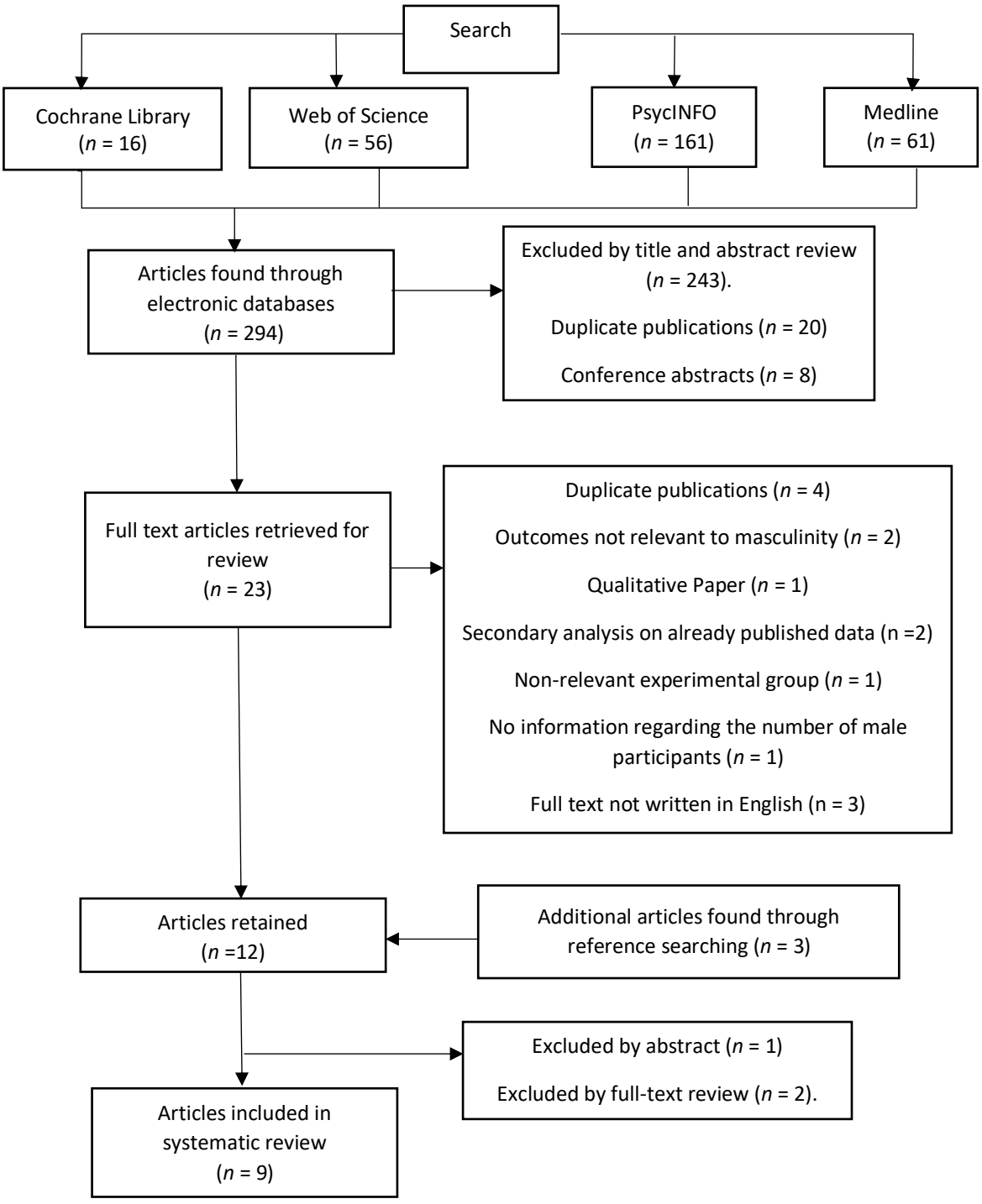
A total of 294 articles were identified. The first and fifth authors reviewed the titles and abstracts of the articles for relevance. Articles were excluded at this stage for obvious violations of the inclusion criteria including: unrelated subject matter, papers other than original research and research with non-psychotic type populations. Disagreements were resolved through discussion until a consensus was reached and in case of doubt, articles were kept for final screening.

Twenty-three papers remained after this process. A full text review of these articles resulted in four publications being removed as they were duplications. Three publications had full texts which were not written in English and were therefore excluded. One paper was qualitative, two papers included outcomes not relevant to masculinity, two were secondary analyses on already published data, one paper included a non-relevant experimental group and one publication had no information regarding the number of male participants. Some articles remained due to the information in the abstract not allowing suitability to be determined, or because no abstract was immediately accessible.

Hand searching of the nine included studies (Bosselman & Skorodin, 1940; Butler & Bieliauskas, 1972; Ecker, Levine, & Zigler, 1973; Kayton & Biller, 1972; Latorre, Endman, & Gossmann, 1976; LaTorre & Piper, 1979; McClelland & Watt, 1968; Peretti & Carberry, 1974; Sajatovic, Jenkins, Strauss, Butt, & Carpenter, 2005) identified three additional potential studies, with two remaining after the initial abstract sift. However, both of these texts were excluded when the full-text was reviewed. An international expert in the field of masculinity was then consulted to check whether there were any omissions from the identified studies (Appendix B).

3.4 Summary of search and selection process

3.41 Figure 1: Prisma Flow Diagram



4.0 RESULTS

4.1 Data abstraction and synthesis

General characteristics were then abstracted from the nine included studies, including: publication year, sample size, study design, outcomes measured and method of analysis. Additional characteristics relating to the sample were also recorded including gender, age and diagnosis. Finally, the findings of each study were abstracted and summarised. All the abstracted data is detailed in Table 1.

4.2 Summary of papers

Of the nine papers included in the review, Bosselman and Skorodin (1940) used the Masculinity-Femininity Test (Terman & Miles, 1936). This comprises of participants completing word association, ink-blot association, information, emotions and ethical attitudes, interests, opinions and introverted response tasks. Butler and Bieliauskas (1972) used a drawing completion test (Franck & Rosen, 1949). This consists of 36 incomplete geometric drawings which participants must complete, to discern their unconscious sexual identification (Aronfreed, 1960; Lansky, 1960). They also used the Gough Brief Femininity Scale (Gough, 1952) which measures sex role preferences by scoring participant's masculinity and femininity ratings on responses to 58 true-false interest-attitude statements.

McClelland and Watt (1968) used the Whiting Figure Preference Test (Whiting, 1965). This comprises of 16 pairs of figures, and asks participants to choose the figure they prefer in order to help examiners determine their gender identity. The Thematic Apperception Test (May, 1966) was also used, which asks participants to tell stories about three pictures. The test is designed to determine whether participants would think first of going up/pleasure (flying high,

killing a bull, or getting up a mountain), or going down/disaster (falling, failure in a ring, or going down a mountain). Additional tests included the Role Preference Test, which asks participants to choose what part they would like to play if given choices (e.g. either scientist versus fashion designer, secretary versus policewoman etc) (McClelland & Watt, 1968). Furthermore, the Body Parts Satisfaction Test was also used, which asks participants to sort cards which have names of the human body into categories of either 'satisfied with' and 'not satisfied with' (Holzberg & Plummer, 1964). Ecker et al., (1973) used both the Role Preference and Body Parts Satisfaction Test, as well as the Humor Test which comprises of cartoons either irrelevant to sex-role behaviour, or men and women engaging in deviant or odd sex role behaviours. During this task, participants' mirth response, preferences (like, indifferent and dislike) and comprehension of the cartoon are assessed to determine sex-role preferences (Redlich et al., 1951).

Both Kayton and Biller (1972) and Peretti and Carberry (1974) asked their participants to complete the Gough and Heilbrun's Adjective Check List. This asks participants to choose their preference of five 'masculine' traits (achievement, aggression, autonomy, dominance and endurance), and five 'feminine' traits (abasement, affiliation, deference, nurturance and succorance - the act of seeking out affectionate care and social support) (Gough & Heilbrun, 1965). Their participants also completed the Gough Femininity Test which asks participants to make choices (e.g. "*I would like to be a nurse*" versus "*I very much like hunting*") to help examiners discern participants' sex role preferences (Gough, 1966).

Latorre et al. (1976), LaTorre and Piper (1979) and Sajatovic et al. (2005) all used the Bem Sex Role Inventory. This consists of 60 personality-related items empirically identified as being associated with Euro-American gender stereotypes, and has produced norms for gender

role identifications for men and women (Bem, 1976). LaTorre (1976) used this inventory as well as the Need for Achievement Test (McClelland, Atkinson, Clark, & Lowell, 1953). This aims to discern an individual's desire for significant accomplishment, mastering of skills, control or high standards. LaTorre and Piper (1979) also used the Embedded Figures Test which requires participants to detect of geometric figures in complex line drawings (LaTorre, Gossmann, & Piper, 1976). They also used the Minnesota Multiphasic Personality Inventory (MMPI) Masculinity and Femininity scale (Hathaway & McKinley, 1940). This contains 56 items and measures interests in vocations and hobbies, aesthetic preferences, activity-passivity and personal sensitivity to help examiners discern how rigidly a person conforms to very stereotypical masculine or feminine roles.

4.3 Table 1 – Summary of data

Primary Author and Publication Year	Sample with a diagnosis of psychosis				Control Group (N, sex, diagnosis, mean age (range)	Methodology and Design Analysis	Masculinity Outcome Measurements	Key Finding(s)
	N (men)	Mean age (range)	Diagnosis	Inpatients or Outpatients				
Bosselman and Skorodin, (1940)	48	N/A (N/A)	Schizophrenia	Inpatients	• 59, female, schizophrenia, N/A (N/A) • 27, female manic depression, N/A (N/A)	• Quantitative. • Experimental Design	• Terman-Miles Analysis (Terman & Miles, 1936)	• The majority (66.6%) of men with schizophrenia deviated to the feminine side as compared with their expected scores
Butler and Bieliauskas, (1972)	15	N/A (21-53)	Paranoid Schizophrenia	Inpatients	• 15, male, passive-aggressive, N/A (21-53)	• Quantitative. • Experimental Design	• Drawing Completion Test (Franck & Rosen,1949) • Gough Brief Femininity Scale (Gough, 1952)	• On the Gough test, both the experimental and control groups were within the range of scores indicating a masculine orientation. • For the drawings test, the range and mean scores for the two groups were again quite similar and in a masculine direction
Ecker et al. (1973)	20	28.4 (20-50).	Schizophrenia	Inpatients	• 10, male, normal, 32.0 (N/A) • 10, female, normal, 30.6 (N/A)	• Quantitative • Repeated measures	• Role Preference Test (McClelland & Watt, 1968) • Body Parts Satisfaction Test (Holzberg & Plummer, 1964) • Humor Test (Redlich et al. 1951)	• There was no significant difference of role preference for the experimental and control groups
Kayton and Biller (1972)	40	N/A (18-49).	• Non-paranoid Schizophrenia (n = 20) • Paranoid schizophrenia (n = 20)	Inpatients	• 20, male, neurotics, N/A (18-49) • 20, male, normal, N/A (18-49)	• Quantitative • Experimental Design	• Gough and Heilbrun's Adjective Check List (Gough & Heilbrun, 1965) • Gough Femininity Scale (Gough, 1966)	• It was consistently found that the disturbed groups were less masculine on the sex-role measures than were the normals
LaTorre et al. (1976)	10	N/A (N/A)	Schizophrenia	Inpatients	• 16, male, normal, N/A (N/A) • 12, female, normal, N/A (N/A) • 13, female, schizophrenia, N/A (N/A)	• Quantitative • Experimental Design	• Bem Sex-Role Inventory (Bem, 1974) • Need for Achievement Test (McClelland, 1953)	• Both male and female schizophrenic groups scored in a more feminine direction than did the normal group

LaTorre and Piper (1979)	22	N/A (18-60)	Non-paranoid Schizophrenia	Inpatients	• 22, female, non-paranoid Schizophrenia, N/A (18-49) • 10, male, manic or major depressive, N/A (18-49) • 12, female, manic or major depressive, N/A (18-49)	• Quantitative • Experimental Design	• Embedded Figures Test (LaTorre et al. 1976) • Minnesota Multiphasic Personality Inventory (MMPI) Masculinity and Femininity *(Mf)* scale (Hathaway & McKinley, 1940) • Bem Sex-Role Inventory (Bem, 1974)	• There was a lessened masculinity among long term admitted non-paranoid schizophrenic males. • Confusion in schizophrenia is related to gender role adoption but not gender identity per se, as people with schizophrenia had an intact gender identity but confused gender role adoption as measured by the BSRI.
McClelland and Watt (1968)	23	36.2 (20-50)	Schizophrenia	Inpatients	• 20, male, normals, 34.9, (20-50) • 22, female, schizophrenia, 36.3 (20-50) • 20, female, normals, 36.8 (20-50) • 21, female, normals, 32.8 (20-50).	• Quantitative • Experimental Design	• Role-Preference test (McClelland & Watt, 1968) • Body-parts satisfaction (Holzberg & Plummer, 1964) • Whiting Figure Preference Test (Whiting, 1965) • Thematic Apperception Test (May, 1966).	• The male schizophrenics chose female roles significantly more often than the normal. • The male schizophrenics differed significantly from normal when the male alternative suggested assertion. • The male schizophrenics were more often feminine as compared to the normal male employees.
Peretti and Carberry (1974)	50	N/A (18-25)	• Non-differentiated schizophrenia (n = 25) • Paranoid schizophrenia (n = 25)	Inpatients	• 25, male, neurotics, N/A (18-25) • 25, male, normal, N/A (18-25)	• Quantitative • Experimental Design	• Gough and Heilbrun's Adjective Check List (Gough & Heilbrun 1965) • Gough Femininity Scale (Gough, 1966)	• Schizophrenic participants had lower scores of typical masculine traits such as dominance and achievement as compared to controls.
Sajatovic et al. (2005)	49	40 (N/A)	Schizophrenia or schizoaffective disorder	N/A	• 41, females, schizophrenia or schizoaffective disorder, 41.5 (N/A)	• Quantitative • Repeated Measures	• Bem Sex Role Inventory (Bem, 1974)	• Both men and women scored lower on traditional masculine descriptive measures compared with persons without schizophrenia.

4.4 Key Findings

As the identified studies were not randomised controlled trials, and there was considerable heterogeneity within the populations, settings, outcomes and designs of the identified studies (Jackson & Waters, 2005), a meta-analysis was not possible. Therefore, a narrative analysis was completed, which involved describing and comparing the main findings from the included studies and discussing their methodological strengths and weaknesses (Centre for Reviews and Dissemination, 2009).

Six (66.7%) research studies were completed in the 1970's, seven (77.8%) studies used an experimental design and the age ranges of participants varied from 18 to 60 years of age. Although masculinity was measured in all of the studies, a wide range of outcome measures were used. The most commonly used outcome measurement tool was the Bem Sex Role Inventory (Bem, 1974) and variations of the Gough Femininity scale (Gough, 1952, 1966) which were used in three (33.3%) of the studies. Eight (88.9%) studies used inpatient samples, and the number of experimental group participants ranged from 10 to 50.

A range of control groups were also used. The most common control group included male non-psychotic participants which were used within six (66.7%) of the studies, and five (55.6%) studies utilised females with a diagnosis of psychosis. Seven (77.8%) studies (including all studies which utilised the Bem Sex Role Inventory), reported male patients with a diagnosis of psychosis either choosing less masculine roles or scoring lower on traditional masculine descriptive measures as compared to controls. One (11.1%) study showed that their male participants with a diagnosis of psychosis held a masculine disposition, and one (11.1%) study found no significant difference of role preference between either their experimental or control groups.

Some measures used within the studies included subscales in respect of masculinity. For example, the Gough and Heilbrun's Adjective Check List (Gough & Heilbrun, 1965) used within Kayton and Biller's (1972) study highlighted that the normals scored higher on the combined masculine scales than did the paranoid schizophrenics ($p < .05$). Furthermore, the paranoid schizophrenic group scored lower on all 5 masculine subscales as compared to the normal group. This included achievement (45.50 as compared to 55.45); aggression (51.95 as compared to 53.70); autonomy (47.30 as compared to 54.55); dominance (43.15 as compared to 55.05) and endurance (44.45 as compared to 51.80). The paranoid schizophrenic group also scored higher on 3 of the 5 feminine subscales as compared to the normal group. This included abasement (54.75 as compared to 44.55) deference (54.75 as compared to 44.55) and succorance (56.70 as compared to 47.35).

Peretti and Carberry (1974) also used this assessment, and found that the paranoid schizophrenic group scored lower on all 5 masculine subscales as compared to the normal group. This included achievement (46.80 as compared to 58.45); aggression (51.90 as compared to 53.70); autonomy (46.40 as compared to 56.55); dominance (42.20 as compared to 54.00) and endurance (45.45 as compared to 51.65). The paranoid schizophrenic group also scored higher on the same 3 subscales as compared to the normal group, which were also the same 3 subscales found within Kayton and Biller's (1972) study. This included abasement (54.65 as compared to 42.56) deference (55.80 as compared to 40.50) and succorance (53.65 as compared to 44.35).

Furthermore, McClelland and Watt (1968) used a questionnaire (not stated) which deals with self-reports of sex-typed attitudes and interests. They found that of those participants who were above the median on predominantly feminine attitudes and interests, a greater proportion of male schizophrenics (not including black participants) scored higher than non-schizophrenic

men on 3 of the 4 feminine subscales. These included unassertiveness (26% as compared to 25%), yielding (42% as compared to 35%) and sex concern (37% as compared to 35%).

4.5 Quality assessment

Each included study was assessed for methodological quality by the first and fifth authors using the 16-item Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh, Lawton, Gardner, & Armitage, 2011) (Appendix C). Using this method each paper is given a quality score, and the sum of these provides an overall score for the body of evidence which is expressed as a percentage of the maximum possible score (Table 2). In order to assess the inter-rater reliability of the quality appraisal tool, all the studies were independently rated by the first and fifth authors. Any disagreements were resolved by rechecking the original articles leading to a consensus decision. Due to the limited number of relevant reports, no studies were excluded on the basis of the quality ratings, however, the quality ratings were used to guide interpretation of the results. The two researchers agreed upon 57 of the 126 available ratings (45.24% agreement) (Appendix D).

4.6 Table 2. Results of Quality Appraisal

Study	Theoretical Framework 1.	Aims & Objectives 2.	Description of research setting 3.	Sample Size 4.	5.	Data Collection 6.	7.	Recruitment 8.	Reliability and validity of measurement Tools 9.	Fit between research question and method 10.	11.	12.	Justification for analytical method 13.	Reliability of analytical process 14.	Service user involvement 15.	Strengths & Limitations 16.	Overall Quality (%)
Bosselman and Skorodin (1940)			++								N/A	+	+	N/A			9.52
Butler and Bieliauskas (1972)	++	+	+		++	++	++			++	N/A	+	++	N/A		++	40.48
Ecker et al. (1973)	++	+++			++	++	++		+	+++	N/A	+++	++	N/A		+	50
Kayton and Biller (1972)	+		+++		+	+				+++	N/A	++		N/A		+	28.57
LaTorre et al. (1976)	+	+			++ +	+	+		++	+++	N/A	++	++	N/A		++	42.86
LaTorre and Piper (1979)	++		++		+	++	+			+++	N/A	+++	++	N/A		+	40.48
McClelland and Watt (1968)	+++	+	++	+	++ +	+++	++			+++	N/A	+++	++	N/A		++	59.52
Peretti and Carberry (1974)	++		++		++	++	++			++	N/A	+	++	N/A			35.71
Sajatovic et al. (2005)	+++	+++	++		+	+	++	+	+	+++	N/A	+++	++	N/A		++	57.14
																	AVERAGE: 37.14

Key	
	Very high risk of bias
+	High risk of bias
+	Moderate risk of bias
+++	Low risk of bias

There has been criticism of the use of arbitrary cut-off scores in quality assessment tools, as important quality elements can be masked by the overall score and related overall quality label (Schulz, Chalmers, Hayes, & Altman, 1995). Furthermore, single elements of quality can be more important than others in answering posed questions (Jüni, Witschi, Bloch, & Egger, 1999). Therefore, this review adapted the tool developed by the Cochrane Collaboration (Higgins & Green, 2011) whereby shades represent levels of quality/bias. Although usually separated within Cochrane reviews, in this review quality and bias are combined. No shading signifies low quality/high risk of bias, light shading represents moderate quality/moderate risk of bias, and dark shading signifies high quality/low risk of bias (Table 3).

4.7 Results of quality assessment

As can be seen in Table 2, the quality between and within the studies is mixed. The quality ratings ranged from 9.52 to 59.52, and the average quality rating across the nine studies was 37.14 which could be considered to be low. There appears to be a number of reasons for this, including no evidence of any service user involvement within the studies. This may be due to the fact that the studies were mostly conducted in the 1970's, and service user involvement in research is a more recent development starting in the mid-1990s, becoming increasingly embedded in the research enterprise (in the UK at least) in the last decade (Szmukler, Staley, & Kabir, 2011).

Furthermore, there is generally a lack of detailed recruitment data in respect of demographics such as IQ, length of hospitalisation and use of medication reported within the studies. This makes it difficult to compare and contrast the salient characteristics of the research participants. Additionally, there was a lack of information in respect of a statistical assessment of the reliability and validity of the measurement tool(s) that were used. Considering that a significant proportion of these tools were established prior to the 1970's, this is a significant limitation.

Many of these scales exaggerated the differences between men and women, the feminine characteristics within these scales often carried negative connotations, and the scales did not frequently account for androgyny (individuals having both masculine and feminine characteristics) (Morawski, 1987).

4.8 Table 3. Synthesis of quality of evidence

Item	Criteria	Overall Quality of Evidence
1	Explicit theoretical framework	
2	Statement of aims/objectives in main body of 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 tool(s)	
8	Detailed recruitment data	
9	Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	
10	Fit between stated research question and method of data collection (Quantitative only)	
11	Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative only)	N/A
12	Fit between research question and method of analysis	
13	Good justification for analytical method selected	
14	Assessment of reliability of analytical process (Qualitative only)	N/A
15	Evidence of user involvement in design	
16	Strengths and limitations critically discussed	
		25% 50% 75% 100%

Key	
	Very high risk of bias
	High risk of bias
	Moderate risk of bias
	Low risk of bias

4.9 Synthesis of quality

As can be seen in Table 3, the overall evidence is not of a high standard. Only one criteria (fit between stated research question and method of data collection) was considered as having a low risk of bias in over 50% of the studies. Furthermore, there is a lack of information in respect of any evidence of sample size being considered in terms of analysis. This could be considered to be another significant limitation, as the use of smaller samples can provide results which may not be sufficiently powered to detect a difference between the groups and/or lead to a type II error (Nayak, 2010).

5.0 DISCUSSION

This review evaluated nine studies relating to the examination of the gender expression of men with a diagnosis of psychosis. The results indicated that most (seven) of the studies found that these men chose less masculine roles or scored lower on traditional masculine descriptive measures as compared to controls. However, at this time the heterogeneous and poor quality studies which are available to review makes it difficult for any conclusions to be drawn regarding how men with a diagnosis of psychosis consider their gender expression.

For example, the statistically significant outcomes in the studies suggest that a difference exists between men with and without a diagnosis of psychosis regarding their gender expression. Yet without conducting a meta-analysis it is unclear how robust such findings were to type I errors (false positives, where an effect is detected but it can be attributed to chance) (Ellis, 2010). Furthermore, the sample sizes were relatively small and comprised primarily of inpatients. It is therefore unlikely that the studies fully represent the wider population of men who experience psychotic phenomena, and are unlikely to approximate population outcomes (Ellis, 2010). Additionally, the lack of outpatient samples may have resulted in a heightened bias towards

feminised scores. For example, the inpatients may have considered themselves to have become more 'feminised' due to the removal of their independence, autonomy and self-sufficiency. Also, the plethora of control groups makes it difficult to discern any consistent differences between studies.

The most commonly used tools to discern masculinity (i.e. the Bem Sex Role Inventory and Gough Femininity scales) are both over three decades old. It should be noted that masculinity is a dynamic concept that changes over time and across cultures, so these measures may not approximate to current times. They also impose a correctness upon participants in terms of what is appropriately masculine and are self-report inventories. Therefore, their accuracy depends upon how accurately participants rate themselves and are open to purposeful distortions (O'Brien & Haynes, 1993). Additionally, the literature was very old with only one of the reported studies being completed within the last 30 years. Consequently, it is very likely that gender role perceptions have changed since this time (Holt & Ellis, 1998).

5.1 Strengths and Limitations

Strengths of this review include the comprehensive list of search terms used across a range of databases, covering an extended time period. This allowed a comprehensive review of the literature and consideration of a range of settings and service contexts which increases the likelihood of all relevant literature being included in the review. However, it should be noted that there have been a number of terms associated with psychosis over the years, and the inclusion of additional terms such as delusion*, mad* and paranoi* to name but a few, may have further enhanced this process.

Furthermore, the masculinity and psychosis research pool remains small. Although an initial scour of the available research regarding gender differences in psychosis would lead one to believe that a substantial body of research in this area exists, this is misleading. This is partly due to the terms *sex differences* (demographic categories of male and female) and *gender differences* (the nature of femaleness and maleness) (Deaux, 1993; Nasser et al., 2002) being

used both inconsistently and interchangeably (Lewine, 1994; Nasser et al., 2002) throughout the research literature. The small research pool may have also had an effect upon the synthesis of the quality assessment. The system developed by the Cochrane Collaboration (Higgins & Green, 2011) aims to review large amounts of studies, therefore using it in the current review with only nine studies may be less useful.

Another limitation includes that the criteria for this review led to an exclusion of qualitative research. However, it was noted nonetheless that there was only one qualitative paper available to review. Masculinity is a constantly evolving social, historical and psychological phenomenon. Therefore, quantitative studies are somewhat limited as they typically define masculinity as a unitary and stable construct, whereas qualitative research conceptualise masculinity as a more fluid and multi-faceted construct (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Therefore, a more balanced commentary which integrated the findings of both quantitative and available qualitative research would have been beneficial.

Furthermore, the QATSDD quality appraisal tool relies upon the reviewers' knowledge and expertise to enable fair and consistent assessments to be drawn. It has also yet to be assessed in a large-scale validation study, and the inclusion of a 4-point scoring scale limits the degree to which inter-rater reliability is likely to be established (Sirriyeh et al., 2011). Therefore, this is likely to have been a significant factor responsible for the relatively low inter-rater reliability highlighted within this study.

Additionally, the decision to exclude non-English studies due to the time constraints of competing the work may have precluded relevant literature from being reviewed. Research suggests that the inclusion of non-English literature has changed the results of some systematic reviews (Egger et al., 1997; Grégoire, Derderian, & Le Lorier, 1995). Therefore, considering that masculinity and masculine norms are different between and within diverse populations (Fields et al., 2015; Hergenrather, Zeglin, Ruda, Hoare, & Rhodes, 2014), this is yet another limitation of the review.

5.2 Future research

Future research could endeavour to employ more statistically rigorous designs, which involve larger, broader sample sizes and utilise more recent masculinity inventories with reliable and valid psychometric properties (e.g. the Conformity to Masculine Norms Inventory - Mahalik et al., 2003). However, an alternative to this could involve utilising methodology which does not benchmark participants against a scale of correctness, but simply aims to understand the individual's explanation of what has happened to them and why, in a non-threatening and collaborative way. Q-methodology (Stephenson, 1953) is such an approach. This methodology asks participants to sort a pack of statements in respect of masculinity into a quasi-normal distribution according to their agreement or disagreement with the statements (Stephenson, 1953; Brown, 1980). Considering that this method has previously been used successfully in discerning how men identify themselves (Horwood, 2000), this approach may have substantial relevance for its application in this field. Similarly, qualitative methods may also be helpful in gaining a narrative of an individual's understanding of masculinity. This could include discussions in relation to how masculinity relates to an individual's identity, how masculinity impacts on their experiences of psychosis and how they think their perception of masculinity differs from other men within the general population.

6.0 CONCLUSIONS

The systematic review identified a small number of studies investigating how men with a diagnosis of psychosis consider their gender expression. Of the nine studies which were found, the majority of studies found that men score lower on traditional masculine descriptive measures as compared to controls. However, the results remain speculative, as the quantitative investigations of masculinity and psychosis were shown to have significant methodological flaws. This includes the use of psychometrically flawed assessment tools and confounded/diverse sample selections. Consequently, new studies using more rigorous

empirical methods are needed in order to revisit questions concerning gender expression among men who experience psychotic phenomena (Nasser et al., 2002).

7.0 REFERENCES

Addis, M.E., Reigeluth, C.S., & Schwab, J.R. (2016). Social norms, social construction, and the psychology of men and masculinity. In *APA handbook of men and masculinities.*, (pp. 81-104). Washington, DC, US: American Psychological Association.

Aronfreed, J. (1960). The nature, variety, and social patterning of moral responses to transgression. *Journal of Abnormal and Social Psychology*, 63, 223-240.

Bem, S.L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology*, 42, 155-162.

Bosselman, B., & Skorodin, B. (1940). Masculinity and femininity in psychotic patients. *American Journal of Psychiatry*, 97(3), 699-702.

British Psychological Society (2014). *Understanding Psychosis and Schizophrenia. Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help*. A report by the British Psychological Society Division of Clinical Psychology. Leicester, BPS.

Brown, S. (1980). *Political Subjectivity: Applications of Q Methodology in Political Science*. New Haven, CT: Yale University Press.

Butler, R., & Bieliauskas, V. (1972). Performance of paranoid schizophrenics and passive-aggressives on two masculinity-femininity tests. *Psychological Reports*, 31(1), 251-254.

Centre for Reviews and Dissemination. (2009). *Systematic Reviews: CRD's guidance for undertaking systematic reviews in health care*. University of York.

Chu, J.Y., & Gilligan, C. (2014). *When boys become boys*: *development, relationships, and masculinity*. New York: New York University Press.

Cialdini, R.B., & Trost, M.R. (1999). Social influence: Social norms, conformity, and compliance. In D. Gilbert, S. Fiske, & G. Lindzy (Eds.), *The handbook of social psychology* (Vol. 2, pp. 151–192*)*. Boston: McGraw-Hill, Inc.

Connell, R.W. (1995). *Masculinities*. California: University of California Press.

Courtenay, W.H. (2011). Best practices for improving college men's health: Designing effective programs and services for college men. In J.A. Laker & T. Davis, (Eds.) *Masculinities in higher education: Theoretical and practical considerations* (pp. 177-193). New York: Routledge.

Deaux, K. (1993). Commentary: Sorry, wrong number—A reply to Gentile's call. *Psychological Science*, 4, 125-126.

Dickerson, F., Sommerville, J., Origoni, A., Ringel, N., & Parente, F. (2002). Experiences of Stigma Among Outpatients with Schizophrenia. *Schizophrenia Bulletin*, 28(1), 143-155.

Ecker, J., Levine, J., & Zigler, E. (1973). Impaired Sex-Role Identification in Schizophrenia Expressed in the Comprehension of Humor Stimuli. *The Journal of Psychology*, 83(1), 67-77.

Egger, M., Zellweger-Zähner, T., Schneider, M., Junker, C., Lengeler, C., & Antes, G. (1997). Language bias in randomised controlled trials published in English and German. *The Lancet*, 350, 326–329.

Ellis, P.D. (2010). *The Essential Guide to Effect Sizes: An Introduction to Statistical Power, Meta-Analysis and the Interpretation of Research Results. 1st ed*. Cambridge: Cambridge University Press.

Fields, E.L., Bogart, L.M., Smith, K.C., Malebranche, D.J., Ellen, J., & Schuster, M.A. (2015). ‘‘I always felt I had to prove my manhood’’: Homosexuality, masculinity, gender role strain, and HIV risk among young Black men who have sex with men. *American Journal of Public Health*, 105(1), 122–131.

Fowler, D., Garety, P. A. & Kuipers, E. K. (1995). *Cognitive Behaviour Therapy for Psychosis: Theory and Practice*. John Wiley: Chichester.

Franck, K., & Rosen, E. (1949). A projective test of masculinity-femininity. *Journal of Consulting Psychology*, 13(4), 247-256.

Fraser, E. (2017). Military veterans’ experiences of NHS mental health services. *Journal of Public Mental Health*, 16(1), 21-27.

Gough, H.G. (1952). Identifying psychological femininity. *Educational and Psychological Measurement*, 12, 427-439.

Gough, H.G. (1966). A cross-cultural analysis of the CPI femininity scale. *Journal of Consulting Psychology*, 30, 136-141.

Gough, H.G., & Heilbrun, A.B. (1965). *Joint manual for the Adjective Check List and the Need scales for the ACL.* Palo Alto, Calif.: Consulting Psychologists Press.

Grégoire, G., Derderian, F., & Le Lorier, J. (1995). Selecting the language of the publications included in a meta-analysis: Is there a Tower of Babel bias? *Journal of Clinical Epidemiology*, 48, 159–163.

Harrop, C., & Trower, P. (2001). Why does schizophrenia develop at late adolescence? *Clinical Psychology Review*, 21(2), 241–266.

Hathaway, S.R., & McKinley, J.C. (1940). A multiphasic personality schedule (Minnesota): I. Construction of the schedule. *Journal of Psychology*, 10, 249-254.

Hergenrather, K.C., Zeglin, R.J., Ruda, D., Hoare, C., & Rhodes, S.D. (2014). *Masculinity across culture*: Implications for counselling male clients. Poster presented at the 14th annual conference of the National Council on Rehabilitation Education, Manhattan Beach, CA.

Higgins, J.P.T, & Green, S. (ed.) (2011). *Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0* [updated March 2011]. Last accessed 25th March 2017: www.cochrane-handbook.org.

Hirschfeld, R., Smith, J., Trower, P., & Griffin, C. (2005). What do psychotic experiences mean for young men? A qualitative investigation. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(2), 249-270.

Holt, C., & Ellis, J. (1998). Assessing the Current Validity of the Bem Sex-Role Inventory. *Sex Roles*, 39, 929-941.

Holzberg, J., & Plummer, J. (1964). Sex differences in schizophrenics: Satisfactions with body parts. *Unpublished paper*, Wesleyan University.

Horwood, J. (2000). VI. The search for diversity in male identity using Q-Methodology. *Feminism & Psychology*, 10(4), 492–497.

Iwamoto, D.K., Cheng, A., Lee, C.S., Takamatsu, S., & Gordon, D. (2011). 'Man-ing' up and getting drunk: The role of masculine norms, alcohol intoxication and alcohol-related problems among college men. *Addictive Behaviors*, 36(9), 906–911.

Jackson, N. & Waters, E. (2005). Criteria for the systematic review of health promotion and public health interventions. *Health Promotion International, 20,* 367-374.

Jansz, J. (2000). Masculine Identity and Restrictive Emotionality. In A. H. Fischer (Ed.), *Gender and Emotion: Social Psychological Perspectives* (pp. 166-188). Cambridge, UK: Cambridge University Press.

Jüni, P., Witschi, A., Bloch, R., & Egger, M. (1999). The hazards of scoring the quality of clinical trials for meta-analysis. *JAMA*, 282, 1054-1060.

Kaufman, M. (1987) 'The Construction of Masculinity and the Triad of Men's Violence', in M. Kaufman (ed.) *Beyond Patriarchy: Essays by Men on Pleasure, Power and Change*, Oxford University Press, New York

Kayton, R., & Biller, H. (1972). Sex-role development and psychopathology in adult males. *Journal of Consulting and Clinical Psychology*, 38(2), 208-210.

Lansky, L.M. (1960). Mechanisms of defense: sex identity and defense against aggression. In D. R. Miller & G. E. Swansoo (Eds.), *Inner conflicts and defense.* pp. 272-289. New York: Holt.

LaTorre, RA. (1984). Schizophrenia. In Widom C. S. (Ed.), *Sex roles and psychopathology*. New York: Plenum. pp. 157-181.

Latorre, R.A., Endman, M., & Gossmann, I. (1976). Androgyny and need achievement in male and female psychiatric inpatients. *Journal of Clinical Psychology*, 32(2), 233-235.

LaTorre, R.A., Gossmann, I., & Piper, W.E. (1976). Cognitive style, hemispheric specialization, and tested abilities of transsexuals and nontranssexuals. *Perceptual and Motor Skills,* 43, 719-722.

LaTorre, R.A., & Piper, W. (1979). Gender identity and gender role in schizophrenia. *Journal of Abnormal Psychology*, 88(1), 68-72.

Lewine, R.R. (1994). Sex: An imperfect marker of gender. *Schizophrenia Bulletin*, 20(4), 777-779.

Lynch, L., Long, M., & Moorhead, A. (2016). Young men, help-seeking, and mental health services: Exploring barriers and solutions. American Journal of Men's Health, N/A, 1-12.

Mac an Ghaill, M., & Haywood, C. (2012). Understanding boys*:* Thinking through boys, masculinity *and* suicide. *Social Science* & *Medicine*, 74(4), 482–489.

Mahalik, J.R., Locke, B.D., Ludlow, L.H., Diemer, M.A., Scott, R.P.J., Gottfried, M., & Freitas, G. (2003). Development of the conformity to masculine norms inventory. *Psychology of Men & Masculinity*, 4(1), 3–25

May, R. (1966). Sex differences in fantasy patterns. *Journal of Projective Techniques,* 30, 576-586.

McClelland, D.C., Atkinson, J.W., Clark, R.A., & Lowell, E.L. (1953). *The achievement motive.* New York: Appleton-Century.

McClelland, D.C., & Watt, N.F. (1968). Sex role alienation in schizophrenia. *Journal of Abnormal Psychology*, 73, 226-239.

Mckeown, M., Robertson, S., Habte-Mariam, Z., & Stowell-Smith, M. (2008). Masculinity and emasculation for black men in modern mental health care. *Ethnicity and Inequalities in Health & Social Care*, 1(1), 42-51

Mitropoulos, G.B., Gorgoli, D., Houlis, D., Korompili, K., Lagiou, C., & Gerontas, A. (2015). Psychosis and societal prescriptions of gender; a study of 174 inpatients. *Psychosis*, 1–12.

Möller-Leimkühler, A. (2003). The gender gap in suicide and premature death or: Why are men so vulnerable? *European Archives of Psychiatry and Clinical Neuroscience*, 253(1), 1-8.

Morawski J.G. (1987). The troubled quest for masculinity, femininity, and androgyny. W: P. Shaver, & C. Hendrick (red.), *Sex and Gender* (ss. 44-69). Newbury Park: Sage.

Nasser, E.H., Walders, N., & Jenkins, J.H. (2002). The experience of schizophrenia: What's gender got to do with it? A critical review of the current status of research on schizophrenia. *Schizophrenia Bulletin*, 28(2), 351-360.

Nayak, B. (2010). Understanding the relevance of sample size calculation. *Indian Journal of Ophthalmology*, 58(6), 469.

O'Brien, W.H., & Haynes, S.N. (1993). Behavioral assessment in the psychiatric setting. In A.S. Bellack & M. Hersen (Eds.). *Handbook of behavior therapy in the psychiatric setting* (pp. 39– 71). New York: Plenum Press.

Peretti, P.O., & Carberry J. (1974). Sex-role identification, conflict, and psychopathology in adult males. *Acta Psychiatrica Belgica*, 4, 357-364

Redlich, F., Levine, J., & Sholder, T. (1951). A mirth response test: Preliminary report on a psychodiagnostic technique utilizing dynamics of humor. *The American Journal of Orthopsychiatry*, 21(4), 717–34.

Robinson, T.L., & Watt, S.K. (2001). "Where no one goes begging*":* Converging gender, sexuality, and religious diversity. In D.C. Locke, J.E. Myers, & E.L. Herr (Eds.), *The Handbook of counselling* (pp. 589-599). Thousand Oaks, CA: Sage.

Sajatovic, M., Jenkins, J., Strauss, M., Butt, Z., & Carpenter, E. (2005). Gender Identity and Implications for Recovery Among Men and Women with Schizophrenia. *Psychiatric Services*, 56(1), 96-98.

Schrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review. *Social Science and Medicine*, 74, 554–564.

Schulz, K.F., Chalmers, I., Hayes, R.J., & Altman, D.G. (1995). Empirical evidence of bias. Dimensions of methodological quality associated with estimates of treatment effects in controlled trials. *JAMA*, 273, 408-412.

Seidler, Z., Dawes, A., Rice, S., Oliffe, J., & Dhillon, H. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106–118

Sirriyeh, R., Lawton, R., Gardner, P., & Armitage, G. (2011). Reviewing studies with diverse designs: The development and evaluation of a new tool. *Journal of Evaluation in Clinical Practice*, 18(4), 746–752.

Sheffield, C. (2016) *Men's help seeking behaviour in the domain of mental health: what are the implications for social work practice?* MSc dissertation, University of Portsmouth.

Stephenson, W. (1953). *The study of Behavior: Q-technique and its Methodology*. Chicago: University of Chicago Press.

Szmukler, G., Staley, K., & Kabir, T. (2011). Service user involvement in research. *Asia-Pacific Psychiatry*, 3(4), 180-186.

Terman, L.M., & Miles, C.C, (1936). *Sex and Personality*. New York: McGraw-Hill.

von Reventlow, H.G., Kruger-Özgurdal, S., Ruhrmann, S., SchultzeLutter, F., Heinz, A., Patterson, P., Heinimaa, M., Dingemans, P., French, P., Birchwood, M., Salokangas, R.K., Linszen, D., Morrison, A., Klosterkötter, J., & Juckel, G. (2014). Pathways to care in subjects at high risk for psychotic disorders — A European perspective. *Schizophrenia Research*, 152(2-3), 400-407.

Whiting, J.W.M. (1965). *Figure Preference Test*. Cambridge, Mass.: Harvard University, Department of Social Relations, Mimeo.

Wilkinson, W.W. (2004). Authoritarian hegemony, dimensions of masculinity, and male antigay attitudes. *Psychology of Men & Masculinity*, 5, 121– 131.

SECTION B: THE IMPACT OF MASCULINITY UPON MEN WITH A DIAGNOSIS OF PSYCHOSIS WHO RESIDE IN SECURE FORENSIC SETTINGS

8.0 ABSTRACT

A man's perception of masculinity influences his attitudes and behaviours. Yet there is limited research investigating how men with a diagnosis of psychosis who reside in secure forensic settings perceive masculinity. In the present study, Q-methodology was used to elucidate how such men perceive their masculinity. Ten participants from a secure forensic setting completed a 49 statement Q-sort task. Principle component factor analysis with varimax rotation was performed on the 10 completed Q-sorts. This revealed a 3 factor solution accounting for 57% of the variance in the data. The 3 factors were interpreted and discussed under the following descriptions of masculinity: "*assured and asserting maverick*", "*calm, confident, composed conformist*" and "*nurturing provider in the face of adversity*". This revealed that men who have a diagnosis of psychosis and reside in secure settings endorse predominantly pro-social beliefs regarding masculinity, differing to conventional norms. Such beliefs about masculinity could be considered in the context of rehabilitation for this population.

Keywords: Forensic Science, Masculinity, Violence, Psychosis, Q Methodology, Forensic Mental Health

9.0 INTRODUCTION

Research suggests that some behaviours indicative of masculinity (qualities traditionally associated with men) include:

- *Engaging in risky activities* (Creighton & Oliffe, 2010; Dolan, 2011; Miller et al., 2003; Miller, Farrell, Barnes, Melnick, & Sabo, 2005; Miller, Melnick, Farrell, Sabo, & Barnes, 2006; Miller, Melnick, Barnes, Sabo & Farrell, 2007; Pittman, 1990).
- *Anti-effeminacy* (Haldeman, 2006; Schwartzberg & Rosenberg, 1998).
- *Being sexually successful, active and skilled with women* (Barker & Ricardo, 2005; Hyde, DeLamater & Byers, 2006; Phillips, 2006; Terry, Hogg, & McKimmie, 2000).
- *Being powerful, competitive and dominant* (Kaufman, 1987).
- *Not showing vulnerability, emotions or weakness* (Jansz, 2000).
- *Being successful in their work and in control of themselves, others, and their environments* (Möller-Leimkühler, 2003; Robinson & Watt, 2001).
- *Aggressive behaviour* (Malamuth & Thornhill, 1994).

Men who regularly engage in violent behaviour tend to have a higher conformity to masculine norms (Amato, 2012), and their perception of masculinity has a role in organising their attitudinal and behavioural process (Tennant & Hughes, 1998). Although forensic psychiatric care is primarily populated by men who have committed violent acts, there is limited research focusing upon the meaning of masculinity in this context (Kumpula & Ekstrand, 2009). This is in spite of evidence which shows that maladaptive perceptions of masculinity can be reinforced during time spent residing in secure settings. For example, the environment within psychiatric units is often characterised by locked doors, protection, rules and routines (Höglund, 1996, cited in Kumpula & Ekstrand, 2009). Due to the focus upon safety and protection within psychiatric units, characteristics such as aggressiveness and toughness can become dominant (Kumpula & Ekstrand, 2009). Furthermore, Courtenay (2011) states that men are often reluctant to engage with psychological therapies whilst residing in secure settings due to conformity to masculine

roles, namely the belief that help-seeking is a sign of weakness. He also proposed that this innate sense of weakness could lead such men to feel inadequate and shameful if they were to seek help. Additionally, Safran (1990) claims that help-seeking could result in men believing that they will be perceived as being vulnerable by other service users, thereby increasing their likelihood of being at risk of harm by such individuals.

When considering risk, Whitehead (2005) states that masculinity can emerge as a dominant dynamic risk factor if the offender believes that any man in his situation would have committed the offence. However, he also states that in these cases, existing interventions are not fully equipped to facilitate change. Therefore, the rehabilitation of men with a history of violent offending may be limited without some consideration of their conception of their masculinity (Tennant & Hughes, 1998). Furthermore, if the care and treatment of men who reside in forensic psychiatric settings is to continue to have security and protection as its key aspects, it is possible that a greater consideration of masculinity could enhance the effectiveness of existing custodial and community interventions (Whitehead, 2005).

The impact of masculinity upon men with a diagnosis of psychosis has also received little attention (Nasser, Walders, & Jenkins, 2002; Searle, Hare, Davies, Morgan, & Majumdar, in press); and the literature has yet to identify masculinity as a distinct theme of psychosis (Mitropoulos et al., 2015). Yet there appears to be an overlap between perceptions of masculinity and the difficulties experienced by some men with a diagnosis of psychosis. For example, the cultural notion that men should not talk about feelings or weaknesses is a significant factor in the development of psychosis, as it leads men to become withdrawn and bottle up their feelings (Hirschfeld, Smith, Trower, & Griffin, 2005). Furthermore, since men with a diagnosis of psychosis are often reluctant to talk about either their psychotic phenomena or concept of masculinity, mental health professionals are less likely to enquire (Semp & Read, 2014). This creates a vicious cycle whereby men with a diagnosis of psychosis believe they should not talk about their feelings, leading others to become less likely to ask about them. Not talking about feelings may also exacerbate the risk of men with a diagnosis of psychosis

engaging in violent acts. A recent meta-analysis demonstrated that the presence of untreated persecutory ideation was the strongest risk factor in predicting violence (Silversteen, Pozzo, Roché Boyle, & Miskimen, 2015). This is an important consideration, since persecutory ideation has been regarded as functional in maintaining an idealised and internalised sense of masculinity (Whitehead, 2005).

Hospitalisation can also limit a man's abilities to fulfil the requirements of his perceived masculinity. This includes the hindrance of a man's independence, autonomy and self-sufficiency (Chu & Gilligan, 2014); as well as the pursuit of status and being able to earn money to support their family (Mahalik et al., 2003). This is supported by Evenson, Rhodes, Feigenbaum, and Solly (2008) who found that hospitalisation due to an acute episode of psychosis was generally a negative experience for their male participants, partly in respect of their perception of masculinity. This was due to lengthy separations from their families and a reluctance to be visited by their children, thus thwarting their ability to fulfil their roles as a father.

9.1 Aims/objectives

This study used a cross-sectional design to systematically explore how adult males with a diagnosis of psychosis who reside in forensic settings perceive their masculinity. It was hypothesised that the men would consider risky activities, anti-effeminacy, sexual ability and number of partners, power competition and dominance, restrictive emotionality, career success and the ability to exert control over others as being indicative of masculinity.

10.0 METHOD

10.1 Participants

A panel of local experts within the psychosis field and men who resided at a secure forensic setting with a diagnosis of psychosis were invited to take part in the research study. The local experts comprised of 6 clinical psychologists who took part in the development of the Q-set phase of the project from a possible 8 who were invited to the study. The sample of clinical psychologists were 33.3% women (n = 2) and 66.6% men (n = 4). All the clinical psychologists were UK nationals and aged between (31-52 years old) (mean = 44, SD = 8.36). All the clinical psychologists were white and their mean years of qualification was 16.5 (see Table 1). Clinical psychologists were used at the expense of other healthcare professionals, as it was considered that a clinical psychologist's ability to draw upon and apply key concepts and knowledge in different contexts using a range of evidence based and theoretical models would prove conducive to the research process.

All ten male service users who were invited to take part in the study consented to their involvement. Six service users were interviewed to help develop the Q-set and all ten participants completed Q-sorts. Most service users had a history of illicit substance misuse and all the service users had received various diagnoses of psychosis including schizophrenia (n = 2), paranoid schizophrenia (n = 5), hebephrenic schizophrenia (n = 1), schizoaffective disorder (n = 1) and disorganised schizophrenia (n = 1). Their index offences also varied and included grievous bodily harm (n = 3), fire setting (n = 1), murder (n = 1), indecent assault (n = 1), manslaughter with diminished responsibility (n = 1) and unlawful wounding (n = 3). Eighty percent of the men (n = 8) identified themselves as heterosexual, 10% (n = 1) identified themselves as homosexual, and 10% (n = 1) identified themselves as bisexual. The service users were 90% white (n = 9) and 10% Afro-Caribbean (n = 1) (see Table 2).

10.2 Table 1: Participants Demographic Details

Clinical Psychologists	**Mean [SD] or (%)**
Age	44 [8.63]
Sex	
Male	4 (66.7)
Female	2 (33.3)
Sexual Orientation	
Heterosexual	6 (100)
Ethnicity	
White	6 (100)
Mean Years Qualified	16.5 [9.99]
Service Users who were interviewed	**Mean [SD] or (%)**
Age	38.17 [10.40]
Diagnosis	
Schizophrenia	1 (0.17)
Paranoid Schizophrenia	4 (0.67)
Schizoaffective Disorder	1 (0.17)
Index Offence	
Grievous Bodily Harm	2 (0.33)
Fire Setting	1 (0.17)
Indecent Assault	1 (0.17)
Manslaughter with Diminished Responsibility	1 (0.17)
Unlawful Wounding	1 (0.17)
Sexual Orientation	
Heterosexual	5 (0.83)
Homosexual	1 (0.17)
Ethnicity	
White	6 (100)
Service Users who completed Q-sorts	**Mean [SD] or (%)**
Age	42.1 [12.03]
Diagnosis	
Schizophrenia	2 (20)
Paranoid Schizophrenia	5 (50)
Hebephrenic Schizophrenia	1 (10)
Schizoaffective Disorder	1 (10)
Disorganised Schizophrenia	1 (10)
Index Offence	
Grievous Bodily Harm	3 (30)
Fire Setting	1 (10)
Murder	1 (10)
Indecent Assault	1 (10)
Manslaughter with Diminished Responsibility	1 (10)
Unlawful Wounding	3 (30)
Sexual Orientation	
Heterosexual	8 (80)
Homosexual	1 (10)
Bisexual	1 (10)
Ethnicity	
White	9 (90)
Afro-Caribbean	1 (10)

10.3 Inclusion/exclusion criteria

The inclusion criteria for the Clinical Psychologists included that they were experts in the field of psychosis due to research or academic knowledge, reputation or experience. Participants were accepted if they were working directly with people experiencing psychosis, or had written academic publications in respect of men with a diagnosis of psychosis.

The service users were required to be male, be at least 18 years of age, have received a diagnosis of psychosis, have committed a violent index offence or exhibited a past history of violent offending and have resided at their forensic setting for at least 6 months to ensure a familiarity with their surroundings. Service users were excluded if they were experiencing an acute phase of their psychosis or did not have capacity to consent to their involvement. The decision as to whether participants met the exclusion criteria was discerned by liaising with the psychology team to which the service user resided and asking them for their professional opinion. Participants were also assessed for the appropriateness of their inclusion in the research study prior to completion of the interview and card sort, namely during the chief researcher's explanation of the participant information forms.

10.4 Ethical approval

Prior to the commencement of the research, ethical approval was sought and approved on 25th July 2016 from North East – Tyne & Wear South Research Ethics Committee (Appendix E). Ethical approval was also necessary at a local level, and granted on 4th February 2016 from Cardiff University Research and Innovation Services (Appendix F) and Abertawe Bro Morgannwg University Health Board Research and Development Department on 20th October 2016 (Appendix G).

10.5 Methodology

Q-methodology (Stephenson, 1953) was used for a number of reasons. Q-methodology has a reputation for being a robust technique for revealing individual points of view and highlighting shared understanding (Wastell, Skirrow, & Hare, in press). However, it also enables the diversity of subjective beliefs to be systematically and empirically investigated without recourse to predetermined structures (Absalom-Hornby, 2012). Furthermore, Q-methodology does not test participants or benchmark them against a scale of correctness. Dudley, Siitarinen, James and Dodgson (2008) highlight that it simply aims to understand the individual's

explanation of what has happened to them and why, in a non-threatening and collaborative way, and has been shown to help participants consider some potentially distressing statements in the presence of an unfamiliar person. Researcher bias is also minimised, as data used in Q-methodology is generated by and structured by interested participants rather than researchers (Barry & Proops, 1999).

10.6 Procedure

10.6.1 Stage 1 – Development of the Q-set

To develop the initial Q-set, a range of sources of information which discussed masculinity including grey literature, websites and research from academic papers were reviewed. Six clinical psychologists and six male service users were then interviewed to gain their opinions in relation to how men with a diagnosis of psychosis perceive their masculinity. Interviews took place at the psychologist's work place and all service users were interviewed at their forensic residence. All participants were provided with a participant information sheet (Appendix H) and required to sign a consent form (Appendix I) before taking part. If participants wished to engage in the interview process, they were asked to sign the consent form and a mutually convenient time was arranged for them to meet with the chief investigator. This provided participants with a cooling off period should they change their mind. Use of a semi-structured questionnaire (Appendix J) was used to aid discussion, and demographic information was ascertained (age, sexual orientation and ethnicity) from all participants, as it was considered likely that these different demographics would likely influence a respondent's opinions regarding masculinity. Interviews were audio recorded using a digital recording device, and all data was anonymised during the transcription process (Appendix K). No further interviews were undertaken after completion of the twelve interviews, as it was considered that a 'saturation point' had been reached and the completion of additional interviews would not add any diversity to the existing set of statements.

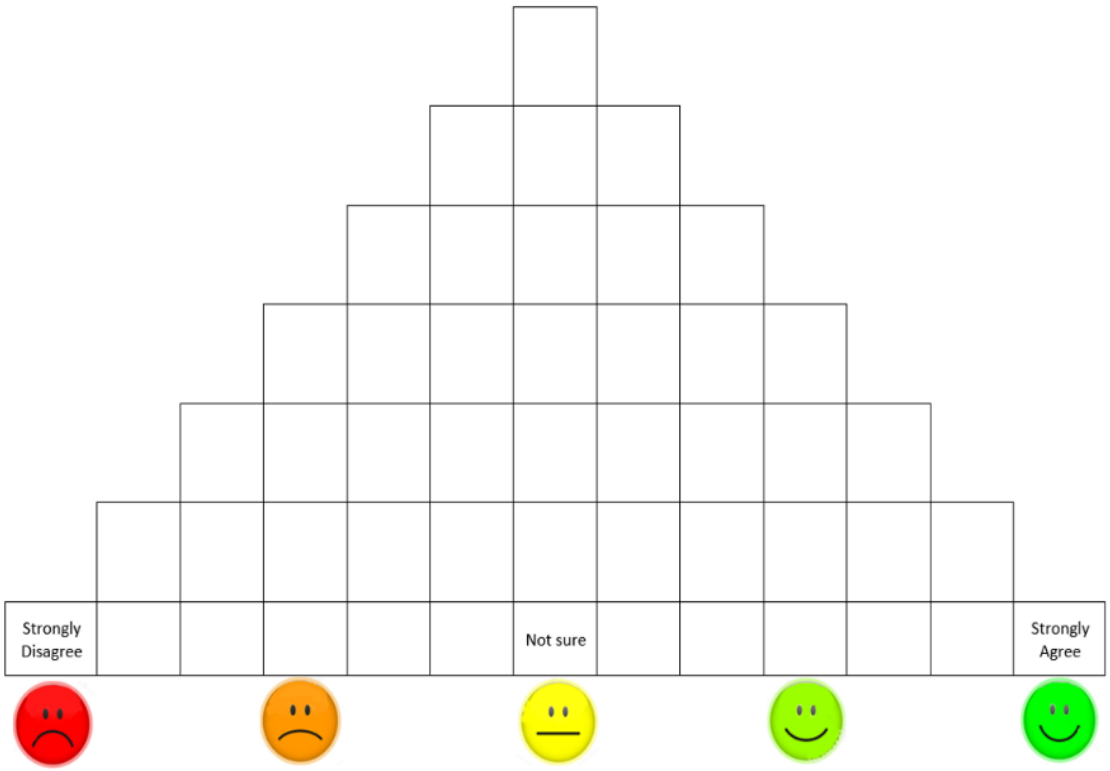
10.6.2 Stage 2 – Developing a Q-Sample

A Q-sample was then developed, which reduces the large set of opinion statements (182) to what was considered by the researchers to be a more manageable number (49). This led to the researchers (R.S, B.D and S.M) independently reviewing the relevance, accuracy and content of statements ascertained within the Q-set, and choosing the statements which they believed to be most representative of masculinity. This resulted in 27 statements being uniformly agreed by all three researchers and 19 being agreed upon by two researchers. The three additional statements were chosen by the chief researcher in an attempt to ensure that the brevity of masculinity was covered (Appendix L).

10.6.3 Stage 3 – The Q-sort

All ten service users were then contacted, and asked if they wished to participate in phase 2 of the study. If so, they were asked to read a participant information sheet (Appendix M), sign a consent form (Appendix N) and a mutually convenient time was arranged for them to meet with the chief investigator to complete their Q-sort. Once again, the decision as to whether participants would be included in this phase of the project was discerned by liaising with the psychology team to which the service user resided by asking them for their professional opinion, and assessed prior to completion of the card sort. All ten service users were considered appropriate for inclusion. During the card-sort, participants were asked to read each statement in turn and then allocate it to a quasi-normal distribution according to their agreement or disagreement with the statement (Stephenson, 1953; Brown, 1980). This included one of 13 categories (e.g. +6 = strongly agree, +3 = agree, 0 = neutral, -3 = disagree, -6 = strongly disagree) (see Figure 1). In performing this process, the participants were simultaneously ranking and rating each statement against all others in the Q-set.

10.6.4 Figure 1



10.6.5 Stage 4 – Factor Analysis

The ten completed Q-sorts were entered into PQMethod 2.11 (Schmolck & Atkinson, 2002), and the inter-correlations amongst Q-sorts were then subject to factor analysis using principle component analysis[1]. Varimax procedure was used to rotate the factors in an attempt to maximise the dispersion of factor loadings within the factors, thereby increasing the sum of variance explained by the extracted factors. The ensuing factor sort showed the similarities between individuals, and enabled the identification of exemplar Q-sorts that defined each factor. These were the statistically weighted average of all of the Q-sorts that loaded[2] significantly onto each factor (Z score) (Schmolck & Atkinson, 2002) (Appendix O).

[1] A statistical technique used to examine the interrelations among a set of variables in order to identify the underlying structure of those variables

[2] How much a factor explains a variable in factor analysis

11.0 RESULTS

The ten Q sorts yielded eight factors with eigenvalues[3] ≥1.00. PQMethod 2.11 is limited to rotating eight factors maximum, which highlighted the heterogeneity of masculinity within this population. However, upon review, there was a significant overlap between the eight factors. Consequently, each factor rotation was examined to discern how many participants loaded significantly onto each factor. From this it was highlighted that for a four factor solution, only four participants loaded significantly onto either of the factors. Whereas for a three factor solution, eight participants loaded significantly onto either of the factors. Following this, a decision was made to retain a three factor solution.

The loading onto each factor could potentially range from 1.0 (complete agreement) to 0 (no agreement or disagreement) and to -1.0 (complete disagreement) (Webler et al., 2007). For the present study, a high loading was calculated using the formula $1.96 / \sqrt{N}$ (where N = number of statements). Therefore, a minimum loading of 0.28 was necessary for the participants' data to be considered as having a high degree (95%) of statistical confidence that it contributed towards their perception of masculinity (Brown, 1980).

As can be seen in Table 2, six participants loaded onto factor 1, five participants loaded onto factor 2 and five participants loaded onto factor 3. Five participants loaded significantly onto more than one factor. However, PQMethod 2.11 is not concerned with identifying loadings that are above statistical confidence (Webler et al., 2007). Instead it is the *highest* loading scores which determine the perspectives. It should also be noted that no factor substantially correlated with the other factors. Therefore, these factors should be considered to be distinct from each other.

It is also important to consider negative scorings within the Q-sort analysis as these indicate disagreement with that factor. For example, participant 1 disagreed somewhat with factor 1,

[3] How much variance is explained by a factor

participant 4 disagreed somewhat with factor 2 and participant 7 disagreed somewhat with factor 3. Participants 2 and 6 had mixed loadings, that is, they had very similar scores on more than one factor.

11.1 Table 2: Rotated factor matrix and defining Q sorts

Participant Number	Factor 1	Factor 2	Factor 3
1	-0.0274	**0.5299***	**0.3031**
2	**0.5776**	0.2427	**0.5527**
3	**0.3058**	**0.6877***	0.1725
4	**0.8230***	-0.0185	0.1064
5	0.1452	**0.3882**	**0.6875***
6	**0.4096**	**0.4173**	**0.2804**
7	0.1561	**0.8134***	-0.0273
8	**0.4721***	0.2259	0.2780
9	**0.6744***	0.1888	0.0127
10	0.1369	0.0101	**0.8723***
Eigenvalue	3.7000	1.0389	0.9911
Cumulative % of explained variance	37%	47%	57%

Note: All significant loadings in bold, asterisk demarks loadings that define that factor.

All the Q-set statements relating to the factors are listed below (average factor scores for participants in the groupings are given in parentheses). A summary of the factors are highlighted in Table 3.

11.2 Factor 1: Assured and Asserting Maverick

Three participants exemplified the principal factor, accounting for 37% of the total variance. Pre-eminent within this factor is the idea that a man should not actively seek out situations that give rise to conflict, but be self-assured, take action and assert themselves even when faced with risk. For example, in regards to not looking for conflict, participants strongly agreed with statement 7 (+6) "*A man does not go looking for trouble*".

In relation to being self-assured, participants agreed with statement 40 (+4) "*Men should be confident*" and for taking action participants agreed with statement 14 (+5) "*Men should be*

competitive", statement 9 (+3) "*Men should stop others from being hurt*", statement 11 (+4) "*Arguing back with voices who belittle you is the right thing to do*" and statement 41 (+3) "*Men should look after their family*".

In regards to risk, participants agreed with statement 46 (+3) "*It is important for a man to take risks even if he might get hurt*" and statement 48 (+3) "*A man should break the rules occasionally*". Although participants disagreed with statement 49 (-5) "*Men should rebel against society*", this may have been due to this statement being perceived as risk taking to an extreme sense.

A second emergent theme was that participants considered their sexual functioning as opposed to the number of their sexual partners as being indicative of their masculinity. For example, participants agreed with statement 33 (+4) "*A man should be able to get erections*" but disagreed with statement 31 (-3) "*A man should have sex with as many women as possible*".

Participants who exemplified this factor held no objection to showing weakness or emotion. For example, participants disagreed with statement 22 (-6) "*Men who cry are weak*", statement 27 (-3) "*Men should not show any emotion*" and statement 28 (-4) "*A man should use drugs to cope with their emotions*". However surprisingly, participants agreed with statement 25 (+5) "*Men should not be vulnerable*". Therefore, this statement may have been interpreted as being indicative of susceptibility or defenceless as opposed to emotional vulnerability. Furthermore, participants were happy to receive help from others, as participants disagreed with statement 29 (-3) "*A man should not tell his problems to other people*", statement 21 (-5) "*A man should prefer to be ill than ask for help*" and statement 37 (-4) "*Men should be able to solve problems on their own*". Additionally, participants held no anti-effeminacy attitudes, as participants disagreed with statement 45 (-4) "*I would be uncomfortable to be with a gay man on my own*", statement 43 (-2) "*A man should never compliment another man*" and statement 42 (-3) "*I would think less of another man if I were to find out he was gay*".

11.3 Factor 2: Confident, calm, composed conformist

Accounting for 10% of the total variance, three participants exemplified this factor, which emphasised that a man should be a confident, calm, composed conformist. For example,

participants strongly agreed with statement 6 (+4) "*A man talks his way out of trouble*" and statement 10 (+4) "*Ignoring voices who belittle you is the right thing to do*". Perhaps unsurprisingly, these participants disagreed with statement 11 (-4) "*Arguing back with voices who belittle you is the right thing to do*".

However, in contrast to factor 1, participants were more reticent to take risks, as participants disagreed with statement 46 (-2) "*It is important for a man to take risks even if he might get hurt*" and statement 49 (-5) "*Men should rebel against society*". Nonetheless, there was some overlap with factor 1, as participants again agreed with statement 33 (+6) "*A man should be able to get erections*" but disagreed with statement 31 (-4) "*A man should have sex with as many women as possible*". Furthermore, similar to factor 1, participants held no objection to showing emotion or receiving help from others, as these participants disagreed with statement 24 (-6) "*Men should not talk about their emotions",* statement 28 (-4) *"Men should use drugs to cope with their emotions",* statement 26 (-2) *"Men should not show that they are upset"* and statement 21 (-3) *"A man should prefer to be ill than ask for help".* As per factor 1, participants held no anti-effeminacy attitudes, as participants disagreed with statement 45 (-5) "*I would be uncomfortable to be with a gay man on my own*", statement 42 (-3) "*I would think less of another man if I were to find out he was gay*" and statement 44 (-3) "*Men should never hold hands or show affection towards another man*".

11.4 Factor 3: Nurturing provider in the face of adversity

Two participants loaded significantly onto factor 3, which accounted for 10% of the variance. This factor emphasised masculinity as being indicative of protecting and providing for family members. For example, participants agreed with statement 12 (+6) "*Men should protect and provide for their families*" and statement 41 (+4) "*Men should look after their family*". However, within this factor is the opinion that men may need to endure hardship and risk in order to be a man, as participants agreed with statement 47 (+5) "*Pain is temporary glory is forever*", and statement 46 (+3) "*It is important for a man to take risks even if he might get hurt*".

As per factors 1 and 2, participants held no objection to showing emotion or receiving help from others, as these participants disagreed with statement 22 (-6) "*Men who cry are weak*", statement 28 (-3) "*Men should use drugs to cope with their emotions*", statement 25 (-5) "*Men should not be vulnerable*", statement 23 (-4) "*Men should cope with difficulties on their own*" and statement 36 (-3) "*A man should not be reliant upon other people*". Once again, participants held no anti-effeminacy attitudes, as participants disagreed with statement 45 (-3) "*I would be uncomfortable to be with a gay man on my own*", statement 42 (-1) "*I would think less of another man if I were to find out he was gay*" and statement 44 (-1) "*Men should never hold hands or show affection towards another man*".

11.5 Table 3: Summary of three factors

Variable of masculinity	***Factor 1: Assured and asserting maverick***	***Factor 2: Confident, calm, composed conformist***	***Factor 3: Nurturing provider in the face of adversity***
Aggression and Violence	Neither agree nor disagree	Neither agree nor disagree	Neither agree nor disagree
Not showing vulnerability, emotions or weakness	Disagree	Disagree	Disagree
Anti-effeminacy	Disagree	Disagree	Disagree
Using drugs to cope with emotions	Disagree	Disagree	Disagree
Protecting and providing for your family	Agree	Neither agree nor disagree	Agree
Engaging in risky activities	Agree	Disagree	Agree
Ability to achieve erections	Agree	Agree	Neither agree nor disagree
Having sex with multiple women	Disagree	Disagree	Neither agree nor disagree

12.0 DISCUSSION

The present study used Q-methodology to examine the beliefs that men with a diagnosis of psychosis who reside in forensic settings hold about their masculinity. This process yielded three distinct clusters of beliefs (factors), highlighting the heterogeneity of masculinity beliefs for this population. The three factors included that men should either be an "*assured and asserting*

maverick" (factor 1), a "*calm, confident, composed conformist*" (factor 2) or a "*nurturing provider in the face of adversity*" (factor 3). All the factors comprised of both agreement and disagreement with variables indicative of conventional masculine norms. No factor substantially correlated with the other factors, therefore, these factors were considered to be distinct from each other.

Interestingly, these three beliefs could be viewed as pro-social, as participants neither agreed nor disagreed in respect of conventional masculine statements associated with aggression and violence across all 3 factors. Therefore, despite all participants having past histories and index offences in relation to acts of violence towards others, the findings do not imply that these participants consider masculinity to be indicative of violence and aggression. This is in contrast with previous research, which suggest that men who regularly engage in violent behaviour tend to have a higher conformity to conventional masculine norms (Amato, 2012), which include striving for power and dominance over others (Kaufman, 1987) and aggressive behaviour (Malamuth & Thornhill, 1994). The findings are also surprising, since threats and violence in forensic psychiatric care are common among male service users (Kumpula & Ekstrand, 2009). Therefore, these men do not appear to have engaged in violent behaviour due to an adherence to masculinity norms (e.g. "*I did it because that's what men do*") (Whitehead, 2005). It may instead be the case that these participants engaged in such behaviour due to other reasons. This could include lacking the skills to manage their difficulties in a more pro-social manner.

It was also highlighted across all three factors that these participants believe that men should seek help and talk about their emotions. This again suggests that these men do not adhere to conventional masculinity norms; as previous research suggests that men with a diagnosis of psychosis (Hirschfeld et al., 2005; Semp & Read, 2014) believe that behaviours indicative of masculinity include not showing vulnerability, emotions or weakness (Jansz, 2000). Yet there would appear to be an inconsistency considering that the men in the present study appear to be receptive to talking about emotions, yet have engaged in significantly violent behaviour. This

leaves questions as to why talking about emotions was not a protective factor for these men. It could be that whilst the men were open to opportunities for emotional support, they did not have the availability of social networks which could provide it. Alternatively, they may have become more accustomed to the provision of psychological support offered to them since residing within their current setting.

Despite anti-effeminacy attitudes being a factor representative of conventional masculinity (Haldeman, 2006; Schwartzberg & Rosenberg, 1998) and the majority of participants being heterosexual, no anti-effeminacy attitudes were highlighted across all three factors. This once again suggests that these men differ from conventional masculine norms, and may not consider effeminate behaviour to be in conflict with their conception of masculinity.

Across all three factors, men disagreed with the concept of using drugs to cope with their emotions. This is an interesting finding, as many of the men had a history of illicit substance misuse. Therefore, questions remain as to whether the participant's views of drug use have changed since their admission to forensic services, or whether they previously used illicit substances at the expense of their sense of masculinity, possibly due to feelings of being overwhelmed. Nonetheless, at the time of their interviews, all the participants were regularly receiving anti-psychotic medication as part of their rehabilitation. Therefore, receiving anti-psychotic medication could possibly undermine their sense of masculinity and create an internal conflict.

The findings, however, are generally consistent with conventional masculine norms in respect of being in control of oneself, others, and the environment (Möller-Leimkühler, 2003; Robinson & Watt, 2001). For example, participants within factors 1 and 3 reported that their perception of masculinity required them to protect and provide for their family. Yet considering that admission

to a forensic unit would likely inhibit a man's ability to fulfil roles in this regard, this may also create an internal conflict for these men.

The findings are mixed in regards to engaging in risky activities as being indicative of masculinity. Individuals who loaded onto factor 1 agreed that men should take risks, whereas those who loaded onto factor 2 did not. This is surprising, as all the participants have engaged in violent behaviour which would result in the risk of a criminal conviction. Furthermore, the findings are mixed in respect of sexual activity. Within factors 1 and 2, participants agreed with the idea that men should be able to get erections, but disagreed with the idea of needing to have sex with multiple women. Therefore, it is likely that these men consider their sexual functioning as opposed to the number of their sexual partners as being indicative of masculinity.

12.1 Clinical and service implications

The findings have important clinical implications, and it would be potentially valuable to understand how these patterns of masculinity map onto coping, recovery style and service engagement. For example, the men consistently disagreed with the concept of using drugs to cope with their emotions, and for some men, the ability to achieve an erection was a significant factor in their representation of masculinity. Although the use of anti-psychotic medication can help to make psychotic experiences less frequent, intense or distressing; antipsychotic-induced sexual dysfunction is commonplace for many men who use such medication. Therefore, discussions between professionals and service users in regards to the possibility of discontinuing the use of anti-psychotic medication within a risk assessment, and a trusting collaborative relationship should be a necessary prerequisite of any treatment approach.

In terms of therapy, discussions in respect of masculinity itself could prove to be beneficial. This includes providing men with the opportunity to develop more adaptive conceptualisations of

themselves; understand the sources of their presenting concerns and enhancing a clinician's formulation of their difficulties (Perelberg, 1999). Furthermore, the study found that men had differing opinions in regards to how they should manage hearing voices who belittle them. Consequently, person-centred therapeutic approaches in this regard could prove beneficial. For example, participants who considered that arguing back with voices is representative of masculinity may benefit more from a Cognitive Behavioural Therapy (CBT) approach to manage such difficulties; whereas for those participants who preferred to ignore such voices, an Acceptance and Commitment Therapy (ACT) approach may prove to be more congruent with their self-identity as a man.

The current findings also raise a number of service implications for men with a diagnosis of psychosis who reside in forensic services. For example, services could benefit from becoming more aware of hospitalisation being a shameful stigmatising time for these men. This is particularly the case considering that men who reside in forensic services will be limited in their ability to protect and provide for their family, which can be a significant representation of their perception of masculinity. Additionally, public attention has increasingly been directed to concerns regarding the quality of psychiatric inpatient provision (Woodward, Berry, & Bucci, 2017). The standard of such provisions could be enhanced if services identified and met the needs of men with regards to their families (Evenson et al., 2008). For example, inpatient units could ensure that service users are able to meet their families in safe and comfortable surroundings and/or communicate via telephone, email and Skype messaging services.

It may also be pertinent for staff members to become more aware of how service users perceive their masculinity, so the existential and deeper needs of male service users are considered (Kumpula & Ekstrand, 2009). It is hoped that this research will help enhance the therapeutic engagement of practitioners in mental health professions, who are currently neglecting to enquire about men's psychotic experiences and gender expression (Semp & Read, 2014).

12.2 Strengths and limitations

The current study demonstrates that Q-methodology can provide structure and clarity to a complex and multi-faceted area (Plummer, 2012). It has enabled a collaborative exploration of what men with a diagnosis of psychosis who reside in secure forensic settings consider to be representative of masculinity. The study was limited however, by participants not being interviewed after the card sort task. It is therefore difficult to discern whether the participant's perceptions of masculinity were factors responsible for their admission to secure settings, whether they have changed since their admission or are likely to change in the future. Consequently, the interpretation of the findings remains speculative. It could also be considered that the participants may have attempted to promote themselves in a positive light during interview; yet all participants were informed that their responses would not affect their prospective care or treatment. Another strength of the study includes that some of the people who complete Q-sorts were used as interviewees, which ensured that it was their views that were being addressed (Coogan & Herrington, 2011). However, the inclusion of a more diverse subset of Q-sorts (Q-sorts being completed by participants who were not interviewed) would have enhanced the representativeness of the factors which were generated.

It is possible that participants may have found certain statements difficult to comprehend (e.g. "*Men should not be vulnerable*"). This is an important consideration, as the validity of Q-methodology can be affected if a participant's lack of comprehension leads to misrepresentation (Dennis, 1986). It could also be argued that completing card sorts with more 10 participants, and/or including a control group, may have enhanced the representativeness and generalisability of the findings. It should be noted, however, that the results of Q-studies are less influenced by low response rates compared with the results of other methodologies (Brown, 1980; Brown, 1993; McKeown & Thomas, 1988). Additionally, Q-methodology acknowledges that no Q-sort can ever be complete as every possible view cannot be included (Watts & Stenner, 2005). Moreover, Kitzinger (1987) states that Q-methodology is exploratory in nature and has no interest in

estimating population statistics or making claims about the percentage of people expressing them. The aim is simply to sample the range and diversity of views expressed.

12.3 Further research

The acquisition of the participants' masculinity beliefs were not explored. Further research could investigate whether there is a relationship between early experiences and masculinity. Darrell-Berry et al. (2017) suggests that avoidant attachment styles may predispose individuals towards subduing intolerable feelings, such as vulnerability, with less aversive emotions such as anger. It would therefore be interesting to explore whether a man's attachment style has any connection to his beliefs about masculinity, particularly in regards to anger and aggression. Furthermore, service users have a unique perspective on services, and their views can be used to ensure that services are of high quality (Smith et al., 2014). Therefore, a Q-methodological study in respect of how services could improve their care of men with a diagnosis of psychosis who reside in forensic services could also prove to be a valuable research endeavour.

13.0 CONCLUSIONS

The study demonstrated that the use of Q-methodology can help facilitate a collaborative exploration of what men with a diagnosis of psychosis who reside in forensic settings consider to be representative of masculinity. The results indicated that these men have predominantly pro-social beliefs regarding masculinity. The elicitation of such beliefs could be used to help men in the context of their rehabilitation.

14.0 REFERENCES

Absalom-Hornby, V. (2012). *An Investigation into Family Intervention within Forensic Services*. A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy (Clinical Psychology) in the Faculty of Medical and Human Sciences.

Amato, F.J. (2012). The Relationship of Violence to Gender Role Conflict and Conformity to Masculine Norms in a Forensic Sample. *The Journal of Men's Studies,* 20(3), 187-208.

Barker, G., & Ricardo, C. (2005). *Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence*. Washington DC: World Bank.

Barry, J., & Proops, J. (1999). Seeking sustainability discourses with Q methodology. *Ecological Economics,* 28, 337-345.

Brown, S. (1980). *Political Subjectivity: Applications of Q Methodology in Political Science*. New Haven, CT: Yale University Press.

Brown, S.R. (1993). A primer on Q methodology. *Operant Subjectivity,* 16, 91-138.

Chu, J.Y., & Gilligan, C. (2014). *When boys become boys*: *development, relationships, and masculinity*. New York: New York University Press.

Coogan J., Herrington N. (2011). Q methodology: an overview. *Research in Secondary Teacher Education*, 1(2), 24– 28.

Courtenay, W.H. (2011). Best practices for improving college men's health: Designing effective programs and services for college men. In T.L. Davis & J.A. Laker (Eds), *Masculinities in higher education: Theoretical and practical implications* (pp. 177-192). New York: Routledge.

Creighton, G., & Oliffe, J.L. (2010). Theorising masculinities and men's health: a brief history with a view to practice. *Health Soc. Rev.*, 409–418.

Darrell-Berry, H., Bucci, S., Palmier-Claus, J., Emsley, R., Drake, R., & Berry, K. (2017). Predictors and mediators of trait anger across the psychosis continuum: The role of attachment style, paranoia and social cognition. *Psychiatry Research,* 249, 132-138.

Dennis, K. (1986). Q methodology: relevance and application to nursing research. *Advances in Nursing Science*, 8(3), 6-17.

Dolan, A. (2011). ''You can't ask for a Dubonnet and lemonade!": working class masculinity and men's health practices. *Sociology of Health & Illness*, 33(4), 586-601.

Dudley, R., Siitarinen, J., James, I., & Dodgson, G. (2008). What do people with Psychosis think caused their Psychosis? A Q methodology study. *Behavioural and Cognitive Psychotherapy*, *37*(01), 11.

Evenson, E., Rhodes, J., Feigenbaum, J., & Solly, A. (2008). The experiences of fathers with psychosis. *Journal of Mental Health*, 17(6), 629-642.

Haldeman, D. (2006). Queer eye on the straight guy: A case of gay male heterophobia. In M. Stevens and M. Englar-Carlson (Eds.), *In the Room with Men: A Casebook for Psychotherapy with Men*. Pp. 301- 317, Washington, D.C.: APA Books.

Hirschfeld, R., Smith, J., Trower, P., & Griffin, C. (2005). What do psychotic experiences mean for young men? A qualitative investigation. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(2), 249–270.

Hyde, J.S., DeLamater, J.D., & Byers, E.S. (2006). *Understanding human sexuality*. Toronto: McGraw-Hill Ryerson.

Jansz, J. (2000). Masculine Identity and Restrictive Emotionality. In A. H. Fischer (Ed.), *Gender and Emotion: Social Psychological Perspectives* (pp. 166-188)

Kaufman, M. (1987). 'The Construction of Masculinity and the Triad of Men's Violence', in M. Kaufman (ed.) *Beyond Patriarchy: Essays by Men on Pleasure, Power and Change*, Oxford University Press, New York

Kitzinger, C. (1987). The *Social Construction of Lesbianism.* Sage, Bristol.

Kumpula, E., & Ekstrand, P. (2009). Men and Masculinities in forensic psychiatric care: An interview study concerning male nurses' experiences of working with male caregivers and male patients. *Issues in Mental Health Nursing*, 30(9), 538–546.

Lewine, R.R. (1994). Sex: An imperfect marker of gender. *Schizophrenia Bulletin*, 20(4), 777-779.

Mahalik, J.R., Locke, B.D., Ludlow, L.H., Diemer, M.A., Scott, R.P.J., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity*, 4, 3–25.

Malamuth, N., & Thornhill, N. (1994). Hostile masculinity, sexual aggression, and gender-biased domineeringness in conversations. *Aggressive Behavior*, 20(3), 185-193.

McKeown, B.F., & Thomas, D.B. (1988). *Q Methodology*. Newbury Park, CA: Sage.

Miller, K.E., Farrell, M.P., Barnes, G.M., Melnick, M.J., & Sabo, D. (2005). Gender/racial differences in jock identity, dating, and adolescent sexual risk. *J Youth Adolesc*, 34, 123–136.

Miller, K.E., Hoffman, J.H., Barnes, G.M., Farrell, M.P., Sabo, D., & Melnick, M.J. (2003). Jocks, gender, race, and adolescent problem drinking. *J Drug Educ*, 33, 445–462.

Miller, K.E., Melnick, M.J., Barnes, G.M., Sabo, D., & Farrell, M.P. (2007). Athletic involvement and adolescent delinquency. *J Youth Adolesc*, 36, 711–723.

Miller, K.E., Melnick, M.J., Farrell, M.P., Sabo, D., & Barnes, G.M. (2006). Jocks, gender, binge drinking, and adolescent violence. *J Interpers Violence*, 21, 105–120.

Mitropoulos, G.B., Gorgoli, D., Houlis, D., Korompili, K., Lagiou, C., & Gerontas, A. (2015). Psychosis and societal prescriptions of gender; a study of 174 inpatients. *Psychosis*, 1–12.

Möller-Leimkühler, A. (2003). The gender gap in suicide and premature death or: Why are men so vulnerable? *European archives of psychiatry and clinical neuroscience*, 253(1), 1-8.

Nasser, E., Walders, N., & Jenkins, J. (2002). The experience of schizophrenia: What's gender got to do with it? A critical review of the current status of research on schizophrenia. *Schizophrenia bulletin*, 2(28), 351-362.

Perelberg, R. (1999). *Psychoanalytic understanding of violence and suicide*. London: Routledge.

Phillips, D.A. (2006). Masculinity, male development, gender, and identity: Modern and postmodern meanings. Issues in Mental Health Nursing, 27(4), 403-423.

Pittman, F. (1990). "The Masculine Mystique". *The Family Therapy Networker* May/June, 40-52.

Plummer, C. (2012). *Who Cares? An Exploration, using Q methodology, of Young Carers' and Professionals' Viewpoints.* DEdCPsy thesis, University of Sheffield.

Robinson, T.L., & Watt, S.K. (2001). "Where no one goes begging*":* Converging gender, sexuality, and religious diversity. In D.C. Locke, J.E. Myers, & E.L. Herr (Eds.), *The Handbook of counselling* (pp. 589-599). Thousand Oaks, CA: Sage.

Safran, J. (1990). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review*, 10(1), 87–105.

Schmolck, P., & Atkinson, J. (2002). PQMethod (Version 2.11). Computer program, available at http://www.qmethod.org.

Schwartzberg, S., & Rosenberg, L.G. (1998). *Being gay and being male: Psychotherapy with gay and bisexual men*. In W. S. Pollack & R. F. Levant (Eds.), New psychotherapy for men (pp. 259–281). New York: Wiley.

Searle, R.J., Hare, D.J., Davies, B., Morgan, S., & Majumdar, S. (in press). A systematic review of how men with psychosis perceive their masculinity. *Journal of Men's Studies.*

Semp, D., & Read, J. (2014). *'Queer conversations: Improving access to, and quality of, mental health services for same-sex-attracted clients.* Psychology & Sexuality, 6(3), 217-228.

Silversteen, S.M., Pozzo, J.D., Roché, M., Boyle, D., & Miskimen, T. (2015). Schizophrenia and violence: realities and recommendations. *Crime Psychology Review,* 1(1), 21-42.

Stephenson, W. (1953). *The study of Behavior: Q-technique and its Methodology*. Chicago: University of Chicago Press.

Tennant, A., & Hughes, G. (1998). Men talking about dysfunctional masculinity: an innovative approach to working with aggressive, personality disordered offender-patients'. *Psychiatric care,* 5(3), 92-99.

Terry, D., Hogg, M., & McKimmie, B. (2000). Attitude-behaviour relations: The role of in-group norms and mode of behavioural decision-making. *British Journal of Social Psychology,* 39(3), 337-361.

Wastell, S., Skirrow, P., & Hare, D.J. (in press). Factors influencing the use of psychotropic medication for challenging behaviour: A Q method investigation. *Journal of Applied Research in Intellectual Disabilities.*

Watts, S., & Stenner, P. (2005). Doing Q-methodology: theory, method and interpretation. *Qualitative Research in Psychology, 2,* 67–91.

Webler, T., Danielson, S., & Tuler, S. (2007). *Guidance on the Use of Q Method for Evaluation of Public Involvement Programs at Contaminated Sites.* MA: Social and Environmental Research Institute.

Whitehead, A. (2005). Man to man violence: How masculinity may work as a dynamic risk factor. *The Howard Journal of Criminal Justice*, 44(4), 411–422.

Woodward, S., Berry, K., & Bucci, S. (2017). A systematic review of factors associated with service user satisfaction with psychiatric inpatient services. *Journal of Psychiatric Research*, 92, 81-93.

SECTION C: CRITICAL EVALUATION

15.0 INTRODUCTION

Based upon the two papers (above), the following section provides a reflective account and critical appraisal of the decision-making processes that shaped the current research. Initially, the critical appraisal will summarise the research process. This includes the decision to explore the impact of masculinity upon men in forensic services who experience psychotic phenomena, the experience of Q-methodology as well as the systematic review process. Following this, the challenges of the research; reflections on professional and personal development; methods of dissemination; strengths and weaknesses of the project; limitations of the line of enquiry as a whole; implications for theory, clinical practice and service development as well as suggestions for further research will be outlined.

16.0 DECISION TO EXPLORE CONCEPTIONS OF MASCULINITY WITH MEN WITH A DIAGNOSIS OF PSYCHOSIS WHO RESIDE IN FORENSIC SETTINGS

I initially developed a number of research ideas. However, I also needed to consider both what would be feasible in terms of tight time frames and what would meet the requirements of a doctoral thesis. This was invaluable for the development of skills in relation to conceptualising, designing and conducting independent, original research (British Psychological Society, 2010). However, the appeal of completing a research project exploring the conceptions of masculinity with men with a diagnosis of psychosis was always my preferred option for a number of reasons. For example, it is often our personal experiences which influence our academic trajectory. Throughout my life to date, I have been told that I need to demonstrate certain behaviours, simply because I am male. This included not crying ("*boys don't cry*") and that I should not show any displays of

emotion ("*man up*") when faced with difficulty. My frustration and dissatisfaction with these expectations partly kindled my interest in clinical psychology as a profession. This included the possibility of helping men to challenge their conceptions of masculinity, connect with their emotions and facilitate their own psychological growth.

Before commencing clinical training, I gained extensive experience of working with men who due to violent behaviour resided in forensic settings. During this time, I noticed that these men and I shared similar experiences of pressure to conform to conventional masculinity norms. Yet despite working under the guidance and supervision of qualified and experienced clinical psychologists, I was never encouraged to discuss these issues. This was in spite of the service user's experiences appearing to be significant factors responsible for the difficulties they had undergone throughout their lives.

My interest in psychosis evolved after I learned how there is a continuum of personality characteristics and experiences representative of psychosis. I then used this knowledge to complete my MSc dissertation which was subsequently published (Randell, Searle, & Reed, 2012). Consequently, l was keen to use this current research process as an opportunity to amalgamate my personal interest in masculinity with research interests in psychosis. I was also hoping to step back from the demands of clinical practice to listen to the difficulties service users may have encountered throughout their lives to date. Furthermore, there was limited available research exploring factors associated with masculinity with men who have engaged in violent behaviour and experience psychotic phenomena. Subsequently, the research provided me with an exciting opportunity to contribute to the evidence-base.

17.0 USE OF METHODOLOGICAL APPROACH

Although a variety of methodological approaches were available to me for completion of the empirical paper, I decided to utilise Q-methodology for a number of reasons. Initially, I considered that grounded theory would be a useful approach to help me consider how my participants conceptualise masculinity. However, I was also aware of my significant prejudices and judgments regarding masculinity. Furthermore, I understood that researcher positions inevitably influence the process of conducting investigations (Veseth, Binder, Borg, & Davidson, 2017). I was also very conscious of the limited time frame in which I needed to complete the research. Therefore, I was quite keen to find an alternative methodological design during completion of my research.

Consequently, I met with my academic supervisor on a number of occasions. During these meetings, I learned that Q-methodology could help me systematically explore the attitudes my participants held regarding the concept of masculinity in a manner that was time-efficient and with minimal bias on my part. I also learned that I was entitled to spend up to £250 money from a research budget for costs associated with the research project. Consequently, I decided to use the entirety of my research budget on a transcriber, whom I have since recommended to the Cardiff doctoral course as a useful resource (Appendix P).

Furthermore, although I did my best to safeguard against such difficulties, I was aware that I could possibly encounter problems obtaining research participants. I was therefore pleased to learn that Q-methodology typically uses small sample sizes (Valenta & Wigger, 1997) and that a control group would not be required. It was also pleasing to learn that the results of Q-studies are less influenced by low response rates compared with the results of survey studies (Brown, 1993; Brown, 1980; McKeown & Thomas, 1988).

Also, Q-methodology can be, and has been effectively employed as a powerful technique for single case studies of various kinds (Smith, 2001; Stephenson, 1953). This is because Q-methodology is exploratory in nature. Its aim is therefore to sample the range and diversity of views expressed, as opposed to estimating population statistics or making claims about the percentage of people expressing respective opinions (Kitzinger, 1987). Nonetheless, Q-methodological studies have often been criticised for their reliability and consequently the generalisation of their findings (Thomas & Baas, 1992). However, according to Brown (1980), an important notion behind Q-methodology is that only a limited number of distinct viewpoints exist on any topic. Therefore, the most important type of reliability for Q-methodology is replicability (i.e. will the same condition of instruction lead to factors that represent similar viewpoints on the topic) across similarly structured yet different Q-samples, and when administered to different sets of persons (Van Exel & de Graaf, 2005). Consequently, I hoped that I would develop a well-structured Q-sample to comprise the wide range of existing opinions on masculinity to reveal these perspectives.

Additionally, I was informed that Q-methodology does not test participants or place them into categories of correctness. It simply aims to understand the individual's explanation of what has happened to them and why, and has been shown to help participants consider some potentially upsetting statements in the presence of an unfamiliar person (Dudley, Siitarinen, James & Dodgson, 2008). I considered this to be particularly important, as conversations in relation to masculinity could have possibly elicited distressing memories of violence and emotional vulnerability for my research participants. Therefore, after considering all the relevant information (highlighted above), I ultimately believed that Q-methodology could help me navigate the research process with a greater sense of ease and simplicity.

18.0 SYSTEMATIC REVIEW – QUALITY APPRAISAL

The research process has been invaluable for the development of key skills, including the ability to identify, review and critically appraise a substantial body of research evidence (British Psychological Society, 2010). I have since gained an astute understanding of the systematic review process. Furthermore, I have gained an appreciation for how systematic reviews are essential for synthesising and disseminating knowledge that has been gathered through empirical work to promote progress, and to assist researchers identify the existing evidence base in their area (Sirriyeh, Lawton, Gardner, & Armitage, 2011).

During the systematic review process, I was faced with a decision of whether to complete a qualitative, quantitative or mixed methods review. However, this decision was eventually taken out of my hands. I eventually discovered that there was only one paper from a qualitative perspective in regards to masculinity and psychosis available to review. At the time, I considered this to be quite disappointing. According to Seidler, Dawes, Rice, Oliffe, and Dhillon (2016), masculinity is a constantly evolving social, historical and psychological phenomenon. Therefore, quantitative studies could be considered as being somewhat limited in capturing the essence of masculinity, as they typically define masculinity as a unitary and stable construct. Qualitative research on the other hand, considers masculinity to be a more fluid and multi-faceted construct. Therefore, a systematic review which integrated the findings of both quantitative and qualitative research would have been beneficial.

After the acquisition of the final nine full text papers, I then needed to decide what quality assessment tool I would use to enable me to comment on the quality of the evidence available to me. Initially, I identified the EPPI-Centre approach (Harden & Thomas, 2005; Thomas et al., 2003; Thomas et al., 2004) as one possible research tool which I could use. However, research suggests that it suffers from a bias towards quantitative methods, and lacks the necessary specificity in its criteria to successfully delineate high-and low quality work (Sirriyeh et al., 2011). Therefore,

despite its own limitations (including that the tool has yet to be assessed in a large-scale validation study), I decided to use the 16-item Quality Assessment Tool for Studies with Diverse Designs (QATSDD). The benefits of this tool included that I could assess the main quality components of the research, whilst also accounting for quality issues that are specific to certain research designs (e.g. the replication of results in quantitative studies) in order to provide a fair and accurate assessment of research quality (Sirriyeh et al., 2011). Unfortunately, however, the scale's use of a 4-point scoring scale limited my ability to gain a high inter-rater reliability correlation with my co-author. Therefore, this was noted as a limitation associated within my systematic review. Nonetheless, I was pleased that both my co-author and I were amenable to discussion and debate regarding our ratings, and were able to negotiate upon our respective ratings to come to a consensus.

19.0 CHALLENGES OVERCOME DURING THE RESEARCH PROCESS

Throughout the research process, a variety of challenges transpired. This firstly included synthesising the existing findings in respect of masculinity and psychosis via a systematic review. I then needed to plan an empirical study which would ultimately enrich the evidence base. In regards to the systematic review, I was disappointed to find a lack of high quality research in respect of masculinity and psychosis, especially after my initial abstract search found nearly 300 papers to review. I came to understand that this was due to the terms *sex differences* (demographic categories of male and female) and *gender differences* (the nature of femaleness and maleness) (Deaux, 1993; Nasser, Walders, & Jenkins, 2002) being used both inconsistently and interchangeably (Lewine 1994; Nasser et al., 2002) throughout the literature. My frustrations were then compounded after finding that many of the research papers which met the inclusion criteria had substantial methodological flaws, mainly due to them being completed over 30 years ago. This included the poor validity and reliability of the research tools which were used. However, this was not surprising considering that the Thematic Apperception Test (May, 1966) discerns masculinity

by asking participants to tell stories about three pictures designed to see whether participants would think first of going up/pleasure (flying high, killing a bull, or getting up a mountain), or going down/disaster (falling, failure in a ring, or going down a mountain). Furthermore, the Role Preference Test determines masculinity by asking participants to choose what part they would like to play if given choices (e.g. either scientist versus fashion designer, secretary versus policewoman etc) (McClelland & Watt, 1968). I was surprised that such stereotypical assessment tools were available in the 1960's. However, I am sure than in years to come, the integrity and veracity of my research but also clinical psychology research more generally will come under similar scrutiny.

Other challenges included difficulties gaining external supervisors to oversee my project. I also experienced a delay in being able to initiate the research process due to my academic supervisor being a new member of staff and relocating to Cardiff. Nonetheless, I was in debt to my academic supervisor for agreeing to supervise my project in the first place. Many other potential supervisors whom I approached declined my requests. They stated that they lacked experience and familiarity of male gender issues. Furthermore, I was informed during one of my interviews with a Clinical Psychologist that masculinity did not exist and was a mere stereotype. Both of these experiences reinforced my frustrations regarding the male gender blindness which appears to exist in the profession of clinical psychology, especially since I believe that discussing masculinity does not lead to stereotyping. Seager, Barry and Sullivan (2016) take this one step further. They argue that collusion with a narrative that reframes masculinity as mere 'social stereotyping' is a failure to live up to our professional values and standards. They also state that this is not in accordance with the standards of a scientific profession and does not constitute the scientific rigour and objectivity that is part of a proud tradition of British psychology. However, I was fortunate to have experienced no difficulties accessing a clinical supervisor. She was the first supervisor I approached and was particularly interested in the concept of masculinity and psychosis. Furthermore, she held a lengthy list of publications, was enthusiastic and her words of "*if you don't complete the research project, then I will"* provided me with a great sense of confidence that she would support me throughout the research process.

Other difficulties include being provided with incorrect information by an administrator tasked with helping me gain research and development approval. I was informed that I needed to have an occupational health check and complete a research passport to undertake research within the NHS (a lengthy document which needed to be signed by multiple professionals). I was fortunate that whilst venting my frustrations in this regard to another member of my cohort, I was informed that I did not need to complete the research passport. Instead, I could complete an NHS to NHS letter of access which would take far less time to complete and get approved, as I held a substantive employment contract within the NHS. Furthermore, I was initially unable to gain NHS ethics approval required for my project to commence. My first review which was given an unfavourable opinion (Appendix E) highlighted that I had not included relevant information required for approval of my project. Not only did this result in more time delays whilst waiting for another NHS ethics review meeting, and other professionals to reply to my correspondence, but I became markedly upset on the car drive home and began to doubt my abilities as a prospective researcher. However, I would consider that this experience has helped me understand the importance of thoroughness and diligence when undertaking research. It will hopefully prove to be a valuable learning experience which will be incorporated within my future NHS-based research.

In an attempt to prevent future trainees from experiencing the same difficulties associated with gaining NHS research approval, I facilitated a training session for the cohort one year below me in collaboration with other members of my cohort who went through the NHS ethics process. This was helpful for the growth of skills in respect of preparing and delivering teaching and training which takes into account the needs and goals of participants (British Psychological Society, 2010). Feedback from this training day highlighted that the trainees were very appreciative of the opportunity to learn more about the NHS ethics process (Appendix Q). Consequently, I hope this is a process which is continued to be incorporated by the Cardiff University doctoral programme.

When designing the information sheets and consent forms, I developed skills in presenting research in accessible and concise ways for the reader. I would have ordinarily liked to have consulted with a service user representative to gain a second opinion in regards to the accessibility of my forms. However, I came to understand the service user representative employed at Cardiff University was no longer employed, and his post was left vacant. I hope the Cardiff University doctoral programme re-recruit for this post, as I have previously been in debt to service user representatives for their insights and perceptiveness in regards to how understandable my documentation has been.

During facilitation of interviews, I was aware that men who experience psychosis could experience delusions, apathy, lack of insight, impaired memory and mental flexibility, all of which could contribute to impaired decision-making (Cohen, McGarvey, Pinkerton & Kryzhanivska, 2004). Therefore, I considered it important to ensure participants had capacity to consent to both interviews and card sorts by liaising with their clinical teams and obtaining a professional opinion in this regard. I also assessed participant's capacity during explanations of the participant information and consent forms. This was invaluable for the development of skills in relation to effectively communicating clinical information from a psychological perspective in a style appropriate to a variety of different audiences, and adapting my style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication (British Psychological Society, 2010). Furthermore, the participants were informed of my research project by their clinical teams prior to meeting with me, to ensure that they did not feel pressured to complete the research. However, I would consider that the participants had time to reflect upon masculinity prior to the interview. Therefore, I do wonder whether some participants' accounts of masculinity were discussed with other participants and/or staff members. If so, this could have resulted in the clustering of views which were identified within my data. Therefore, if I were to complete the project again, I would request within my participant information sheets that all participants refrain from discussing masculinity or the prospect of meeting with me with other people, to ensure that their accounts were purely their own.

Listening back to the recorded audio tracks of my interviews, I noticed that my interviewing style developed in respect of my delivery, speed and engagement with participants. This was useful for the development of my confidence and conviction in my beliefs as a researcher. I have since used audio recordings during my doctoral elective placement to help me reflect more upon my style of communication. However, I was particularly struck by how open and honest my participants were with me in regards to their conceptions of masculinity. Furthermore, having listened back to the transcripts I was pleased that I was able to curtail my enthusiasm by not disclosing any information in regards to my own perceptions. Yet I do wonder if my gender as well as my stocky build, facial hair and confident demeanour may have influenced the interview process. Indeed, research suggests that class, gender, and age shape the process of interviews (Manderson, Bennett, & Andajani-Sutjah, 2006), and of all of these factors, gender appears to have the most obvious impact (McNay, 2003). Therefore, I am aware that if the participants were interviewed by someone else, a different account of masculinity could have possibly emerged. However, this would not have rendered the accounts which I collated as invalid. This would have simply drawn attention to the complexity and variability of experience, and the significance of social interactions in collecting and interpreting research data (Manderson et al., 2006).

Another challenge included the requirement of good organisational and planning abilities to ensure that the research was completed prior to the deadline date. This was especially important after the delays I experienced waiting for my academic supervisor to arrive in post, and my initial NHS ethics review being given an unfavourable opinion. However, my considerable work ethic, resilience and determination ensured that I was able to complete the research a number of weeks prior to the deadline date. This afforded me with time to send both my systematic review and empirical paper to journal publications.

Furthermore, good organisational abilities were also required to ensure that research participants could be interviewed in a timely manner. My clinical supervisor and I showed these abilities in abundance by liaising with the different ward managers and ensuring that interviews were

scheduled over three days. This provided me with less travelling time back and forth to the forensic setting. I also knew that as I would be working with men who were inpatients, there would be an increased likelihood of completing back to back interviews which would reduce the project completion time. My supervisor and I also made sure that we liaised with a nearby mental health unit to ensure that enough participants could be recruited. Nonetheless, I was aware that I was using negotiated research study days to complete interviews, which is a luxury I will not be provided with upon qualification. This highlighted to me the inherent difficulties qualified clinical psychologists experience when conducting research, and is something I will need to manage and reflect upon in the near future.

During analysis of the data from my empirical paper, I was surprised that I was being encouraged to use a (discontinued) Microsoft Disk Operating System (MS-DOS) by my academic supervisor. I came to understand that although there were plans for a new Q-methodology application to be developed by Cardiff University in collaboration with Manchester University, this would not be finalised in time for completion of my research. Therefore, I sought advice and consultation from my academic supervisor during this time. He impressed me with his astute knowledge of the operating system. He also helped me understand the stages within Q-methodology and enabled me to comprehend the mass array of data I collected to ultimately identify the salient factors associated with my research question.

There were also some important decisions to be made in regards to the analysis. After reading a paper by Watts and Stenner (2005), I came to understand that although different types of factor analysis and factor rotation exist, there often seems little reason for preferring one system over another. One option included using a centroid or simple summation method as it offered an abundance of rotated solutions. This would leave me free to consider any data set from a variety of perspectives before selecting the rotated solution which I considered to be the most appropriate and theoretically informative. However, due to its simplicity, reliability as well as its ability to

reveal the range of viewpoints that were favoured by my participant group, I decided to use a modern factor rotation technique called varimax which reveals only the most mathematically (although not necessarily the most theoretically) informative solution. The next step was then to decide which factors should be selected for interpretation. The Watts and Stenner (2005) paper was once again very informative, as it stated that several factors with eigenvalues in excess of 1.00 should be extracted, as random patterns will always arise and be detected. Therefore, I decided to select only those factors with an eigenvalue in excess of 1.00 (although I did include one factor with an eigenvalue of 0.9911). This was an active attempt to safeguard factor reliabilities, as factors which go below 1.00 explain less of the overall study variance as compared to any single Q-sort. The paper also highlighted that I needed to ensure that my factors had at least two Q-sorts which loaded significantly upon them due to my interest in shared orientations. Consequently, due to the new knowledge and skills I have developed, I would now feel far more confident to complete Q-methodology research as an autonomous researcher.

20.0 REFLECTIONS ON PROFESSIONAL AND PERSONAL DEVELOPMENT

As scientist-practitioners, Overholser (2010) states that clinical psychologists should be active in both research and clinical practice. Nonetheless, a number of studies have highlighted the low research productivity of clinical psychologists (Barrom, Shadish, & Montgomer, 1988; Brems, Johnson, & Gallucci, 1996; Eke, Holttum, & Hayward, 2012). As I reflect upon my experience of the research process, I have come to understand how undertaking research during the completion of the clinical duties required of my elective placement has been an especially challenging endeavour. This included working during evening times on occasion, and declining one opportunity to go on holiday with friends. However, on reflection, I now feel far more confident in my role as an autonomous researcher. Especially considering how I was able to navigate the research relatively independently with minimal support from my respective supervisors for the majority of the research process. This will hopefully prove invaluable upon qualification and being

tasked with advising upon and supervising the formal research of trainee clinical psychologists, psychology assistants, psychology undergraduates and colleagues from other professions. However, the times in which I did seek out my supervisors for advice and support were invaluable. This highlighted to me the importance of gaining external perspectives when undertaking research, it has developed my skills of using supervision to reflect on practice, as well as making appropriate use of feedback received (British Psychological Society, 2010) by integrating diverse viewpoints into a coherent narrative.

Other reflections include how I have developed a passion for promoting research alongside clinical duties. I would consider this to be one of the unique selling points of the profession of clinical psychology, and important for maintaining our distinctive professional identity (Richardson, 2014). The current research has also enriched my interest in quantitative research, and helped me develop an appreciation for how valuable Q-methodology can be for exploring service users' experiences and beliefs. Furthermore, the research process has broadened my understanding of masculinity. I had assumed that based upon their past behaviour, all the research participants would understand masculinity in terms of violence, dominance and authority. These prejudices I held were in stark contrast to what I discovered, and I will endeavour never to make any assumptions in respect of a man's perception of masculinity. Instead, I will remain curious and non-judgmental in this regard, but always attempt to remain inquisitive regarding how the men I come to work with in the future consider their masculinity.

In terms of personal development, l have come to understand how clinical psychology is often a gruelling and demanding profession in terms of the emotional impact, stress and time pressures inherent within the role. Consequently, I now feel more confident to consistently ensure my self-care to safeguard my ongoing wellness and professional competence throughout the remainder of my career. This has comprised of regular gym sessions, mindfulness meditation and reading non-psychology related material! Furthermore, this process has also emphasised the importance of having good working relationships with supervisors, both in terms of their expertise and advice,

but also gaining their support during the most difficult periods. My clinical supervisor was particularly empathic, warm and containing after my initial NHS research ethics proposal was not approved. Furthermore, she remained supportive during times in which I thought of disengaging from the research project to complete another study which would be far less demanding! Additionally, if I were to complete the research again, I would endeavour to keep a reflective diary. There have been a number of times (highlighted above) whereby the research process has proved to be an especially challenging endeavour. Therefore, the use of a diary could have revealed a far more substantial account of the complexities and interactions abound in the experience of stress. Consequently, this could have enabled these experiences to be reported with a minimum of retrospection and distortion, and its use could have proved to have been a cathartic experience which would have been of value within my personal development (Travers, 2011).

21.0 METHODS OF DISSEMINATION

I hope my research endeavours trigger a rejuvenation of interest in respect of masculinity and its impact upon men experiencing a range of psychological difficulties. However, one of the greatest challenges facing health promotion is translating research findings into evidence based public health and clinical practices that are actively disseminated and widely adopted (Kerner, Rimer, & Emmons, 2005). Therefore, it is pleasing that the Cardiff University doctoral programme provided my cohort and I with an option of writing up our research into a 'portfolio format', Research suggests that approximately 75% of clinical psychology doctoral theses are left unpublished, which provides scant justification for the significant NHS investment in clinical training, which is more expensive as compared to many other health care professions in training (Cooper & Turpin, 2007). Furthermore, undertaking doctoral level research in and of itself solely to fulfil the criteria of professional training could be considered unethical. The goal of all clinical psychology research should surely be to increase our collective understanding of psychological phenomena to inform our practice. However, Cooper and Turpin (2007) found that the commonly held belief that a

journal paper format leads to more publications as opposed to a traditional thesis was not supported. Therefore, it could be argued that this issue is still subject to debate.

I was fortunate to have been able to conceptualise and design my own research study. However, Cooper and Turpin (2007) argue that research projects should follow the research interests and expertise of course staff rather than the trainees' own interests. I would consider this to be in disparity with promoting diversity within the profession of clinical psychology, and impedes the development as trainees as independent autonomous researchers. Therefore, I hope the doctoral programme in Cardiff University continue to encourage future trainees to follow their own research interests in accordance with their passions and values base.

In regards to publications, Cooper and Turpin (2007) claim that much of the research is published in modest impact-rated journals and lacks the thematic coherence of a research programme. However, I would consider this to be a moot point, as a journal cannot in any way be taken as representative of an article. Not only are self-citations not corrected for and authors can heavily cite their review articles to inflate the impact factor, but citation impact is primarily a measure of scientific utility rather than scientific quality (Seglen, 1997). Therefore, I have attempted to publish my systematic review and empirical paper in the journals most representative of my studies. This includes publishing my systematic review in the Journal of Psychosis (Appendix R), and my empirical paper in the Journal of Forensic Studies (Appendix S). However, I am also aware of the pressure I felt in regards to writing a concise research report that adequately reflected the rich data obtained from my participants' Q-sorts, and wanting to do my participants and supervisors justice by writing a piece of research that was worthy of publication. This necessitated writing papers within a word count stipulated by my target journals which resulted in some insights and deductions needing to be removed. However, this also helped ensure my research reports were concise, and I would consider this to be a particularly relevant skill for writing publications which I hope to continue honing with increasing efficacy in the future.

I have also come to learn that just because my paper fits journal requirements, this does not necessarily mean that it will be published! For example, my initial submission of my empirical paper to the Journal of Forensic Psychiatry and Psychology was rejected (Appendix T). This was based upon the viewpoint that my sample was too small, that the analysis was arguably not justified with such a sample size and that there was no suitable comparison meaning that conclusions could not be drawn. I found this to be particularly disappointing given the reasons for why Q-methodology can be used with small samples (highlighted above). Furthermore, research suggests that in keeping to smaller numbers, an emphasis on quality is maintained, pattern and consistency can still be detected within the data and the prospects of publication are increased (Watts & Stenner, 2005). Another reason for rejection included that that there was perceived to be an absence of attention to concepts such as hyper-masculinity which are well considered in the aggression field. Yet my Q-set encompassed a plethora of statements indicative of hyper-masculinity including: "*Sometimes you've got to fight or people will walk all over you*" "*Men should be muscular*", "*Being dominant stops others from attacking you*" and "*A man should go to the gym and lift weights*". Therefore, I would consider that just because my participants did not relate to these statements, this does not mean that they were not attended to. Nonetheless, I have come to understand that rejected publications are relatively normal in the field of clinical psychology, and that this should not detract my enthusiasm for publication.

Other ways in which I have decided to disseminate my research findings include the Three Minute Thesis competition, the 2018 Division of Clinical Psychology Conference and the Male Psychology Network. I would consider that attending this network may be helpful in generating new research ideas and fostering new working alliances. Unfortunately, I was unable to inform members of the multidisciplinary team or the service users themselves how the participants loaded onto masculinity constructs. One could argue that this was an oversight as such information could have be incorporated into the participant's Positive Behavioural Support Plans, Care and Treatment Plans and considered in terms of their rehabilitation. However, the confidentiality

agreement the service users and I subscribed to prevented this from occurring and this needed to be respected.

22.0 STRENGTHS AND WEAKNESSES OF THE RESEARCH STUDY

I believe that the use of Q-methodology in this study has helped to bring structure and clarity to a complex and multi-faceted area, provided service users with an opportunity to reflect upon their sense of masculinity and enabled them to use an innovative and interactive process to register their viewpoints in a holistic and comprehensive manner (Plummer, 2012). Indeed, one of the benefits of conducting a Q-study include that Q-sorters often spontaneously indicate that they have enjoyed participating in the study and experience it as being instructive (Van Exel & de Graaf, 2005). I also found that this was the case for my research participants. Despite not being required of them, several participants provided in-depth rationales for their card sorts and said that they considered their perceptions of masculinity to be useful for discussion within the context of their individual therapy sessions. Furthermore, despite the extensive time and effort required to create the Q-set, it would now be readily available to be used within future research endeavours. The process also provided a detailed account of the experiences and views of those individuals who participated in the interviews and card sorts. However, due to time constraints I was only able to complete them with a small sample of participants which (although is not the aim of Q-methodology) limits generalisability significantly. Therefore, with more time and scope to complete the research, it would have been useful to collect data from multiple NHS Trusts in a variety of geographical areas. This would also enable the opportunity to examine differences in regards to the perception of masculinity between men who have different sexual orientations and reside in different socio-economic residences.

I was also struck by how differently the clinical psychologists and service users spoke about masculinity during their respective interviews. The clinical psychologists appeared to have more

difficulty providing me with specific examples of masculinity. I would consider to be related to fears around stereotyping. Conversely, the service users themselves had no such difficulty and provided me with a wealth of celebrities, iconic figures and examples of 'masculine' behaviours. It was outside the scope of this study to discern why this was. However, further analysis of the differences in transcripts via use of a grounded theory approach could be especially enlightening. Additionally, it should be noted that whilst masculinity is associated with poorer mental health outcomes in males, it is arguable how much variance in psychosis masculinity would explain, given the wider range of correlates associated with a diagnosis of psychosis.

As a research methodology, Q-methodology has various limitations. One of the main limitations is that the Q-sorting process is extremely time-consuming (McKeown & Thomas, 1988). This may be why very few participants took the time to change their card sorts after they had initially been sorted. These participants may have become fatigued, may have benefitted from being provided with an opportunity to review their card sort at a later time as well the opportunity to discuss if there were any additional items they might have included in their own Q-set. Van Exel and de Graaf (2005) state that this is particularly important, as these aspects of recognition and flexibility provide the participant with a greater sense of control over their contribution to the research process, and enhances the reliability of the study as a whole. Furthermore, I highlighted within my empirical paper that as participants were not interviewed after the card sort, the interpretation of the findings remains speculative. This could be considered to be a significant limitation. Watts and Stenner (2005) state that post hoc analyses are a vital part of the Q-methodological procedure, as this process aids the later interpretation of the sorting configurations (and viewpoints) captured by each of the emergent factors. They also state that Q-methodology is not well suited to dealing with the unfolding temporality of narratives. They instead provide a 'snap shot' of a connected series of viewpoints. Therefore, if I were to utilise Q-methodology again in the future, I would endeavour to provide participants with an opportunity to review their card sorts at a later time. This would in turn provide me with a chance to discuss their card sorts after the analysis phase of the research process.

Another limitation of Q-methodology include that its validity can be affected if the participant's lack of comprehension leads to misrepresentation (Dennis, 1986). This is relevant for my study, as some participants asked me to clarify what certain statements were referring to, including whether "*vulnerability*" was referring to physical, emotional or psychological vulnerability. Additionally, all participants were asked to sort their cards into a pre-determined normal distribution chart. One of the benefits of this method include that sortings are more stable and discriminating. Yet this requires participants to pay close attention to the statements, and can lead them to become frustrated because they are forced to place the Q-sort cards on specific places under the distribution markers (Du Plessis, 2005). Although I did not notice such occurrences, in hindsight, participants may have benefitted from completing a free-sort condition of instruction. This involves participants determining how many piles or categories are needed to sort their cards. This could have led participants to become less frustrated and does not require as much close attention to the statements, but this can lead statements to become less stable and discriminating (Du Plessis, 2005).

23.0 LIMITATIONS OF THE LINE OF ENQUIRY

23.1 Diagnosis, terminology, stigma and stereotyping

A diagnosis of psychosis was warranted as part of the inclusion criteria for participants. One of the advantages of the use of diagnosis included that it provided me with a framework to enable participants to be included in the research study. However, it should be noted that the reliability for most diagnoses remains low in everyday clinical practice where diagnoses are often made without detailed reference to the official manuals (Hacking, 2013). Furthermore, clinicians tend to have diagnostic 'preferences' and people are often given a range of diagnoses during their contact with mental health services (British Psychological Society, 2014). Additionally, diagnoses can deflect attention away from underlying social and emotional problems that could otherwise be addressed in a restorative way (Herman, 1997). Consequently, this research was an active attempt

to consider the participants as men as opposed to a psychiatric label. This may have been a factor responsible for the lack of participants refusing to engage with the research project.

There is considerable debate regarding the most helpful way of referring to psychotic experiences (British Psychological Society, 2014). Throughout my systematic review, I noticed that some participants within the papers I reviewed were referred to as "*normal*" which left me feeling quite uncomfortable. Therefore, when referring to participants throughout the systematic review and empirical paper, I used terms which are as neutral as possible. Sometimes I used the term 'psychosis' because it is the term in common use within our society to describe these experiences. However, I recognise that not everyone is comfortable with this term. Furthermore, in recognition that not everyone agrees that there is an underlying illness, I have used the wording 'a diagnosis of psychosis' rather than 'with psychosis'. I also referred to the experiences in question as 'experiences' or 'phenomena' rather than 'symptoms'. Although the word "symptom" was used within my semi-structured questionnaire (Appendix J) this was an oversight on my part, and I used the term "experiences" when asking this question during interviews.

There has also been a variety of efforts to reduce the stigma to which individuals who experience psychotic phenomena experience every day. Therefore, it should be noted that although my research focuses upon men with a diagnosis of psychosis who have committed violent acts, few people who experience paranoia or hear distressing voices ever hurt anyone else (British Psychological Society, 2014), and diagnoses like schizophrenia do not predict dangerousness (Elbogen & Johnson, 2009). Research suggests that most violence is committed by people who have never been in contact with mental health services, and the overwhelming majority of mental health service users have never been violent (Large, Nielssen, Slade, & Harris, 2008; Taylor & Gunn, 1999). Furthermore, factors such as gender, alcohol or drug use and a past history of violent behaviour are usually more important elements to consider than the mental health issues themselves (British Psychological Society, 2014). Therefore, it is hoped that my research will help

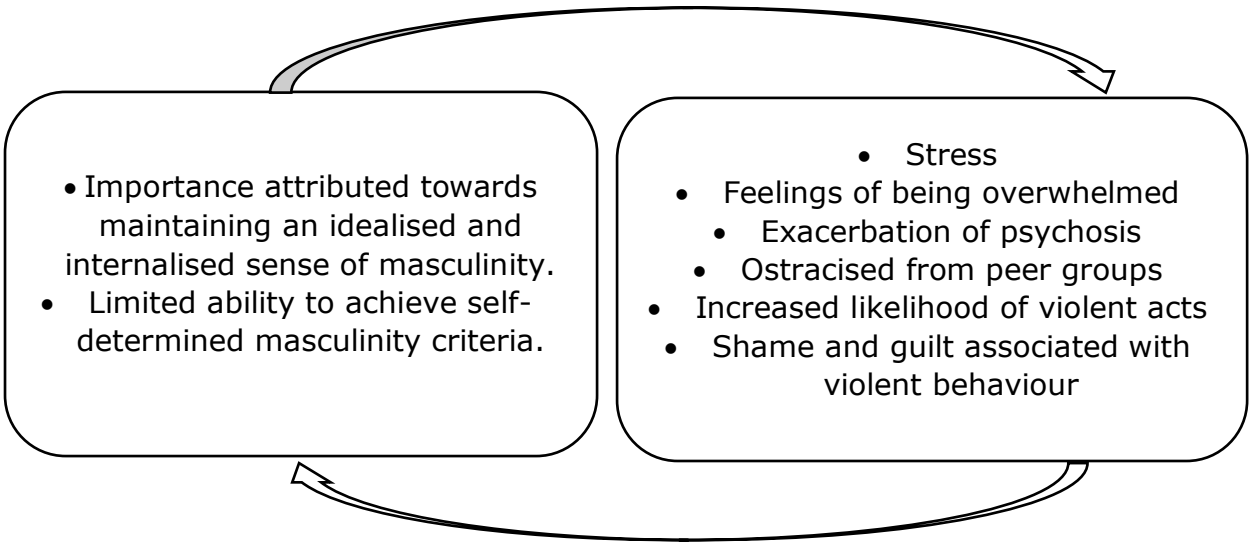
practitioners who work with men with a diagnosis of psychosis to become more aware of gender expression as a factor worth exploration and consideration.

24.0 SPECIFIC IMPLICATIONS FOR THEORY

From an evolutionary perspective, it may have been very adaptive for men to adopt and enact hyper-masculine traits such as violence, dominance and status. These characteristics would help ensure his survival and increase the likelihood of being able to provide for himself and others. Yet, these ancient pressures do not appear to have changed across time and culture in our species (Seager et al., 2016). For example, it has been demonstrated that such attributes increase the likelihood of attracting a female partner and ensuring a man's lineal heritage, as females still show a clear preference for males who possess or who demonstrate the potential to acquire material resources particular to their society (Dunn & Searle, 2010). Therefore, different rules, expectations and pressures appear to have evolved within the male psyche. However, the way that societies and cultures respond to these pressures clearly can and does vary. Furthermore, recognising that some aspects of gender difference are archetypal within our species does not prevent us from expressing these pressures in new ways (Seager & Sullivan, 2016). For example, I was surprised to hear from one of my interviewees (a Clinical Psychologist) that men can never transcend their organic nature. He also inferred that masculinity was a biologically based mechanism which is not amenable to change or adaptation. Although it could be argued that masculinity is a universal concept and is therefore biologically based, this is not necessarily the case. For example, Gilmore (1990) described the cultures of Tahiti and Semai, in which males are no more aggressive than females. Therefore, these cultures either strongly socialise males against their 'natural' aggressive instincts, or most cultures socialise males to be aggressive against a 'natural' proclivity for more cooperative and empathic responses.

In regards to psychosis, LaTorre (1984) proposed a diathesis-gender-stress model. It suggests that the stressors involved in gender identity including disturbed family dynamics and expectations of ideal gender identities that individuals may find objectionable, inhibit an individual's ability to gain a sex-congruent gender identity. It is hypothesised that this subsequently increases the likelihood that the individual will experience psychotic phenomena (Nasser et al., 2002). The lack of empirical evidence to fully support this model when it was published was not due to an absence of the phenomenon, but was largely due to the poor state of gender identity assessment at this time (LaTorre, 1984). However, my empirical paper has provided some preliminary support for this model. This is because my research highlights that the way in which masculinity is perceived by men with a diagnosis of psychosis could be one of a large range of factors responsible for the precipitation and perpetuation of psychotic experiences. For example, if masculinity beliefs are inflexible, a limited ability to achieve and adhere to conventional masculinity norms could lead an individual to become stressed, overwhelmed, exacerbate their psychosis, lead them to become ostracised from their peer group and increase the likelihood of a violent behaviour. The shame and guilt associated with this behaviour could then lead an individual to double their efforts to maintain an idealised and internalised sense of masculinity, which perpetuates the vicious cycle (see Figure 1).

24.1 Figure 1: Provisional formulation of the impact of masculinity upon men with a diagnosis of psychosis.



25.0 SPECIFIC IMPLICATIONS FOR CLINICAL PRACTICE AND SERVICE DEVELOPMENT

There is a danger that people reading the empirical paper will assume that adherence to conventional masculinity norms is toxic, and that masculinity is a construct which should be abolished. Whilst there are aspects of masculinity which can be harmful and destructive, there are other conceptions of masculinity which are associated with the qualities needed to be successful in plethora of life's challenges. It is instead hoped that psychological services as well as society more generally become more mindful of how masculinity can impact upon someone's psychological functioning. It is also hoped that the research will foster a greater awareness of how multiple masculinities can be produced within society, and how a strict adherence to conventional masculine norms can sometimes be disadvantageous.

In terms of clinical practice, to this author's knowledge, there has only been one attempt made at initiating and evaluating a men's group focusing upon perceptions of masculinity. Tennant and Hughes (1998) attempted this and had some success in helping their participants to reflect upon their attitudes and behaviour. However there appears to have been a lack of follow up in this regard. Consequently, Clinical Psychology could start to provide services that are specifically designed around men's needs (Wilkins, 2010). This could include further utilisation of Q-methodology. For example, research by Yao, Xu, Ni, Zheng, and Lin (2015) highlighted that after participants completed Q-sorts, the researchers engaged in planning and selecting appropriate intervention measures to treat them. In regards to masculinity, interventions based upon Q-sorts could include helping men to increase their psychological flexibility (being aware of thoughts and feelings that unfold in the present moment without needless defence, and persisting or changing behaviour to pursue central interests and goals - Hayes, Luoma, Bond, Masuda & Lillis, 2006) from an Acceptance and Commitment Therapy (ACT) approach. This is supported by Kashdan and Rottenberg (2010). They argue that a psychologically prosperous person is someone who can

manage themselves in the uncertain, unpredictable world around them, where novelty and change are the norm rather than the exception. Therefore, they argue that interventions aimed towards increasing psychological flexibility have great untapped potential to help people find greater efficacy and fulfilment in their daily lives. This is supported by Bem and Lenne (1976) who claim that individuals who are androgynous (have high levels of both masculinity and femininity) or comfortable engaging in behaviours appropriate for either gender, may have an increased sense of flexibility and adaptability because their range of behaviours are not bound by behaviours associated with a traditional gender role.

However, it may be that for other individuals, challenging their conceptions of masculinity may prove more beneficial. For example, if a man wants to maintain his masculinity he will strengthen the characteristics he understands to be masculine (Kumpula & Ekstrand, 2009). Therefore, Seager et al. (2016) claim that the gender neutral or perhaps feminised message that is increasingly being given to men by mental health agencies to open up and share their feelings is likely to be far less effective as compared to informing men that seeking help means taking control. This is because the message of taking control widens the definition of strength, and honours the gendered pressure on men to be in control rather than denying this reality. Furthermore, considering that the evolutionary function of the physiological stress response is commonly referred to during stress management psycho-education, perhaps the evolutionary function of masculinity (discussed above) and the normalisation of this process could help free some men of their proclivity to engage in behaviours no longer required for their joy and fulfilment. There may also be opportunities to help young boys think and reflect upon their conceptions of masculinity. For example, sex differences in help-seeking are shown to emerge by around age six (Benenson & Koulnazarian, 2008). Furthermore, the first signs of sexual maturation (e.g., genital growth, pubic hair, testicular growth etc) usher in a host of psychosocial concerns that influence the future experiences of children. Yet research suggests that parents and guardians often overlook the importance of communicating with young boys about puberty and social development, which can result in missed

opportunities to establish appropriate norms, standards of masculinity and behavioural expectations for manhood (Harris, 2015).

For those men who experience difficulties associated with their conception of masculinity, another danger is that people will assume that their stubbornness and unwillingness to change are the only forces preventing change. Indeed, Fogg (2017) states that the notion of men having the power to change themselves is the ultimate patriarchal delusion. He states that this is not to deny individual agency or personal responsibility for one's choices, but is instead a recognition of the sociology of hegemonic culture (Connell, 1995). This identifies that the collated trends of human behaviour are shaped in specific ways to provide value to the powers that be. For example, some masculine gender roles (e.g. risk-taking, violence, stoicism, protecting and providing) were once desirable and would secure employment to a society that primarily needed working class men to spend time risking their lives during war time, or exerting themselves in an agricultural or coalmining environment (Fogg, 2017). Therefore, for men to change, society has to change first. This may seem like an arduous task, especially considering how contemporary advertising promote images of men which are often highly idealised, exaggerated examples of male stereotypes that may be difficult or even impossible to attain (Gee, 2014). Nonetheless, we can take inspiration from feminism in regards to how inequalities for women have been recognised and addressed (Seager et al., 2016). This includes how women historically copied and distributed flyers highlighting the inequalities within society. More recently, efforts to encourage pop culture icons to provide their support (e.g. Beyoncé explicitly labelling herself a feminist) and feminist blogs are creating the space for important conversations about inequality, opening up discourses on intersectionality and transnational feminism ("23 Ways Feminists Have Made the World Better for Women", 2017).

In regards to the profession of Clinical Psychology however, Seager et al. (2016) claim that the profession is disappointingly no different to the rest of society in respect of male gender issues. Indeed, Eichenfield and Stevens (1987) first introduced the need for psychology training to include

discussions of male gender role issues. Yet 30 years later, the profession seems to have made little progress. This includes a lack of discussion in respect of men's suicide rates, despite research which suggests that men between the ages of 20 and 49 are more likely to die from suicide than any other single form of death (Jones, 2017). There is also research to suggest that men make up 90% of the homeless population and 95% of those housed in our prison system (Seager et al., 2016), and that men continue to not seek help for their physical or emotional problems as readily as women do (Addis & Mahalik, 2003).

26.0 SUGGESTIONS FOR FURTHER RESEARCH

The full spectrum of the human condition in all its variation and diversity should be the object of our psychological curiosity and research (Seager et al., 2016). Nonetheless, psychological research has developed a culture of 'beta-bias' – the tendency to minimise or overlook gender differences (Hare-Mustin & Marecek, 1988) particularly in regards to men (Russ, Ellam-Dyson, Seager, & Barry, 2015; Seager, Sullivan, & Barry, 2014). Male gender blindness is nowhere more evident than in the relative lack of research into problems affecting the male gender (Seager et al., 2016), notably in the United Kingdom (Wilkins, 2010). It would appear that we are currently living in a post-feminist culture where it is commonly believed that only females can suffer because of their gender (which clearly they can and do). Unfortunately, this is perpetuating the lack of understanding as to why the male suicide rate is so high, and why society is so much more tolerant of males being exposed to risk and danger (Seager et al., 2016). Both men and women have a lot to gain from gender equality. For women this includes payment and salary increases, whereas men stand to gain emotional benefits which is more difficult to measure (Jonze, 2016). Therefore, we must overcome these barriers before we can effectively improve psychological services for men (Seager et al., 2016). This could include building upon notable successes in the men's health field, including men being recognised for the first time as an at risk group in the government's strategy on addressing suicide (Department of Health, 2012).

In respect of psychosis, millions of pounds are currently being spent in the elusive search for a gene for schizophrenia. If such a gene is found/exists, it would partially absolve us responsibility for the way in which we treat each other. Although genetics might be one part of the jigsaw of psychosis, it has ultimately diverted resources away from the circumstances of people's lives, not only in the way in which we try to help people in distress, but also in research and in efforts to prevent such difficulties (Bentall & Varese, 2012; Boyle, 2004). Therefore, further research in regards to the psychological needs of men with a diagnosis of psychosis also warrants further investigation. Indeed, recent research by Lewine, Martin and Hart (in press) highlight that we have for many years ignored individual differences among those who experience psychotic phenomena, consequently reducing those individuals to their diagnosis.

Yet these endeavours will not be easy, as they would require men to challenge their conceptions of their masculinity, which may have buffered them against the harsh realities of life, and been integral to their sense of self-esteem, worth and identity. However, surely the end goal of freeing some men from the shackles of masculinity which constrain and restrict their psychological growth is a battle worth fighting for?

27.0 REFERENCES

23 Ways Feminists Have Made the World Better for Women. (2017). Mic.com. Retrieved 16 May 2017, from https://mic.com/articles/87809/23-ways-feminists-have-made-the-world-better-for-women#.HkPrH4tJC

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity and the contexts of help seeking. *American Psychologist*, 5(1), 5–14.

Barrom, C.P., Shadish, W.R., & Montgomery, L.M. (1988). PhDs, PsyDs, and real-world constraints on scholarly activity: Another look at the Boulder model. *Professional Psychology: Research and Practice*, 19(1), 93–101.

Bem, S.L., & Lenne, Y.E. (1976). Sex typing and the avoidance of cross-sex behaviour. *Journal of Personality and Social Psychology*, 33, 48-54.

Benenson, J.F., & Koulnazarian, M. (2008). Sex differences in help-seeking appear in early childhood. British *Journal of Developmental Psychology*, 26(2), 163–170.

Bentall, R.P., & Varese, F. (2012). A level playing field?: Are bio-genetic and psychosocial studies evaluated by the same standards? *Psychosis*, 4(3), 183–190.

Boyle, M. (2004). Preventing a non-existent illness?: Some issues in the prevention of 'schizophrenia'. *Journal of Primary Prevention*, 24(4), 445–469.

Brems, C., Johnson, M.E. & Gallucci, P. (1996). Publication productivity of clinical and counselling psychologists. *Journal of Clinical Psychology*, 52(6), 723–725.

British Psychological Society. (2010). *Additional guidance for clinical psychology training programmes: The NHS Knowledge and Skills Framework (KSF) and clinical psychology training.* Accessed 30th April 2017 from http://www.bps.org.uk/system/files/documents/pact_knowledge_and_skills_framework.pdf

British Psychological Society. (2014). Understanding Psychosis and Schizophrenia. Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help. *A report by the British Psychological Society Division of Clinical Psychology*. Leicester, BPS.

Brown, S.R. (1980). *Political subjectivity: application of Q-methodology in political science*. New Haven, CT: Yale University Press.

Brown, S.R. (1993). A primer on Q-methodology. *Operant Subjectivity*, 16:91–138.

Cohen, B.J., McGarvey, E.L., Pinkerton, R.C., & Kryzhanivska, L. (2004). Willingness and competence of depressed and schizophrenic inpatients to consent to research, *J Am Acad Psychiatry Law*, vol. 32 (pg. 134-143).

Connell, R.W. (1995). *Masculinities.* Berkeley: University of California Press

Cooper, M., & Turpin, G. (2007). Clinical psychology trainees' research productivity and publications: An initial survey and contributing factors. *Clinical Psychology & Psychotherapy*, 14, 54-62.

Deaux, K. (1993). Commentary: Sorry, wrong number—A reply to Gentile's call. *Psychological Science,* 4:125-126.

Department of Health (2012). *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives*. London: HMSO.

Dennis, K. (1986). Q methodology: relevance and application to nursing research. *Advances in Nursing Science,* 8(3), 6-17.

Dudley, R., Siitarinen, J., James, I., & Dodgson, G. (2008). What do people with Psychosis think caused their Psychosis? A Q methodology study. *Behavioural and Cognitive Psychotherapy*, 37(1), 11.

Du Plessis, T.C. (2005). *A theoretical framework of corporate online communication: a marketing public relations (MPR) perspective*. Unpublished doctoral thesis. University of South Africa, Pretoria.

Dunn, M., & Searle, R. (2010). Effect of manipulated prestige-car ownership on both sex attractiveness ratings. *British Journal of Psychology,* 101(1), 69-80.

Eichenfield, G.A., & Stevens, M. (1987). Training others to counsel men. In M. Scher, M. Stevens, G. Good, & G. A. Eichenfield (Eds.), *Handbook of counseling and psychotherapy with men* (pp. 119–131). Newbury Park, CA: Sage.

Eke, G., Holttum, S., & Hayward, M. (2012). Testing a model of research intention among UK clinical psychologists: A logistic regression analysis. *Journal of Clinical Psychology*, 68(3), 263–278.

Elbogen, E., & Johnson, S. (2009). The intricate link between violence and mental disorder. Archives of General Psychiatry, 66, 152–161.

Fogg, A. (2017). The last great masculine delusion: What even Grayson Perry doesn't get. *Heteronormative Patriarchy for Men*. Retrieved 23 April 2017, from http://freethoughtblogs.com/hetpat/2016/05/06/the-last-great-masculine-delusion-what-even-grayson-perry-doesnt-get/

Gee, S. (2014). Bending the codes of masculinity: David Beckham and flexible masculinity in the new millennium. *Sport in Society*, 17(7), 917–936.

Gilmore, D. (1990). *Manhood cultural in concepts the of making masculinity* (1st ed.). New Haven: Yale University Press.

Hacking, I. (2013). Lost in the forest. *London Review of Books*, 35(15), 7–8.

Harden, A., & Thomas, J. (2005). Methodological issues in combining diverse study types in systematic reviews. *International Journal of Social Research Methodology*, 8, 257–271.

Hare-Mustin, R.T., & Maracek, J. (1988). The meaning of difference: Gender theory, post-modernism and psychology. *American Psychologist*, 43(6), 455–464.

Harris, S.M. (2015). *Time for the Talk: Conversations on Masculinity and Manhood with Male Youth*. Accessed 29th April 2017 from http://ideaexchange.uakron.edu/blackmaleideas/Success/session1/3/

Hayes, S.C., Luoma, J.B., Bond, F.W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behavior Research and Therapy*, 44, 1-25.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror* (new edn). New York: Basic Books.

Jones, O. (2017). *Suicide and silence: why depressed men are dying for somebody to talk to*. The Guardian. Retrieved 16 May 2017, from https://www.theguardian.com/society/2014/aug/15/suicide-silence-depressed-men

Jonze, T. (2016). Grayson Perry: 'Boys think they're breaking the man contract if they cry'. *The Guardian Newspaper* available at *https://www.theguardian.com/artanddesign/2016/may/04/grayson-perry-all-man-boys-breaking-man-contract-if-they-cry*

Kashdan, T., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review*, 30(7), 865-878.

Kerner, J., Rimer, B., & Emmons, K. (2005). Introduction to the Special Section on Dissemination: Dissemination Research and Research Dissemination: How Can We Close the Gap? *Health Psychology*, 24(5), 443-446.

Kitzinger, C. (1987). *The Social Construction of Lesbianism.* Sage, Bristol.

Kumpula, E., & Ekstrand, P. (2009). Men and Masculinities in Forensic Psychiatric Care: An Interview Study Concerning Male Nurses' Experiences of Working with Male Caregivers and Male Patients. *Issues in Mental Health Nursing*, 30(9), 538-546.

Large, M., Nielssen, O., Slade, T., & Harris, A. (2008). Measurement and reporting of the duration of untreated psychosis. *Early Intervention in Psychiatry*, 2(1), 201–211.

LaTorre, R. (1984). Schizophrenia. In Widom C. S. (Ed.), *Sex roles and psychopathology*. New York: Plenum, pp. 157-181

Lewine, R.R. (1994). Sex: An imperfect marker of gender. *Schizophrenia Bulletin*, 20(4), 777-779.

Lewine, R.R., Martin, M., & Hart, M. (in press). Sex versus gender differences in schizophrenia: The case for normal personality differences. *Schizophrenia Research.*

Manderson, L., Bennett, E., Andajani-Sutjah, J. (2006). The Social Dynamics of the Interview: age, class and gender. *Qualitative Health Research,* 16(10), 1317-1334.

May, R. (1966). Sex differences in fantasy patterns. *Journal of Projective Techniques,* 30, 576-586.

McClelland, D.C., & Watt, N.F. (1968). Sex role alienation in schizophrenia. *Journal of Abnormal Psychology*, 73, 226-239.

McKeown, B.F., & Thomas, B.D. (1988). *Q-methodology*. Newbury Park, CA: Sage Publications.

McNay, L. (2003). Having it both ways: The incompatibility of narrative identity and communicative ethics in feminist thought. *Theory, Culture and Society*, 20(6), 1-20

Nasser, E.H., Walders, N., & Jenkins, J.H. (2002). The experience of schizophrenia: What's gender got to do with it? A critical review of the current status of research on schizophrenia. *Schizophrenia Bulletin,* 28(2), 351-360.

Overholser, J. (2010). Ten criteria to qualify as a scientist-practitioner in clinical psychology: An immodest proposal for objective standards. *Journal of Contemporary Psychotherapy*, 40(1), 51–59.

Plummer, C. (2012). *Who Cares? An Exploration, using Q methodology, of Young Carers' and Professionals' Viewpoints.* DEdCPsy thesis, University of Sheffield.

Randell, J., Searle, R., & Reed, P. (2012). Influence of schizotypy on responding and contingency awareness on free-operant schedules of reinforcement. *Learning and Individual Differences*, 22(3), 425-428.

Richardson, T. (2014). Clinical psychologists and research: do we do any and should we do more? *PsyPag Quarterly*, 90, 7-12.

Russ, S., Ellam-Dyson, V., Seager, M., & Barry, J.A. (2015). "I hate generalising, but…". Coaches' views on differences in treatment style for male and female clients. *New Male Studies*, 4(3), 75-92.

Seager, M., Barry, J.A., & Sullivan, L. (2016). Challenging male gender blindness: Why psychologists should be leading the way. *Clinical Psychology Forum*, 285, 36-40.

Seager, M., & Sullivan, L. (2016). Reducing male suicide. *Clinical Psychology Forum*, 285, 48-52.

Seager, M., Sullivan, L., & Barry, J.A. (2014). Gender-related schemas and suicidality: Validation of the male and female traditional gender scripts questionnaires. *New Male Studies*, 3(3), 34–54.

Seglen, P.O. (1997). Why the impact factor of journals should not be used for evaluating research. *British Medical Journal*, 314, 498–502.

Seidler, Z., Dawes, A., Rice, S., Oliffe, J., & Dhillon, H. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106–118.

Sirriyeh, R., Lawton, R., Gardner, P., & Armitage, G. (2011). Reviewing studies with diverse designs: The development and evaluation of a new tool. *Journal of Evaluation in Clinical Practice*, 18(4), 746–752.

Smith, N.W. (2001). *Current systems in psychology: history, theory, research, and applications*. London: Wadsworth.

Stephenson, W. (1953). *The study of behaviour: Q technique and its methodology*. Chicago, IL: University of Chicago Press.

Taylor, P.J., & Gunn, J. (1999). Homicides by people with mental illness: Myth and reality. *British Journal of Psychiatry*, 174, 9–14.

Tennant, A., & Hughes, G. (1998). "Men talking" about dysfunctional masculinity: An innovative approach to working with aggressive personality disordered offender-patients. *Psychiatric Care*, 5, 92–99

Thomas, D.B., & Baas, L.R. (1992). The issue of generalization in Q methodology: "reliable schematics" revisited. *Operant Subjectivity*, 16(1): 18-36.

Thomas, J., Harden, A., Oakley, A., Oliver, S., Sutcliffe, K., Rees, R., Brunton, G., & Kavanagh, J. (2004). Integrating qualitative research with trials in systematic reviews. *BMJ*, 328(7446), 1010-1012.

Thomas, J., Sutcliffe, K., Harden, A., Oakley, A., Rees, R., Brunton, G., & Kavanagh, J. (2003). *Children and Healthy Eating: A Systematic Review of Barriers and Facilitators*. London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London.

Travers, C. (2011). Unveiling a reflective diary methodology for exploring the lived experiences of stress and coping. *Journal of Vocational Behavior*, 79, 204-216.

Valenta, A., & Wigger, U. (1997). Q-methodology: Definition and Application in Health Care Informatics. *Journal of The American Medical Informatics Association*, 4(6), 501-510.

Van Exel, N., & de Graaf, G. (2005). Q methodology: A sneak preview. Retrieved 5th May from https://qmethodblog.files.wordpress.com/2016/01/qmethodologyasneakpreviewreferenceupdate.pdf

Veseth, M., Binder, P., Borg, M., & Davidson, L. (2017). Collaborating to stay open and aware: Service user involvement in mental health research as an aid in reflexivity. *Nordic Psychology*, 1-8.

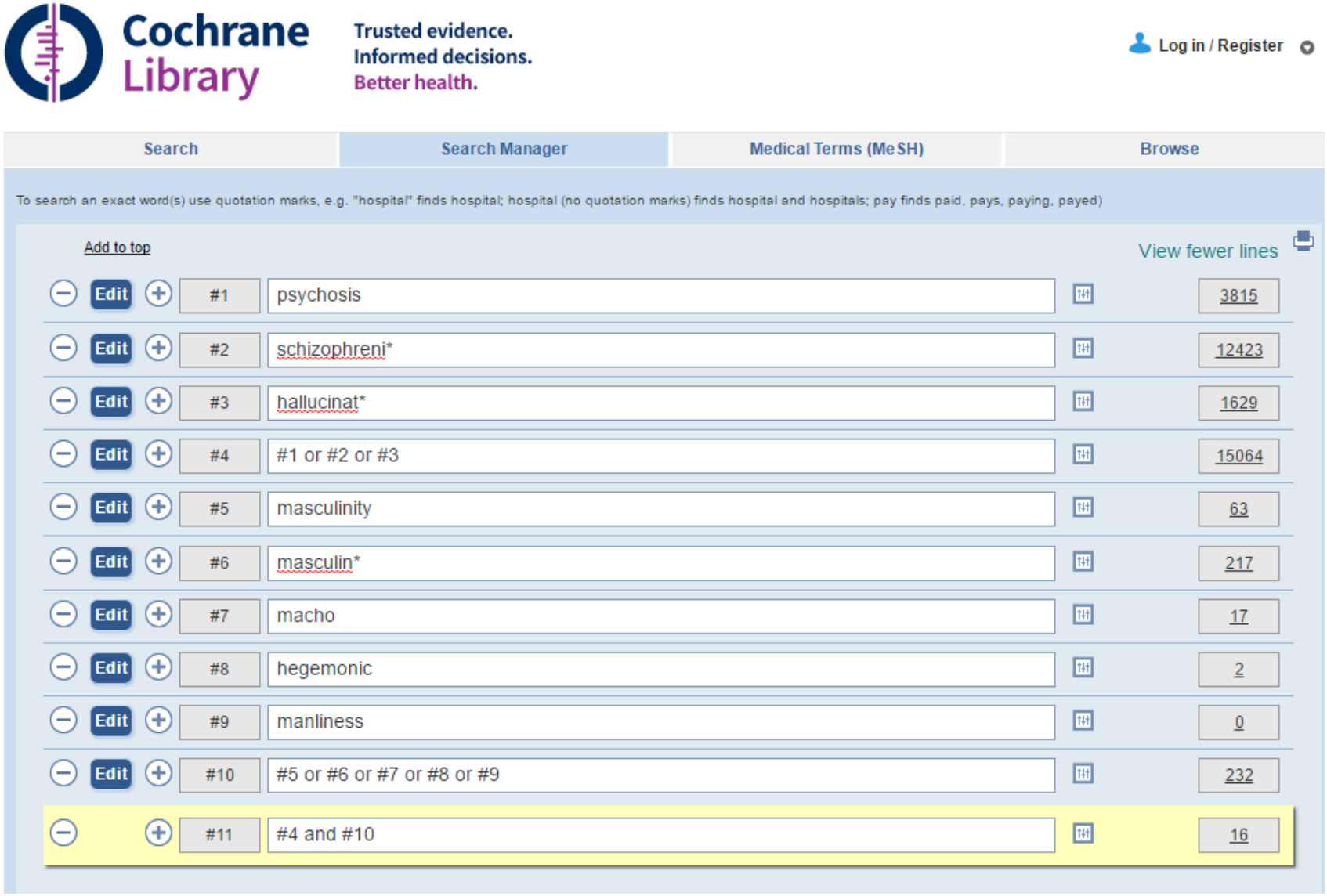
Watts, S., & Stenner, P. (2005). Doing Q methodology: theory, method and interpretation, *Qualitative Research in Psychology*, 2(1), 67-91.

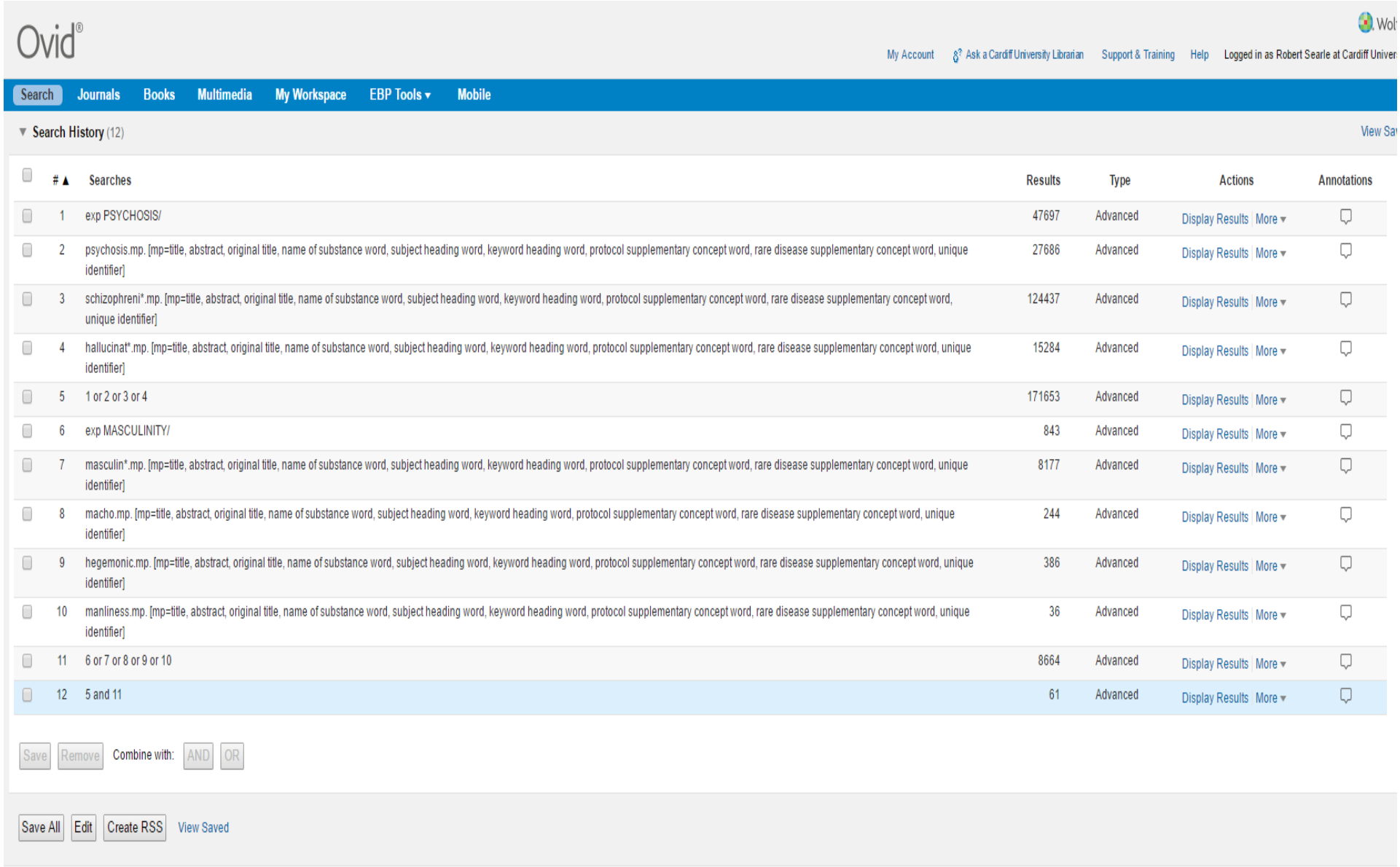
Wilkins, D. (2010). *Untold problems: A review of the essential issues in the mental health of men and boys*. London: Men's Health Forum.

Yao, L., Xu, X., Ni, Z., Zheng, M., & Lin, F. (2015). Use of Q methodology to assess the concerns of adult female individuals seeking orthodontic treatment. *Patient Preference and Adherence*, 47-55.

SECTION D: APPENDICES

28.0 APPENDIX A – SYSTEMATIC REVIEW SEARCHES

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Search History (12)
View Sa
▲ Searches Results Type Actions Annotations
1 exp PSYCHOSIS/ 47697 Advanced Display Results | More
2 psychosis.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] 27686 Advanced Display Results | More
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10 manliness.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] 36 Advanced Display Results | More
11 6 or 7 or 8 or 9 or 10 8664 Advanced Display Results | More
12 5 and 11 61 Advanced Display Results | More
Save
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Combine with:
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Save All
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Create RSS
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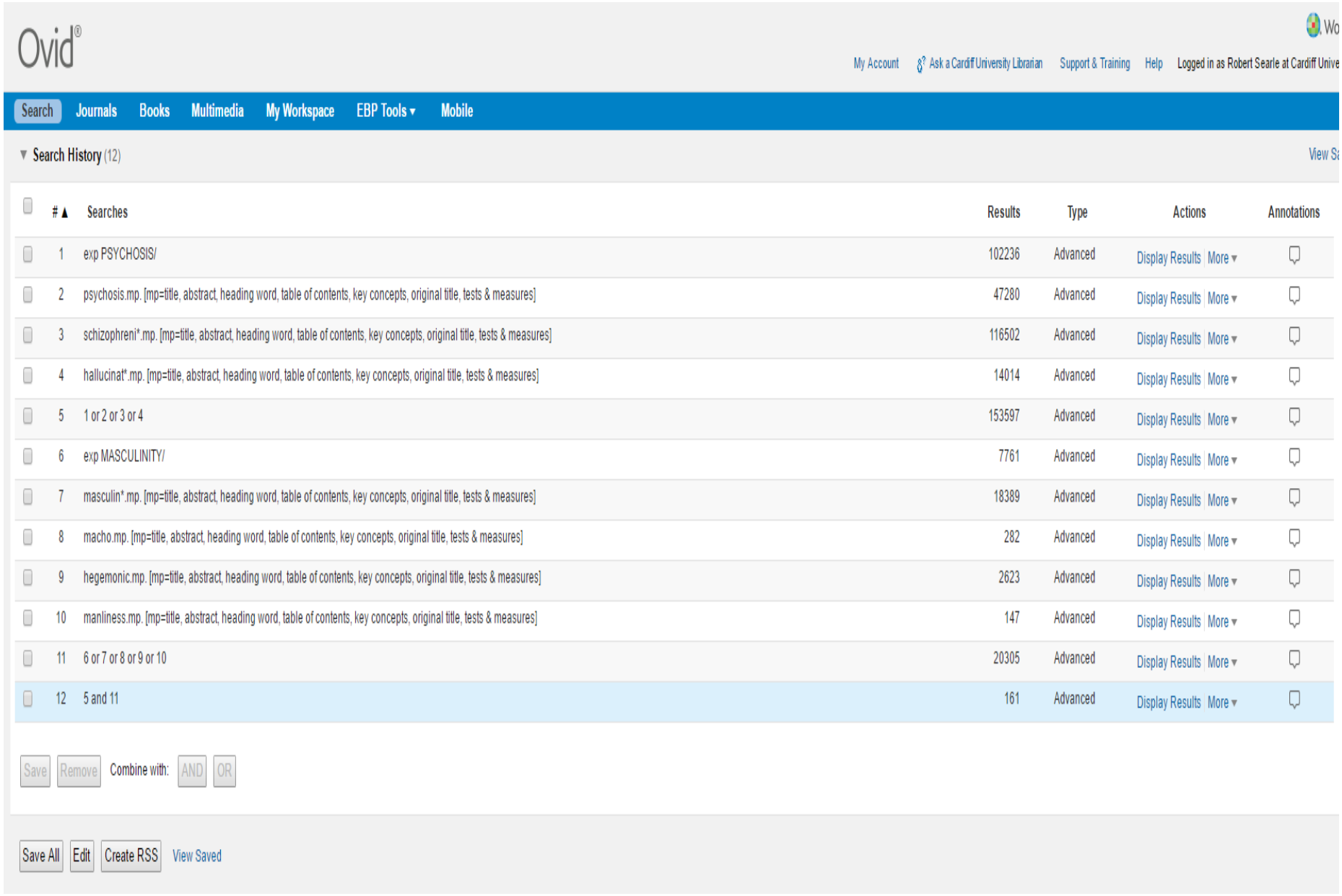
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Ask a Cardiff University Librarian
Support & Training
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Search
Journals
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Search History (12)
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1 exp PSYCHOSIS/ 102236 Advanced Display Results More
2 psychosis.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] 47280 Advanced Display Results More
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11 6 or 7 or 8 or 9 or 10 20305 Advanced Display Results More
12 5 and 11 161 Advanced Display Results More
Save
Remove
Combine with:
AND
OR
Save All
Edit
Create RSS
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Search History:

Set	Results	Save History / Create Alert · Open Saved History	Edit Sets	Combine Sets (AND / OR) Combine	Delete Sets Select All · Delete
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# 9	387	TS=manliness *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI Timespan=All years*	Edit		
# 8	5,602	TS=hegemonic *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI Timespan=All years*	Edit		
# 7	1,784	TS=macho *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI Timespan=All years*	Edit		
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# 5	13,563	TS=masculinity *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI Timespan=All years*	Edit		
# 4	194,876	#3 OR #2 OR #1 *Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI Timespan=All years*	Edit		
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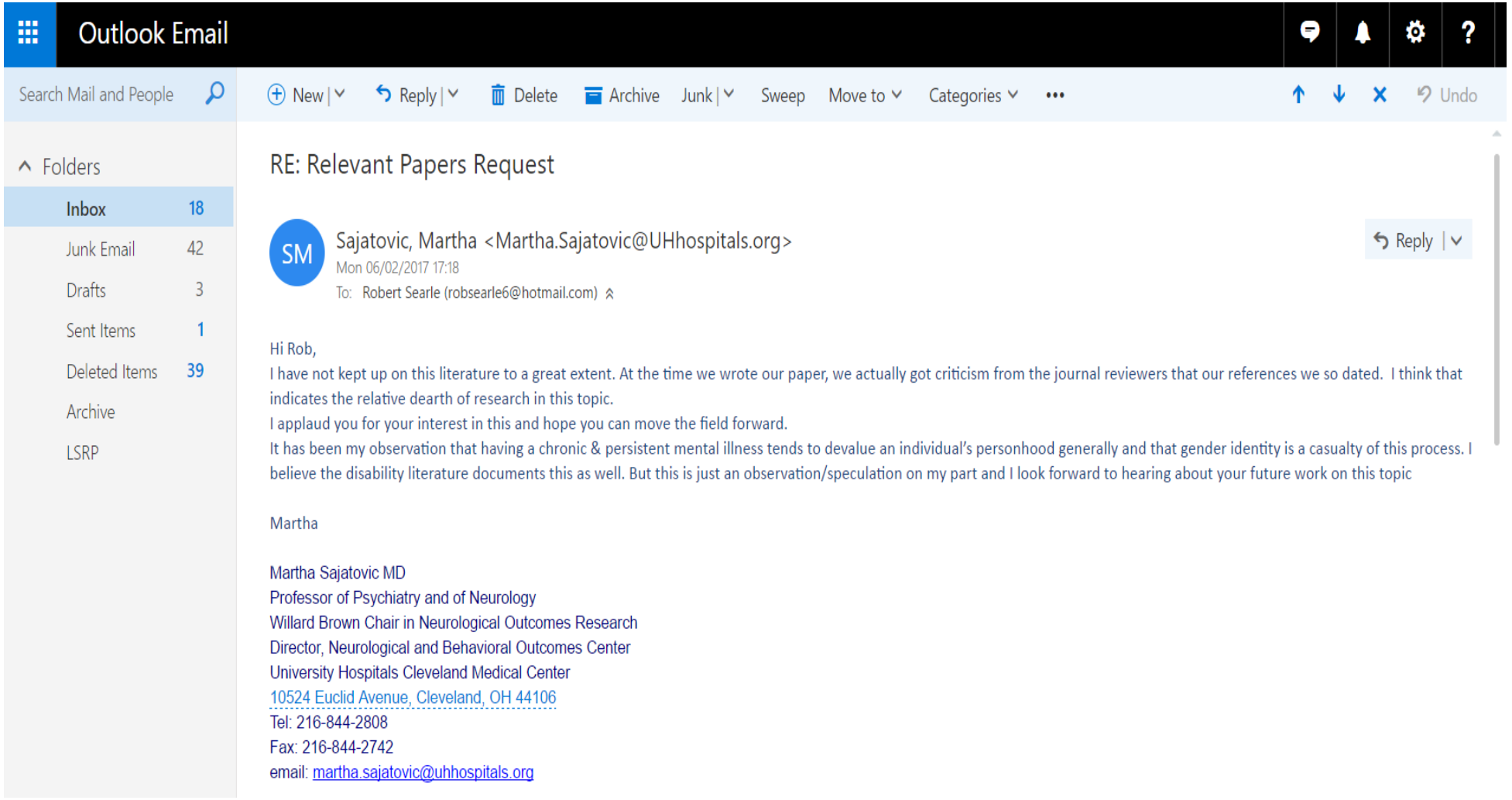
29.0 APPENDIX B - EMAIL TO INTERNATIONAL EXPERT



Outlook Email

Search Mail and People

New | Reply | Delete Archive Junk | Sweep Move to Categories ••• Undo

Folders

Inbox 18
Junk Email 42
Drafts 3
Sent Items 1
Deleted Items 39
Archive
LSRP

RE: Relevant Papers Request

SM Sajatovic, Martha <Martha.Sajatovic@UHhospitals.org>
Mon 06/02/2017 17:18
To: Robert Searle (robsearle6@hotmail.com)

Reply

Hi Rob,
I have not kept up on this literature to a great extent. At the time we wrote our paper, we actually got criticism from the journal reviewers that our references we so dated. I think that indicates the relative dearth of research in this topic.
I applaud you for your interest in this and hope you can move the field forward.
It has been my observation that having a chronic & persistent mental illness tends to devalue an individual's personhood generally and that gender identity is a casualty of this process. I believe the disability literature documents this as well. But this is just an observation/speculation on my part and I look forward to hearing about your future work on this topic

Martha

Martha Sajatovic MD
Professor of Psychiatry and of Neurology
Willard Brown Chair in Neurological Outcomes Research
Director, Neurological and Behavioral Outcomes Center
University Hospitals Cleveland Medical Center
10524 Euclid Avenue, Cleveland, OH 44106
Tel: 216-844-2808
Fax: 216-844-2742
email: martha.sajatovic@uhhospitals.org

30.0 APPENDIX C - QATSDD TOOL

Item	Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
1	Explicit theoretical framework	No mention at all	Reference to broad theoretical basis	Reference to a specific theoretical basis	Explicit statement of theoretical framework and/or constructs applied to the research
2	Statement of aims/objectives in main body of report	No mention at all	General reference to aim/objective at some point in the report including abstract	Reference to broad aims/objectives in main body of report	Explicit statement of aims/objectives in main body of report
3	Clear description of research setting	No mention at all	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'	Specific description of the research problem and target population in the context of the study, e.g. nurses and doctors from GP practices in the east midlands
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
5	Representative sample of target group of a reasonable size	No statement of target group	Sample is limited but represents some of the target group or representative but very small	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace
6	Description of procedure for data collection	No mention at all	Very basic and brief outline of data collection procedure, e.g. 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered
7	Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
8	Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment

9	Statistical assessment of reliability and validity of measurement tool(s) (Quantitative only)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test–retest reliability is unsuccessful but no action is taken	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
10	Fit between stated research question and method of data collection (Quantitative)	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 answer the research question
11	Fit between stated research question and format and content of data collection tool e.g. interview schedule (Qualitative)	No mention at all.	Structure and/or content only suitable to address the research question in some aspects or superficially.	Structure & content allows for data to be gathered broadly addressing the stated research question(s) but could benefit from greater detail.	Structure & content allows for detailed data to be gathered around all relevant issues required to address the stated research question(s).
12	Fit between research question 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, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
13	Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
14	Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
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 of study design.
16	Strengths and limitations critically 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 & analysis.

31.0 APPENDIX D - QUALITY APPRAISAL - INTER-RATER RELIABILITY

	Bosselman & Skorodin (1940)		Butler & Bieliauskas (1972)		Ecker et al. (1973)		Kayton & Biller (1972)		LaTorre et al. (1976)		LaTorre & Piper (1979)		McClelland & Watt (1968)		Sajatovic et al. (2005)		Peretti & Carberry (1974)	
Question	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*	*Rater 1*	*Rater 2*
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15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	0	0	0	2	1	2	1	1	2	2	1	2	2	0	0	2	0	0

32.0 APPENDIX E – ETHICAL APPROVAL FROM NORTH EAST – TYNE & WEAR SOUTH RESEARCH ETHICS COMMITTEE (MOST RECENT APPROVAL/DOCUMENTATION FIRST)

NHS
Health Research Authority
North East - Tyne & Wear South Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Telephone: 0207 104 8085

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

25 July 2016

Mr Robert Searle
Trainee Clinical Psychologist
Cardiff & Vale NHS Foundation Trust
13 Loftus Street
Canton
Cardiff
CF5 1HL

Dear Mr Searle

Study title:	**The impact of masculinity upon males with psychosis**
REC reference:	**16/NE/0216**
Protocol number:	**SPON 1500-16**
IRAS project ID:	**199894**

Thank you for your letter of 11 July 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Kathryn Murray, nrescommittee.northeast-tyneandwearsouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

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

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

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

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

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Ethical review of research sites

NHS sites

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Covering Letter Documenting Appropriate Changes]	1	13 June 2016
Covering letter on headed paper [Covering Letter Documenting Appropriate Changes]	1	30 May 2016
Covering letter on headed paper [Covering Letter Documenting Appropriate Changes 08.07.16]	3	08 July 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]	Version 1	23 February 2016
Interview schedules or topic guides for participants [Semi-Structured Questionnaire - Phase 1 - Version 3 - CLINICAL PSYCHOLOGIST]	3	08 July 2016
Interview schedules or topic guides for participants [Semi-Structured Questionnaire - Phase 1 - Version 3 - SERVICE USER]	3	08 July 2016
IRAS Checklist XML [Checklist_11072016]		11 July 2016
Letter from sponsor [Letter from sponser]	Version 1	23 February 2016
Other [CV - Academic Supervisor 1]	Version 1	26 March 2016
Other [Previous REC Review - Unfavourable - 12.05.2016.]	1	12 May 2016
Other [Covering letter documenting appropriate changes 30.05.16]	1	30 May 2016
Other [Confirmation of appropriate scientific review]	1	08 July 2016
Other [Revised Research Summary]	3	08 July 2016
Other [Research Ethics Committee review 06.07.16]	1	06 July 2016
Participant consent form [Consent Form - Phase 1 - Version 3 - CLINICAL PSYCHOLOGIST]	3	08 July 2016
Participant consent form [Consent Form - Phase 1 - Version 3 - SERVICE USER]	3	08 July 2016
Participant consent form [Consent Form - Phase 2 - Accessible - Version 3 - SERVICE USER]	3	08 July 2016
Participant consent form [Consent Form - Phase 2 - Version 3 - SERVICE USER]	3	08 July 2016
Participant information sheet (PIS) [Participant Information - Phase 1 - Version 3 - SERVICE USER]	3	08 July 2016
Participant information sheet (PIS) [Participant Information - Phase 2 - Version 3 - SERVICE USER]	3	08 July 2016

REC Application Form [REC_Form_08062016]		08 June 2016
Research protocol or project proposal [Project Proposal - Version 2 - 30.05.2016]	2	30 May 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	Version 1	26 March 2016
Summary CV for supervisor (student research) [CV - Academic Supervisor 2]	Version 1	26 March 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Summary, synopsis or diagram (flowchart) of protocol in non-technical language]	1	08 July 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

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

HRA Training

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

16/NE/0216	Please quote this number on all correspondence

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

Yours sincerely

pp.
Mr Paddy Stevenson
Chair

Email:nrescommittee.northeast-tyneandwearsouth@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Miss Helen Falconer, Cardiff and Vale University Health Board*

NHS
Health Research Authority
North East - Tyne & Wear South Research Ethics Committee
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Telephone: 0207 104 8085

06 July 2016

Mr Robert Searle
Trainee Clinical Psychologist
Cardiff & Vale NHS Foundation Trust
13 Loftus Street
Canton
Cardiff
CF5 1HL

Dear Mr Searle

Study Title:	**The impact of masculinity upon males with psychosis**
REC reference:	**16/NE/0216**
Protocol number:	**SPON 1500-16**
IRAS project ID:	**199894**

The Research Ethics Committee reviewed the above application at the meeting held on 27 June 2016. Thank you for being available by telephone to the Committee.

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

1. Submit a copy of the independent scientific review and any response to issues or queries identified for consideration.
2. Provide a clear overview of the consenting process for the study and detail around the two stages of consent.
3. Revise the participant information sheets and consent forms for the study to address the following issues:
    a. (All) Include identifiers on the documents to highlight the intended audience (i.e. staff or patient) at which phase of the project – this can be included as a header/footer for the

documents.

b. (Staff) – revise the wording in the documents to ensure that the full text is directed at the intended participants (i.e. remove ambiguity of '**If you are** a Clinical Psychologist.'.

4. Revise the research summary at question A6-1 of the IRAS application form to be rewritten in lay language. This can be submitted as part of a covering letter – there is no requirement to resubmit the IRAS form.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Miss Kathryn Murray, REC Manager, at the above detailed contact points.

When submitting a response to the Committee, the requested information should be electronically submitted from IRAS. A step-by-step guide on submitting your response to the REC provisional opinion is available on the HRA website using the following link: http://www.hra.nhs.uk/nhs-research-ethics-committee-rec-submitting-response-provisional-opinion/

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 05 August 2016.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Covering letter on headed paper [Covering Letter Documenting Appropriate Changes]	1	13 June 2016
Covering letter on headed paper [Covering Letter Documenting Appropriate Changes]	1	30 May 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]	Version 1	23 February 2016
Interview schedules or topic guides for participants [Semi Structured Questionnaire - Clinical Psychologists - Version 2]	2	30 May 2016
Interview schedules or topic guides for participants [Semi-Structured Questionnaire - Service User - Version 2]	2	30 May 2016
IRAS Checklist XML [Checklist_14062016]		14 June 2016
Letter from sponsor [Letter from sponser]	Version 1	23 February 2016
Other [CV - Academic Supervisor 1]	Version 1	26 March 2016
Other [Previous REC Review - Unfavourable - 12.05.2016.]	1	12 May 2016
Participant consent form [Consent Form - Phase 1- Accessible - Version 2]	2	30 May 2016
Participant consent form [Consent Form - Phase 1 - Version 2]	2	30 May 2016
Participant consent form [Consent Form - Phase 2 - Accessible - Version 2]	2	30 May 2016

Participant consent form [Consent Form - Phase 2 - Version 2]	2	30 May 2016
Participant information sheet (PIS) [Participant Information - Phase 1 - Accessible - Version 2]	2	30 May 2016
Participant information sheet (PIS) [Participant Information - Phase 2 - Accessible - Version 2]	2	30 May 2016
Participant information sheet (PIS) [Participant Information - Phase 1 - Version 2]	2	30 May 2016
Participant information sheet (PIS) [Participant Information - Phase 2 - Version 2]	2	30 May 2016
REC Application Form [REC_Form_08062016]		08 June 2016
Research protocol or project proposal [Project Proposal - Version 2 - 30.05.2016]	2	30 May 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	Version 1	26 March 2016
Summary CV for supervisor (student research) [CV - Academic Supervisor 2]	Version 1	26 March 2016

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

16/NE/0216	**Please quote this number on all correspondence**

Yours sincerely

pp.
Mr Paddy Stevenson
Chair

Email: nrescommittee.northeast-tyneandwearsouth@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Miss Helen Falconer, Cardiff and Vale University Health Board*

North East - Tyne & Wear South Research Ethics Committee

Attendance at Committee meeting on 27 June 2016

Committee Members:

Name	*Profession*	*Present*	*Notes*
Ms Sam Barron	Clinical Lead, Speech and Language Therapist	Yes	
Mr Chris Barron	ECMC & CTU Manager	No	
Mr John Blenkinsopp	Clinical Effectiveness Advisor	Yes	
Mr Ian Campbell	Pharmacy	Yes	
Dr Dorothy Coe	Senior Research Assistant and Lecturer in Nursing Skills	Yes	
Mr David Hill	Lay Member	Yes	
Mrs Louise Jones	Faculty Research Administrator	Yes	
Mrs Debra J Lett	Manager Newcastle Brain Tissue Resource	No	
Mr Graham McClelland	Research Paramedic	Yes	
Miss Rachel Smith	Barrister	No	
Mr Paddy Stevenson (Chair)	Research Operations Manager	Yes	
Miss Hannah Stevenson (Co-opted Member)	Data Manager, Clinical Research	Yes	
Dr Kate Wilson	Retired - Interim Director of Operations	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Kathryn Murray	REC Manager

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

Wales REC 3
Health and Care Research Support Centre
Castlebridge 4
15-19 Cowbridge Road East
Cardiff CF11 9AB

Telephone : 029 2078 5735
E-mail : corinne.scott@wales.nhs.uk
Website : www.hra.nhs.uk

12 May 2016

Mr Robert Searle
Trainee Clinical Psychologist
Cardiff & Vale NHS Foundation Trust
13 Loftus Street
Canton
Cardiff CF5 1HL

Dear Mr Searle

Study title:	**The impact of masculinity upon psychosis**
REC reference:	**16/WA/0127**
Protocol number:	**SPON 1500-16**
IRAS project ID:	**199894**

The Research Ethics Committee reviewed the above application at the meeting held on 12 May 2016. Thank you for attending to discuss the application.

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

Ethical opinion
The members of the Committee present decided to issue an unfavourable opinion for the following reasons:

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

- Members of the Committee present noted that the study design as presented at the REC meeting did not match what was presented in the application documentation. For example, at the meeting, it was stated that there would be two interviews with participants : one to identify items for the scale, and a further one where these scales would then be rated. However, there was no information regarding this second interview with regard to the participant group, recruitment methods, and there were no information sheets and consent forms for this second interview. As such, the Committee was unable to approve the application in its current form because there is a lack of clarity as to what they are being asked to approve.
- The application should be re-written so that it reflects more accurately what the study will entail for all participant groups with an appropriate recruitment strategy and informed consent process.
- Wales REC 3 would be glad to review any new application when it has been finalised.

Informed consent process and the adequacy and completeness of participant information

- Members of the Committee present commend the researchers on the quality of the easy-read documents and that these are used as a basis for any future informed consent process.
- Members of the Committee suggest that all other information sheets and consent forms are written in line with current guidance which can be found here : http://www.hra.nhs.uk/resources/before-you-apply/consent-and-participation/consent-and-participant-information/
- Members of the Committee suggest these documents are piloted before they are resubmitted.

Independent review

- The Committee noted that the study had not been sent for independent review, although it had been reviewed by the academic supervisor and Helen Falconer at Cardiff University. They suggest that any revised project is sent for independent external review before resubmission.

Other general comments

- Members of the Committee present agreed that the participant's GP did not need to be informed of their participation in the study because of the close involvement of the clinical team at the Caswell Clinic with the research team.

I regret to inform you therefore that the application is not approved.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact the Senior Ethics Service Manager, Dr. Corinne Scott, whose contact details can be found at the header of this letter.

Options for further ethical review

You may submit a new application for ethical review, taking into account the Committee's concerns. You should enter details of this application on the application form and include a copy of this letter, together with a covering letter explaining what changes have been made from the previous application.

We strongly recommend that you submit the new application to this REC. The application should be booked through the Central Booking Service (CBS) and would be allocated for review in the normal way.

Alternatively, you may appeal against the decision of the Committee by seeking a second opinion on this application from another Research Ethics Committee. The appeal would be based on the application form and supporting documentation reviewed by this Committee, without amendment. If you wish to appeal, you should notify the relevant Research Ethics Service manager (see below) in writing within 90 days of the date of this letter. If the appeal is allowed, another REC will be appointed to give a second opinion within 60 days and the second REC will be provided with a copy of the application, together with this letter and other relevant correspondence on the application. You will be notified of the arrangements for the meeting of the second REC and will be able to attend and/or make written representations if you wish to do so.

The contact point for appeals is:
Catherine Blewett
HRA Improvement & Liaison Manager
Health Research Authority
Email: hra.appeals@nhs.net

Summary of discussion at the meeting (if appropriate)

You attended the meeting to discuss your application with the Committee. You were accompanied by Dr. Bronwen Davies, clinical psychiatrist at the Caswell Clinic.

Dr. Wall informed you that there were two observers present, and you confirmed that you were content for them to remain present.

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

Members of the Committee sought clarification as to how the first interview would be transcribed to allow for the themes to be identified and then to be scaled.

You explained that there would be an initial interview to obtain the qualitative information followed by a second follow-up interview for the scales to be rated. You confirmed that there would therefore be two interviews.

Members of the Committee present sought clarification as to how the questionnaires had been devised.
You explained that they have been the result of discussions between yourself, Dr. Davies and other colleagues.

Members of the Committee sought clarification with regards to participant numbers.
You explained that you were seeking a minimum of three service users and six health care professionals.
Dr. Davies explained that there were ten possible participants at the Caswell Clinic and that a different site could also be approached if needed. She further explained that the Q method is designed so that small numbers of participants are interviewed in order to identify themes, and then a broader group is used to rate those themes.

Recruitment arrangements and access to health information, and fair participant selection
Members of the Committee present sought clarification as to how potential participants would be identified.
Dr. Davies explained that she would do this by speaking to the psychologists at the clinic to see who might be suitable. She would then check with the clinical tea, to ensure that it would be appropriate to approach the patient, and if it was, she would ask if they were willing to meet with Rob to find out more about the study.
You explained that patients who were unwilling would not be included, and that participants who seem to struggle with the questions or who became upset would also be excluded. You explained to the Committee that you had experience of working with vulnerable people so you are used to being vigilant.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity
Members of the Committee present sought clarification as to whether there was a need to inform the participant's GP.
Dr. Davies explained that the participant's clinical team would be involved throughout and the information sheet would be kept on their records. She further explained that there was no need to inform the GP as they had very little to do with the service.

Independent review
Members of the Committee present sought clarification as to who had carried out the independent review.
You explained that this had been done by your supervisor and Helen Falconer at Cardiff University.

Documents reviewed
The documents reviewed at the meeting were:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]	Version 1	23 February 2016
GP/consultant information sheets or letters [Leaflet 1]	Version 1	26 March 2016
GP/consultant information sheets or letters [Leaflet 2]	Version 1	26 March 2016
GP/consultant information sheets or letters [Leaflet 3]	Version 1	26 March 2016
Interview schedules or topic guides for participants [Interview Schedules]	Version 1	26 March 2016
IRAS Checklist XML [Checklist_21032016]		21 March 2016
IRAS Checklist XML [Checklist_05042016]		05 April 2016
Letter from sponsor [Letter from sponser]	Version 1	23 February 2016
Letters of invitation to participant [Introduction Letter]	Version 1	23 February 2016
Letters of invitation to participant [Letter of invitation - acceptance]	Version 1	26 March 2016
Non-validated questionnaire [Semi Structured Questionnaire]	Version 1	26 March 2016

Other [CV - Academic Supervisor 1]	Version 1	26 March 2016
Other [Letter of invitation - decline]	Version 1	26 March 2016
Other [Psychologist Consent Form]	Version 1	26 March 2016
Other [Psychologists - Semi Structured Questionnaire]	Version 1	26 March 2016
Participant consent form [Consent Form]	Version 1	23 February 2016
Participant consent form [Service User Consent Form]	Version 1	26 March 2016
Participant information sheet (PIS) [Introduction Form]	Version 1	26 March 2016
REC Application Form [REC_Form_21032016]		21 March 2016
Research protocol or project proposal [Project Proposal]	Version 1	26 March 2016
Summary CV for Chief Investigator (CI) [CV]	Version 1	23 February 2016
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	Version 1	26 March 2016
Summary CV for supervisor (student research) [CV - Academic Supervisor 2]	Version 1	26 March 2016

Membership of the Committee
The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

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

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

16/WA/0127	**Please quote this number on all correspondence**

Yours sincerely

Dr. Corinne Scott
Senior Ethics Service Manager
Health and Care Research Wales

pp Dr Pete Wall
Chair

E-mail: corinne.scott@wales.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Ms Helen Falconer

Wales REC 3

Attendance at Committee meeting on 12 May 2016

Committee Members:

Name	Profession	Present	Notes
Dr Gail Boniface	Occupational Therapist	No	
Dr Paul Brown	Radiographer	Yes	
Professor Kate Bullen	Psychologist	No	
Mrs Joy Darch	Nurse	Yes	
Mrs Monika Hare	Vice Chair / Lay member	Yes	
Ms Nicola Heales	Lay Plus member	Yes	
Mr HAO Hughes	Pharmacist	No	
Dr Andrea Longman	Lay member	Yes	
Dr V. Bapuji Rao	Hospital consultant (Psychiatrist)	No	
Ms Paula Strong	Nurse	Yes	
Mrs Wendy Turkie	Retired nurse	Yes	
Dr Richard Walker	Alternate Vice Chair / Lay Plus member	Yes	
Dr Pete Wall	Chair / Clinical Physiologist	Yes	Chaired meeting
Mr Stewart Williams	Lay Plus member	No	

Also in attendance:

Name	Position (or reason for attending)
Ms Donna Duncan	Observer
Dr Llifon Edwards	Observer
Dr Corinne Scott	Senior Ethics Service Manager
Mrs Helen Williams	REC Coordinator

33.0 APPENDIX F - ETHICAL APPROVAL FROM CARDIFF UNIVERSITY RESEARCH AND INNOVATION SERVICES

Research and Innovation Services
Director Geraint W Jones
Gwasanaethau Ymchwil ac Arloesi
Cyfarwyddwr Geraint W Jones

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Cardiff University
7th Floor
30 - 36 Newport Road
Cardiff CF24 0DE
Wales UK
Tel Ffôn +44(0)29 2087 5834
Fax Ffacs +44(0)29 2087 4189
Prifysgol Caerdydd
Llawr 7
30 - 36 Heol Casnewydd
Caerdydd CF24 0DE
Cymru Y Deyrnas Unedig

04 February 2016

Dr Dougal Hare
School of Psychology
Cardiff University
Tower Building
70 Park Place
Cardiff, CF10 3AT

Dear ,

Title: The impact of 'masculinity' upon psychosis
Short title: Masculinity and psychosis

I understand that you are acting as Chief Investigator for the above ClinPsy PhD project to be conducted by Robert Searle.

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

Scientific (Peer) Review
I can also confirm that Scientific (Peer) Review has been obtained from:

- Dr Bronwen Davies – clinical psychologist and clinical supervisor at Caswell Clinic;
- Dr Dougal Hare – academic supervisor at School of Psychology. Cardiff University.

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

Approvals

On completion of your IRAS form (for NHS REC and NHS R&D approvals), you will be required to obtain signature from the Sponsor ('Declaration by the Sponsor Representative').

Please then submit the project to the following organisations for approvals:

- An NHS Research Ethics Committee;
- Health & Care Research Wales Permissions Coordinating Unit (formerly known as NISCHR PCU) -to arrange host organisation R&D approval for Welsh NHS sites).

Once Research and Innovation Services has received evidence of the above approvals, the University is considered to have accepted Sponsorship and your project may commence.

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

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

Contracts
Roles and responsibilities are adequately detailed in the research protocol – no contract required.

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

- ensure you are familiar with your responsibilities under the Research Governance Framework for Health and Social Care;
- undertake the study in accordance with Cardiff University's Research Governance Framework and the principles of Good Clinical Practice;
- ensure the Research complies with the Data Protection Act 1998;
- inform Research and Innovation Services of any amendments to the protocol or study design, including changes to start /end dates and ensure any such amendments are submitted to, and approved by, the relevant bodies (e.g. RECs and/or R&D offices);
- co-operate with any audit inspection of the project files or any requests from Research & Innovation Services for further information.

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

SPON 1500-16

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

Yours sincerely

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

Cc Robert Searle

34.0 APPENDIX G - ETHICAL APPROVAL FROM ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD RESEARCH AND DEVELOPMENT DEPARTMENT

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

R&D
RESEARCH & DEVELOPMENT
Abertawe Bro Morgannwg University Health Board

Dyddiad/Date: 20th October 2016

ABMU Health Board Research & Development
Swansea University
Floor 1, Institute of Life Science 2
Singleton Park
Swansea
SA2 8PP
☎ 01792 530888
✉ abm.rd@wales.nhs.uk

Dr Bronwen Davies
ABMU Health Board
Caswell Clinic
Glanrhyd Hospital
Tondu Road,
Bridgend
CF31 4LN

Dear Dr Davies,

Re: Impact of masculinity upon psychosis
IRAS Ref: 199894
Sponsor: Cardiff University

Thank you for submitting the above named research proposal to ABMU Health Board for NHS R&D permission. The attached listed documents were reviewed.

Health Board R&D Governance checks have been completed and passed. Please accept this letter as confirmation of local NHS R&D Health Board permission.

As part of Research Governance, you are required to:

1. Adhere to the protocol approved and inform the R&D office and the relevant Research Ethics Committee of any changes to the study, including the end date, for review/approval and record update.
2. For Health Board Sponsored studies, notify the R&D office of serious adverse events immediately upon knowledge, in accordance with local Standard Operating Procedure on Pharmacovigilance and as outlined in your Study Initiation meeting.
3. For Externally Sponsored studies, the Health Board should only be notified of SAEs or Suspected Unexpected Serious Adverse Reaction (SUSAR) arising in local ABMU Patients.
4. Complete any interim and final reports requested by the R&D office. If sponsored by ABMU Health Board, you will be asked to complete a 6 monthly progress report for submission to the Joint Scientific Review Committee along with your final report at study completion.
5. Ensure that your research complies with any relevant regulatory requirements and legislation relating to: Clinical Trials, Data Protection Act 1998, Health & Safety, Caldicott Guidelines, the use of Human Tissue for research purposes, Mental Capacity and ICH Good Clinical Practice (GCP). The R&D team can advise you on applicable regulatory and statutory requirements relevant to your study.
6. Comply with Data Protection requirements, notably no personal or patient identifiable data should leave the Health Board unless explicit consent from the individual or patient has been taken and documented. Unless consent is present, all study related documents must be either fully or linked anonymised. *'Identifiable patient data includes name, address, full postcode, date of birth, NHS number and local patient identifiable codes as well as photographs, videos, audio tapes or other images of patients. Personal identifiable information includes the member of staff's name, address, full post code, date of birth, NI number and staff number as well as photographs etc'* – ABMU Data Protection & Confidentiality Policy, Version 2.1 September 2013.

7. Ensure that all training courses requested by the Sponsor are completed by all relevant members of the research team before any research activity is carried out. All research staff undertaking clinical trials of an investigational medicinal product (CTIMPs) must be GCP trained, and should continue to update their GCP training every 2 years. Copies of GCP certificates should be filed in the Trial Site File, with a copy forwarded to the R&D Department.
8. Ensure the research is undertaken in compliance with all Health Board R&D Standard Operating Procedures (SOPs). The latest versions of all SOPs can be obtained by contacting the R&D Department or from the R&D Intranet pages
9. If the study is sponsored by ABMU Health Board you must notify the R&D Office of your intention to open the study in other sites.
10. For ABMU Health Board Sponsored studies, sign a Conditions of Sponsorship Agreement & attend a Study Initiation meeting as organised by the R&D Department.

Clinical Research Portfolio Studies

If your study has been adopted onto the Clinical Research Portfolio (CRP), it will be a condition of our permission that the Chief Investigator site uploads local recruitment data onto the portfolio database.

For more information on the process of uploading recruitment data please look at the following link: http://www.healthandcareresearch.gov.wales/uploading-recruitment-data/

Uploading of recruitment data will enable Health and Care Research Wales to monitor research activity within Health Boards, resulting in NHS R&D allocations to be driven by activity.

For more information and advice on the Health and Care Research Wales Portfolio please email: portfolio@wales.nhs.uk

Amendments to the Study

Any changes made to the study after the issue of this letter will be treated as an amendment. Amendments can be 'substantial' or 'non-substantial'. It is the duty of the Sponsor to classify the amendment and notify all relevant regulatory bodies accordingly, this duty may be delegated to the Chief Investigator or other authorised individual.

For a substantial amendment, the Sponsor or delegated individual will be required to submit a Notice of Substantial Amendment form to the REC, the lead permission co-ordinating function for the study and the MHRA (if applicable). For all ABMU sponsored studies substantial amendments must first be submitted to the Joint Study Review Committee (JSRC) for approval prior to submitting to REC and Health and Care Research Wales Permissions (Research-permissions@wales.nhs.uk).

For non-substantial amendments, the Sponsor or delegated individual are required to submit the amendment details to the lead permission co-ordinating function for the study. They will then pass the amendment details onto all relevant nations, for Wales this would be Health and Care Research Wales who will notify ABMU R&D Department for review.
Details of how to classify your amendment as substantial or non-substantial are available from Health Research Authority - http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/

Indemnity Arrangements

The Sponsor indemnifies and holds harmless ABM University Health Board, its employees and agents for any harm caused by negligence on behalf of the Sponsor, including any harm caused to participants by the administration of the investigational product. However, please note that the Sponsor will not indemnify ABM University Health Board for any harm caused by negligence on behalf of the research team or other individual or agent. Researchers employed by ABM University Health Board, including

those holding Honorary Contract status are indemnified against actions for negligent harm via standard arrangements with Welsh Risk Pool (WRP).

Please discuss any planned use of in-house work instructions/sops with the Sponsor company during Initiation to ensure localised documents correctly summarise the protocol requirements and this is agreed to, in writing, by the Sponsor Company.

ABM University Health Board reserves the right to suspend approval of any research study where deviation from appropriate RG & GCP standards is uncovered.

May I take this opportunity to wish you well in undertaking the research. We will write to you in the future to request updates on the progress of the research and look forward to receiving outcomes of the study.

Yours sincerely,

pp Professor SC Bain
Assistant Medical Director (R&D)
ABMU Health Board

Application Documents Received

Document:	Subtitle:	Version:
Evidence of insurance or indemnity (non-NHS sponsors only)	Insurance Certificate Exp 31.07.2017	
Other (please specify)	Project Proposal - Version 2 30.05.2016	
Other (please specify)	R Goodwin - CD email authorisation	
Other (please specify)	R Goodwin - CD authorisation - PDF version	
Other (please specify)	Confirmation email of Internal Sponsor review	
Other (please specify)	Integrated Research Application System PDF Files	
R&D Application checklist		
R&D Form (Parts A-D) (signed/authorised pdf or hard copy)	NHS R&D Form - FINAL VERSION	26 Jul 2016
REC favourable opinion letter and all correspondence	Favourable Opinion with Additional Conditions	25 Jul 2016
REC favourable opinion letter and all correspondence	Provisional Opinion	06 Jul 2016
REC favourable opinion letter and all correspondence	Unfavourable Opinion	12 May 2016
Research participant consent form - local version	Phase 1 - Service User - Accessible - ABM UHB	v3.0, 08 Jul 2016
Research participant consent form - local version	Phase 1 - Clinical Psychologist - ABM UHB	v3.0, 08 Jul 2016
Research participant consent form - local version	Phase 1 - Service User - ABM UHB	v3.0, 08 Jul 2016
Research participant consent form - local version	Phase 2 - Service User - Accessible - ABM UHB	v3.0, 08 Jul 2016
Research participant consent form - local version	Phase 2 - Service User - ABM UHB	v3.0, 08 Jul 2016
Research participant information sheet (PIS) - local version	Phase 1 - Service User - Accessible - ABM UHB	v3.0, 08 Jul 2016
Research participant information sheet (PIS) - local version	Phase 1 - Clinical Psychologist - ABM UHB	v3.0, 08 Jul 2016
Research participant information sheet (PIS) - local version	Phase 1 - Service User - ABM UHB	v3.0, 08 Jul 2016
Research participant information sheet (PIS) - local version	Phase 2 - Service User - Accessible - ABM UHB	v3.0, 08 Jul 2016
Research participant information sheet (PIS) - local version	Phase 2 - Service User - ABM UHB	v3.0, 08 Jul 2016
Site-Specific Information Form (signed/authorised pdf or hard copy)	ABM UHB	26 Jul 2016
Site-Specific Information Form (signed/authorised pdf or hard copy)	Draft	26 Jul 2016

Re: Impact of masculinity upon psychosis
IRAS Ref: 199894
Sponsor: Cardiff University

Application Documents Received

Document:	Subtitle:	Version:
Site-Specific Information form checklist	ABM UHB	
Summary CV for Academic Supervisor	B Davies	22 Mar 2016
Summary CV for Academic Supervisor	D Hare	22 Mar 2016
Summary CV for Chief Investigator (CI)	R J Searle	
Summary, synopsis or diagram (flowchart) of protocol in non-technical language		
Written final confirmation from the organisation(s) acting as sponsor	Cardiff University	04 Feb 2016

Re: Impact of masculinity upon psychosis
IRAS Ref: 199894
Sponsor: Cardiff University

Amendment Documents Received

Minor AM1 – 29 Sept 2016

Document:	Subtitle:	Version:
REC acknowledgement of minor amendment	16-NE-0216 Minor Amendment 1 18.10.16	18.10.16
Research participant information sheet (PIS)	PIS Clinical Psychologist - Phase 1	v4, 29 Sep 2016
Research participant information sheet (PIS)	PIS Service User - Phase 1	v4, 29 Sep 2016
Research participant information sheet (PIS)	PIS Service Users - Phase 2	v4, 29 Sep 2016

35.0 APPENDIX H – PARTICIPANT INFORMATION FORM (PHASE 1)

PARTICIPANT INFORMATION (PHASE 1)

The impact of 'masculinity' upon males with psychosis

A research study conducted by Robert Searle, Dr Bronwen Davies and Dr Dougal Hare

Hello,

My name is Robert Searle. I am a Trainee Clinical Psychologist enrolled on the Cardiff University Clinical Doctorate Programme. A requirement of my DClinPsy course is to complete a Large Scale Research Project, and I am interested in the societal norms of masculinity, and how they may impact upon men with who have experienced psychotic phenomena.

Outline of the project
I would be very interested in knowing more about your ideas regarding 'masculinity' and its possible influences upon the experience of psychotic phenomena in males. We hope that 6-10 Clinical Psychologists, and 6-10 males who have experienced psychotic phenomena will help us complete this phase of the project.

If you were to agree to take part in this phase, I would be happy to meet with you at a convenient time and location to conduct the interview. I would be happy to conduct the interview over the telephone if this would be more convenient for you. I anticipate that it would take approximately 45 minutes to complete. You could refuse to answer any of the particular questions asked and you can say as much or as little as you want to. You could also end the interview at any time and you could take breaks if you needed to. Furthermore, all the information you would disclose will be kept confidential unless we were to become worried about yours or someone else's safety. If this were to occur, I would endeavor to tell you that confidentiality will be breached, and then inform appropriate personnel according to NHS procedures and professional codes of practice.

Who is organising and funding the research?
The research is funded by Cardiff University as required by the Research Governance Framework for Health and Social care, However, no individual will receive any payment for your participation in the study. The project has also been approved by an NHS Research Ethics Committee.

Personal information
Although an audio recorder would be used and notes would be taken by the researcher throughout the course of the interview, any personal information that could identify you would be removed and the transcriptions will be kept as password protected documents accessible only by the researcher. Furthermore, your consent form will be provided with an identifying number, and be kept in a locked filing

cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. You would have the right to check the accuracy of the data held about you and to correct any errors. A copy of the interview transcript could also be provided to you, on request, and the data would be stored securely while the study is written up with the audio recording then being deleted.

The procedures for handling, processing, storage and destruction of your data would comply with the Data Protection Act (1998), a copy of which is available to you if you so wish. After the study is completed and the doctoral thesis has been examined, the data would be stored securely for 10 years within ABMU Health Board.

What will happen to the results of the research study?
When we have finished the study, we can send you a summary of our findings if you would like. It is intended that the research be published. This is being done to improve our understanding of how concepts of masculinity may have influenced people's lives, and identify ways in which professionals can better support them. You would not be identified in any publication.

Experiencing Distress:
If you were to have concerns in due course about any aspect of this study, or were feeling low in mood as a direct result of participating in this project please let us know (below) and we will do our best to provide you with some support.

Dr Dougal Hare
Research Director
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT
Tel: (02920) 874007

Dr Bronwen Davies
Clinical Psychologist
Caswell Clinic
Tondu Road
Bridgend
CF31 4LN
Tel: (01656) 753025

Mr Robert Searle
Trainee Clinical Psychologist
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT
Tel: (02920) 874007

Raising a concern:
Any concerns about the way you have been dealt with during the study would be treated very seriously. If you were to have a concern about any aspect of this study, please address them to us (details above) and we would do our best to answer them.

If you were still unhappy and wished to raise a concern formally, you could do any of the following.

- Obtain the NHS '*Putting Things Right*' procedure from the Department of Investigations and Redress.
- Contact the Community Health Council:-
  Abertawe Bro Morgannwg University Health Board
  First floor, Cimla Hospital
  Neath
  SA11 3SE

  Tel: 01639 683490
  email: ofice.abm@waleschc.org.uk
  website: http://www.wales.nhs.uk/sitesplus/902/home

Thank you!
Thank you very much for taking the time to read this information leaflet. Please keep it for your own records. To provide your consent to be interviewed, please sign the attached consent form.

Kind regards,

Robert Searle (Trainee Clinical Psychologist)

PARTICIPANT INFORMATION (PHASE 1)

The impact of 'masculinity' upon males with psychosis

A research study conducted by Robert Searle, Dr Bronwen Davies and Dr Dougal Hare

Hello,

My name is Robert Searle. I am a Trainee Clinical Psychologist enrolled on the Cardiff University Clinical Doctorate Programme. A requirement of my DClinPsy course is to complete a Large Scale Research Project, and I am interested in the societal norms of masculinity, and how they may impact upon men with who have experienced psychotic phenomena.

Outline of the project
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If you were to agree to take part in this phase, I would be happy to meet with you at a convenient time and location to conduct the interview. I anticipate that it would take approximately 45 minutes to complete. You could refuse to answer any of the particular questions asked and you can say as much or as little as you want to. You could also end the interview at any time and you could take breaks if you needed to. Furthermore, all the information you would disclose will be kept confidential unless we were to become worried about yours or someone else's safety. If this were to occur, I would endeavor to tell you that confidentiality will be breached, and then inform appropriate personnel according to NHS procedures and professional codes of practice.

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cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. You would have the right to check the accuracy of the data held about you and to correct any errors. A copy of the interview transcript could also be provided to you, on request, and the data would be stored securely while the study is written up with the audio recording then being deleted.

The procedures for handling, processing, storage and destruction of your data would comply with the Data Protection Act (1998), a copy of which is available to you if you so wish. After the study is completed and the doctoral thesis has been examined, the data would be stored securely for 10 years within ABMU Health Board.

Second phase
We would like to contact you again at a later time to take part in the second phase of the project. This would involve rating how much/little you think particular statements/information are representative of psychosis. However, your consent to take part in the next phase of the project will not be taken now, and is not required to take part in this phase of the project.

What will happen to the results of the research study?
When we have finished the study, we can send you a summary of our findings if you would like.
It is intended that the research be published. This is being done to improve our understanding of how concepts of masculinity may have influenced people's lives, and identify ways in which professionals can better support them. You would not be identified in any publication.

Experiencing Distress:
If you were to have concerns in due course about any aspect of this study, or were feeling low in mood as a direct result of participating in this project please let us know (below) and we will do our best to provide you with some support.

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Raising a concern:
Any concerns about the way you have been dealt with during the study would be treated very seriously. If you were to have a concern about any aspect of this study, please address them to us (details above) and we would do our best to answer them.

If you were still unhappy and wished to raise a concern formally, you could do any of the following.

- Obtain the NHS '*Putting Things Right*' procedure from the Department of Investigations and Redress.
- Contact the Community Health Council:-
  Abertawe Bro Morgannwg University Health Board
  First floor, Cimla Hospital
  Neath
  SA11 3SE

  Tel: 01639 683490
  email: ofice.abm@waleschc.org.uk
  website: http://www.wales.nhs.uk/sitesplus/902/home

Thank you!
Thank you very much for taking the time to read this information leaflet. Please keep it for your own records. To provide your consent to be interviewed, please sign the attached consent form.

Kind regards,

Robert Searle (Trainee Clinical Psychologist)

PARTICIPANT INFORMATION

PHASE 1

Study Title: **Impact of masculinity upon psychosis**

	Hi, my name is Robert Searle. I am a Trainee Clinical Psychologist.
	I would like to invite you to take part in a research study. Before you decide if you would like to be involved, we want to provide you with the information you need to understand why the research is being done and what it would involve for you. This means you can make an informed choice about whether or not you wish to participate.
	It is up to you to decide whether you would like to be involved. If after reading this document you believe that you would like to take part, we will then ask you to sign a consent form to show you have agreed to take part.

	**I am currently completing some research into males' experiences of psychotic phenomena, and would like to know more about your beliefs about what it is to be a man and how this relates to your experience of psychosis.**
	**This would involve me interviewing you, and asking you a range of different questions. I hope to interview you and about 5 other service users to help me with this project.**
	**I will also be interviewing clinical psychologists who have worked with men who have experienced psychotic phenomena.**
	**All research in the National Health Service (NHS) is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and agreed by them.**
	**The interviews will be done in a private place on your ward.**
	**The interviews would last approximately 45 minutes. You can have a break or stop at any time.**

	**Anything you say will be private and anonymous. This means that no one will know what you have said except the researcher. We will only tell your clinical team and your responsible clinician that you will be involved in the study, not what you have said.**
	**The only time in which I would not be able to keep what you say private is if you say that you or someone else has/will come to harm.** **I will need to tell someone else if this were to happen. However, I will try to tell you first if I was going to tell someone else.**
	**The interview would be recorded on a Dictaphone to ensure I remember all your important points.**
	**You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.**
	**When I have written down what you said during your interview I will delete the recording. The written interview will then be stored in a locked drawer and will not have your name on it.**
	**You will not receive any payment for your involvement in the project**

	**We cannot promise the study will help you, but by participating in the study, you may find that you learn more about yourself and understand more about masculinity and psychosis. The information we get from this study will try to help improve the treatment of men with psychosis, considering their needs in relation to their male identity.**
	**I care about your safety and wellbeing. Therefore, if you were to become at all distressed during the interview, I could stop the interview and arrange for a staff member to provide you with some support**
	**If you have a concern about any aspect of this study, you should ask to speak to the researchers (details below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the Caswell Clinic.**
	**A copy of what you tell me, and information about the final research study could be provided to you if you wish, please let the researcher know if this is the case. Any personal information that could identify you would be removed from the typed data.**
	**You may be asked to meet with me one more time in phase 2 of the study at a later time. This will be to rate yours and other people's ideas about 'masculinity' and psychosis. You have a choice about whether or not to participate in the second stage, and do not need to decide now.**

	**Thank you very much for taking the time to read this information leaflet. Please keep it for your own records.**
	**If you have any questions about the research project, please let us know! We would be happy to answer any questions and provide more information.**
	**If you would be happy to be involved in this research project, please sign the consent form provided.**
 Dr Bronwen Davies Robert Searle	**Please contact myself (Cardiff University - 02920 870582) or Bronwen (Caswell Clinic - 01656 753025) if you have any questions, or ask a staff member to help you contact us.** **Thank you!**

36.0 APPENDIX I – PARTICIPANT CONSENT FORM (PHASE 1)

ID:_____

CONSENT FORM

PHASE 1

Study Title: **Impact of masculinity upon males with psychosis**

If you would like to participate in the research study, please read the following information and sign your name as indicated below:

- I have read and understood the Participant Information sheet for Phase 1 of the study.
- I understand what is being asked of me during the project.
- I consent for my interview to be recorded and understand that it will be transcribed and anonymised before the recording is deleted.
- I have no questions or have asked all the questions which I had, which have been adequately answered by the researcher.
- I understand that I can withdraw my consent at any time.
- I understand that all the information I disclose will be kept confidential unless the researcher is worried about mine or someone else's safety.
- I am happy that all the information I disclose will be kept anonymized and written up in a report which may be submitted for publication.
- I consent to participate in the study and be interviewed by the researcher either in person or over the telephone.

If you do not want to take part, do not sign your name.

I agree to the above:

_____	_____	_____
Name (printed)	*Signature*	*Date*

_____	_____
Countersigned by researcher	*Date*

ID:_____

CONSENT FORM

PHASE 1

Study Title: **Impact of masculinity upon males with psychosis**

If you would like to participate in the research study, please read the following information and sign your name as indicated below:

- I have read and understood the Participant Information sheet for Phase 1 of the study.
- I understand what is being asked of me during the project.
- I consent for my interview to be recorded and understand that it will be transcribed and anonymised before the recording is deleted.
- I have no questions or have asked all the questions which I had, which have been adequately answered by the researcher.
- I understand that I can withdraw my consent at any time.
- I understand that all the information I disclose will be kept confidential unless the researcher is worried about mine or someone else's safety.
- I am happy that all the information I disclose will be kept anonymized and written up in a report which may be submitted for publication.
- I consent to participate in the study and be interviewed by the researcher.

If you do not want to take part, do not sign your name.

I agree to the above:

_____	_____	_____
Name (printed)	*Signature*	*Date*

_____	_____
Countersigned by researcher	*Date*

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

ID:_____

CONSENT FORM

PHASE 1

Study Title: **Impact of masculinity upon psychosis**

	Yes	No
Have you read (or had read to you) 'Participant Information Phase 1'?	[ ]	[ ]
Do you understand what you have been told about the project?	[ ]	[ ]
Have you asked all the questions you want?	[ ]	[ ]
Do you understand that you can stop taking part at any time?	[ ]	[ ]
Do you understand that everything you say will be confidential unless Rob is worried about someone's safety?	[ ]	[ ]
Would you like to meet Rob and take part in a recorded interview?	[ ]	[ ]
Do you agree to the things you say and do being written up in a report (anonymised)?	[ ]	[ ]

If you do not want to take part, do not sign your name.

I agree to the above:

Service User's name (printed)	*Signature*	*Date*
Countersigned by researcher		*Date*

37.0 APPENDIX J - SEMI-STRUCTURED QUESTIONNAIRE

Semi Structured Questionnaire

Service Users

Name: _____

Participant ID: _____

Age: _____

Sexual Orientation: _____

Ethnicity: _____

As we complete this questionnaire together, there may be questions in which you find it difficult to understand. Please let me know if this happens, and I will try my very best to better explain myself.

1- What does the term 'masculinity' mean to you?

Possible Prompt Questions:

Males are different from females. How are men different from women? In what ways? What do you think is different about being male?

Being a man, is there anything that you think you should or should not do? What do you think are masculine or man-like behaviours?

What kind of man would you say you are/describe yourself as (at the moment)?

Is there anything that you think that a man should not do in order to act in a masculine or manly way?

Have your views about the type of man you are made things easier or more difficult for you? For example, affected the way you express yourself, affected how you feel about yourself or others, affected the way others have treated you.

Do you think your views or behaviours linked with being a man have affected the way other people see or treat you?

2- Do you think your ideas about masculinity or being a man change?

Possible Prompt Questions

Did you have an early understanding of what a man should be like?

What kind of man would you say you were (in the past)?

Do you think your ideas about masculinity or being a man, have changed over time? (For instance, are they different now than when you were in school? If so, in what ways?)

Do you think your behaviours, in terms expressing your male identity, have changed over time? Is there anything you wish you had done differently?

Do you think your views on masculinity or being a man are different in different places, for example home, work, hospital? OR- Do you think that what is expected of men is different in different places?

What kind of man would you want to be in the future? How far away from this are you? What do you need to do to achieve this?

3- How do others view Masculinity?

Possible Prompt Questions

What do other people close to you (family/friends/peers) expect a man to be like?

How do you think the media and culture (e.g. music, TV) portray masculinity?

Do you think this has impacted on you? If so how?

What do you think women think about masculinity?

What do you think they expect from men?

4- Do you think your beliefs about being a man have affected your experience of psychosis (e.g. paranoia, voices, emotions)?

Possible Prompt Questions

Have your beliefs about being a man have affected the way you responded to symptoms of psychosis? For example, if you felt paranoid or threatened did your beliefs around what it is to be a man impact on how you reacted?

How did your views of masculinity affect how you dealt with strong emotions?

Do you think women and men experience psychosis/ distress/ paranoia/ voices differently?

If different then in what ways?

Do you think any difference in men's experience is related to beliefs about how a man should respond or act?

Do you think that stigma towards men experiencing psychotic phenomena is related in any way to ideas about masculinity?

5- Do you think beliefs about being a man can affect an individual's experience of treatment and recovery form psychosis

Possible Prompt Questions

Has treatment of psychosis had any impact on your male identity/ views about masculinity? If so how?

Has medication had any impact on your masculine identity?

When stressed, what coping strategies do you use?

Do you think these are affected about your views about being a man?

Are these different from women who experience psychotic phenomena?

Do you think that beliefs about being a man impact on your motivation to seek help?

Do/did your beliefs about being a man impact on your motivation to access psychological therapy? Have they shaped your views about therapy, now or in the past?

Do you think your beliefs about masculinity/what it is to be a man have impacted on your recovery in any way? If so how?

Sometimes psychotic experiences can make people feel quite powerless (for instance if people cannot control voices, if they are paranoid and fearful that someone wants to hurt them, or if they are detained against their will or force medicated). Have your masculinity beliefs been affected by any of these?

What challenges to masculinity do you believe exist in the treatment of psychosis?

How do you think these could be addressed?

6- How do you think males experiencing psychotic phenomena experience forensic mental health services?

<u>Possible Prompt Questions</u>

Is it important for forensic mental health services to consider masculinity in the way they try to support service users?

Do forensic mental health services consider your needs as a man? Do they consider masculinity as important?

What challenges to muscularity do you believe exist within services/ practices?

Do services recognise challenges to masculinity within practices?

What do you think about being cared for by women?

How should practitioners in mental health settings ask you about masculinity?

How would you change services to be more considerate of male issues?

Has your contact with mental health services changed your view of masculinity? If so in what way? What do think influenced the change? What factors were important in the change?

What can mental health services do to help you become the man you want to become?

38.0 APPENDIX K – EXAMPLE OF TRANSCRIPT

Audio title: [redacted]
Audio length: 15 minutes

I Okay, so what does the word masculine mean to you?

R To have a family and be grounded with your family you know. To ((?)) working and it's a bugger.

I Okay, so to be masculine is to have a family and to be working as well?

R Well it's ((?)) to support your family you know.

I Oh right, okay. So working to support your family, so you are getting money in order to provide for them, is that right?

R Yeah.

I Okay. So is there anyone say in – on TV or on films that you think, yeah, that's a masculine person?

R ((pause)) ((?)) ((pause)) Yeah, there is, yeah ((?)) in Coronation Street, Steve ((?))

I Oh right, that's okay. So Steve from Coronation Street.

R Yeah.

I What does he do to show that he's masculine?

R ((laughing)) ((pause)) Gosh… ((pause)) I can't think of anything, sorry.

39.0 APPENDIX L – DEVELOPMENT OF Q SAMPLE

Quote	*R.S*	*B.D*	*S.M*	*Agreement*	*Included?*
AGGRESSION AND VIOLENCE					
VIOLENCE					
• *If another man tried to have sex with my girlfriend/wife, I would beat him up*				*0%*	
• *Sometimes you need to use physical violence to defend what you have*		*X*	*X*	*66.6%*	✓
• *A man likes to think about the men they've beaten in physical fights*				*0%*	
• *Sometimes you've got to fight or people will walk all over you*		*X*	*X*	*66.6%*	✓
• *A man should initiate a fight if someone threatened him*	*X*	*X*		*66.6%*	✓
• *A man has to threaten people sometimes to make them do what they should*				*0%*	
• *Men enjoy martial arts*				*0%*	
• *A man would fight to defend himself if the other person threw the first punch*		*X*		*33.3%*	
• *A man doesn't mind using verbal or physical threats to get what he wants*				*0%*	
• *Boys should get into play fights*			*X*	*33.3%*	
• *Boys should think about how to attack and ambush people*				*0%*	
• *Boys should get into trouble*				*0%*	
• *It is more acceptable for boys to get into trouble in school than girls*				*0%*	
• *Men need to be violent at times*			*X*	*33.3%*	
• *Men should not accept any trouble off others*				*0%*	
LEISURE					
• *Boys should play with action figures not dolls*				*0%*	
• *Men should excel at contact sports*				*0%*	
• *Men should watch football games instead of soap operas*	*X*	*X*	*X*	*100%*	✓
• *A man likes to watch contact sports like football or boxing*				*0%*	

• *A man should prefer watching action movies to reading romantic novels*	*X*		*X*	*66.6%*	✓
• *Boys should prefer to play with trucks rather than dolls*				*0%*	
TOUGHNESS					
• *Men should be generally aggressive in their behaviour*				*0%*	
• *Men should get angry at times*				*0%*	
• *Men should be tough*	*X*	*X*	*X*	*100%*	✓
• *If people think you are physically weak, they may attack you*	*X*	*X*		*66.6%*	✓
• *A man talks his way out of trouble*	*X*	*X*		*66.6%*	✓
• *When the going gets tough, men should get tough*				*0%*	
• *A young man should try to be physically tough, even if he's not big*				*0%*	
• *A man knows when to walk away from a fight*				*0%*	
• *A man does not go looking for trouble*	*X*	*X*	*X*	*100%*	✓
• *People don't mess with a man*				*0%*	
• *Men should be full of bravado*				*0%*	
• *If a man is being full of bravado, he is actually trying to compensate for being weak*			*X*	*33.3%*	
• *Men should be physically strong*	*X*	*X*		*66.6%*	✓
• *Men should stop others from being hurt*		*X*	*X*	*66.6%*	✓
• *Men should not tolerate bullies*			*X*	*33.3%*	
• *If being threatened, men should tell the attacker that they do not want to fight them*				*0%*	
• *Men should stand up for other people's rights*				*0%*	
• *Men deal with their problems*				*0%*	
• *Men should not back down from others*				*0%*	
• *Ignoring voices who belittle you is the right thing to do*	*X*	*X*	*X*	*100%*	✓
• *Arguing back with voices who belittle you is the right thing to do*	*X*	*X*		*66.6%*	✓
• *Men should solve problems without the use of violence*					
DOMINANCE AND STATUS					
• *Men should work hard*				*0%*	
• *Men should protect and provide for their families*	*X*	*X*	*X*	*100%*	✓
• *Men should have rank and status*				*0%*	
• *Men should be muscular*	*X*	*X*	*X*	*100%*	✓

• *Men should be competitive*	*X*	*X*	*X*	*100%*	✓
• *Men should be assertive, not aggressive*				*0%*	
• *Men should be brave*		*X*		*33.3%*	
• *Men should be the hero*				*0%*	
• *Men should be smartly dressed*	*X*	*X*		*66.6%*	✓
• *The best men are at the top of the pecking order*	*X*	*X*		*66.6%*	✓
• *Men should be competitive*				*0%*	
• *A man should drink alcohol and play drinking games*				*0%*	
• *A man should mark his territory*				*0%*	
• *A man likes pulling pranks on other men*		*X*		*33.3%*	
• *A masculine man should show to others that he is strong without the use of violence*				*0%*	
• *Being dominant stops others from attacking you*	*X*	*X*	*X*	*100%*	✓
• *Men should be the life and soul of the party*				*0%*	
• *A man should make money and provide for his family*				*0%*	
• *A man should be in charge*	*X*	*X*	*X*	*100%*	✓
• *Men who stay home to take care of their children are weak*				*0%*	
• *Men should be the leaders in any group*				*0%*	
• *A man should do the work*				*0%*	
• *Men should make the final decision involving money*				*0%*	
• *The Prime Minister should always be a man*				*0%*	
• *A man should provide the discipline in the family*				*0%*	
• *Having voices/delusions makes you feel more like a man*				*0%*	
• *Having voices/delusions makes you feel less of a man*			*X*	*33.3%*	
• *In a group, it is up to the men to get things organized and moving ahead*				*0%*	
• *A man should look like a gangster*				*0%*	
• *Men should assert their dominance to attract females*				*0%*	
• *The more masculine you are, the better others will treat you*	*X*	*X*		*66.6%*	✓
• *A man should solve problems without resorting to violence*				*0%*	
• *Hearing voices makes you less of a man*				*0%*	
• *Men should be in control*	*X*	*X*	*X*	*100%*	✓
• *Men should provide for their families*		*X*		*33.3%*	
• *Men should be the breadwinners*				*0%*	

• *Men should be the providers*				*0%*	
• *A man should be able to achieve his goals*				*0%*	
• *A man should not be a waiter*				*0%*	
• *A manly job involves working in construction*				*0%*	
• *Men should keep people safe*				*0%*	
• *Men should stand up for the people they love*			*X*	*33.3%*	
• *Men should not be shy or withdrawn*				*0%*	
• *Men should intimidate others*				*0%*	
• *Men should mark and maintain their territory*	*X*			*33.3%*	
RESTRICTIVE EMOTIONALITY					
• *A man should not be too quick to tell others that he cares about them*		*X*		*33.3%*	
• *Fathers should teach their sons to hide their fear*			*X*	*33.3%*	
• *If men express emotions, they are either attention seeking or manipulating others*				*0%*	
• *Men should not be sensitive*				*0%*	
• *Men should not act in feminine ways (e.g. wear pink or anything fluffy).*			*X*	*33.3%*	
• *Me should joke around a lot*				*0%*	
• *Men should not be bothered by anything*				*0%*	
• *A man should prefer to be ill than ask for help*	*X*	*X*		*66.6%*	✓
• *A man should be comfortable expressing his emotions*			*X*	*33.3%*	
• *I would find it embarrassing if a male friend of mine cried over a sad love story*				*0%*	
• *Pain makes you stronger*				*0%*	
• *Even if I was afraid I would never admit it*				*0%*	
• *Men who cry are weak*	*X*	*X*	*X*	*100%*	✓
• *Men who show they are afraid are weak*				*0%*	
• *Men should ignore people who talk about things they are not interested in*				*0%*	
• *Men should not show sympathy to others*				*0%*	
• *Men should not talk to others about their delusions or hallucinations*			*X*	*33.3%*	
• *Men should not take medication*	*X*			*33.3%*	

• *Taking medication makes you less of a man*		*X*		*33.3%*	
• *Men should not ask other people for help*			*X*	*33.3%*	
• *Men who show their emotions frequently are not masculine*				*0%*	
• *It is appropriate for men to join the army*				*0%*	
• *Men should not appear needy*				*0%*	
• *A man should be disciplined*				*0%*	
• *Men should be detached from others*				*0%*	
• *Men cope with difficulties by shutting down and closing off*				*0%*	
• *Men should cope with difficulties on their own*	*X*	*X*	*X*	*100%*	✓
• *Men should not don't trust others*				*0%*	
• *Men should not need support from others*				*0%*	
• *Men should get up to investigate if there is a strange noise in the house at night*				*0%*	
• *Men should not talk about their emotions*	*X*	*X*		*66.6%*	✓
• *Men should be distant from their emotions*				*0%*	
• *Men should be comfortable expressing to others how they feel*			*X*	*33.3%*	
• *Men should not be vulnerable*	*X*	*X*		*66.6%*	✓
• *Men should not show that they are upset*	*X*	*X*	*X*	*100%*	✓
• *Men should not dance*				*0%*	
• *Men should not do the domestic chores (i.e. washing up, cleaning, painting, sorting the kids out at school, bringing them home etc)*				*0%*	
• *Men drink beer as opposed to milk*				*0%*	
• *A man should never admit when other people hurt his feelings*				*0%*	
• *Men should not show any emotion*	*X*	*X*		*66.6%*	✓
• *A man should not be as emotional as a woman*				*0%*	
• *It is better to show emotion in front of one person as opposed to a group*				*0%*	
• *Men should use drugs to cope with their emotions*		*X*	*X*	*66.6%*	✓
• *A man should not tell his problems to other people*	*X*	*X*	*X*	*100%*	✓
• *Men should use alcohol to cope with their emotions*			*X*	*33.3%*	
• *A man should not react when other people cry*				*0%*	
• *Men should not be interested in TV talk shows*				*0%*	
• *A man should be fit and healthy*				*0%*	

• *A man should go to the gym and lift weights*	*X*	*X*	*X*	*100%*	✓
• *Men should not wear make-up, cover-up, or bronzer*				*0%*	
• *A man should have sex with as many women as possible*	*X*	*X*	*X*	*100%*	✓
SEXUALISED BEHAVIOUR TOWARDS WOMEN					
• *A man should watch heterosexual pornography*				*0%*	
• *Antipsychotics lessens my sex drive, which makes me less of a man*	*X*	*X*	*X*	*100%*	✓
• *A woman should not be sexually unfaithful*				*0%*	
• *A man should be able to get erections*	*X*	*X*	*X*	*100%*	✓
• *It is OK for a man to be sexually unfaithful*				*0%*	
• *A man notices women mostly for their physical characteristics like their breasts or body shape*				*0%*	
• *Men should not allow women to pay the bills*	*X*	*X*		*66.6%*	✓
• *A man should brag about his sexual experiences to his male friends*				*0%*	
• *A man should be sexually active and have sexual relationships with women*	*X*	*X*	*X*	*100%*	✓
• *I wouldn't respect a woman who has had a one-night stand*				*0%*	
• *A man should not marry a woman who has slept with a lot of other men*				*0%*	
• *There should be two kinds of women: those I would shag and those I would marry*		*X*		*33.3%*	
• *A man shouldn't bother with sex unless he can achieve orgasm*				*0%*	
• *A man should never turn down sex*	*X*			*33.3%*	
SELF RELIANCE					
• *A man should have home improvement skills*				*0%*	
• *A man should be able to fix most things around the house*				*0%*	
• *A man should know how to repair his car if it should break down*				*0%*	
• *A man should be able to make his own way in the world*				*0%*	
• *A man should be able to do his job, even if he is physically ill or hurt*				*0%*	
• *A man should not be reliant on other people*	*X*	*X*	*X*	*100%*	✓
• *Men should be able to solve problems on their own*	*X*		*X*	*66.6%*	✓
• *A man is too proud to get help*	*X*	*X*	*X*	*100%*	✓
• *A man expects more from himself than other people*				*0%*	

• *A man makes his own decisions*	*X*	*X*	*X*	*100%*	✓
• *A man is what he wants to be, not what other people want to see*				*0%*	
• *Self-reliance conquers any difficulty*				*0%*	
• *Men should be goal oriented*				*0%*	
• *Men should be more interested in tasks than relationships*				*0%*	
• *Men should be confident*	*X*	*X*	*X*	*100%*	✓
• *Men should be talkative*				*0%*	
• *Men should solve problems others cannot solve*				*0%*	
• *Men should work to support their family*				*0%*	
• *Men should look after their family*	*X*	*X*	*X*	*100%*	✓
DISTAIN FOR GAY MEN					
• *I would think less of another man if I were to find out he was gay*	*X*	*X*	*X*	*100%*	✓
• *I would be uncomfortable to be with a gay man on my own*		*X*		*33.3%*	
• *A man should never compliment another man*	*X*	*X*	*X*	*100%*	✓
• *Men should never hold hands or show affection towards another man*	*X*		*X*	*66.6%*	✓
RISK TAKING					
• *It is important for a man to take risks, even if he might get hurt*	*X*	*X*	*X*	*100%*	✓
• *Pain is temporary, glory is forever*		*X*		*33.3%*	
• *Pain and trouble make you appreciate life*	*X*			*33.3%*	
• *A man should break the rules occasionally*	*X*	*X*	*X*	*100%*	✓
• *Men should rebel against society*	*X*		*X*	*66.6%*	✓

40.0 APPENDIX M – PARTICIPANT INFORMATION FORM (PHASE 2)

PARTICIPANT INFORMATION (PHASE 2)

The impact of 'masculinity' upon males with psychosis

A research study conducted by Robert Searle, Dr Bronwen Davies and Dr Dougal Hare

Hello,

My name is Robert Searle. I am a Trainee Clinical Psychologist enrolled on the Cardiff University Clinical Doctorate Programme. A requirement of my DClinPsy course is to complete a Large Scale Research Project, and I am interested in the societal norms of masculinity, and how they may impact upon men with who have experienced psychotic phenomena.

Outline of the project

I would be very interested in knowing more about your ideas regarding 'masculinity', and would like you to sort and rate some information cards to help us identify what you think is important about the relationship between masculinity and psychosis and what it is not. We hope that males who have experienced psychotic phenomena will help us complete this phase of the project.

If you were to agree to take part in this phase, I would be happy to meet with you at a convenient time and location to conduct the card sort. I anticipate that it would take approximately 45 minutes to complete. You could refuse to rate any of the cards if you wish and you can say as much or as little as you want to. You could also end the card sort at any time and you could take breaks if you needed to. Furthermore, all the information you would disclose will be kept confidential unless we were to become worried about yours or someone else's safety. If this were to occur, the researcher would endeavour to tell you that confidentiality will be breached, and then inform appropriate personnel according to NHS procedures and professional codes of practice.

Who is organising and funding the research?

The research is funded by Cardiff University as required by the Research Governance Framework for Health and Social care, However, no individual will receive any payment for your participation in the study. The project has also been approved by an NHS Research Ethics Committee.

Personal information

Although an audio recorder would be used and notes would be taken by the researcher throughout the course of the interview, any personal information that could identify you would be removed and the transcriptions will be kept as password protected documents accessible only by the researcher. Furthermore, your consent form will be provided with an identifying number, and be kept in a locked filing cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. You would have the right to check the accuracy of the data held about you and to correct any errors. A copy of the interview transcript could also be provided to you, on request, and the data would be stored securely while the study is written up with the audio recording then being deleted.

The procedures for handling, processing, storage and destruction of your data would comply with the Data Protection Act (1998), a copy of which is available to you if you so wish. After the study is completed and the doctoral thesis has been examined, the data would be stored securely for 10 years within ABMU Health Board.

What will happen to the results of the research study?

When we have finished the study, we can send you a summary of our findings if you would like.

It is intended that the research be published. This is being done to improve our understanding of how concepts of masculinity may have influenced the lives of men with psychosis, and identify ways in which professionals can better support them. You would not be identified in any publication.

Experiencing Distress:

If you were to have concerns in due course about any aspect of this study, or were feeling low in mood as a direct result of participating in this project please let us know (below) and we will do our best to provide you with some support.

Dr Dougal Hare
Research Director
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT
Tel: (02920) 874007

Dr Bronwen Davies
Clinical Psychologist
Caswell Clinic
Tondu Road
Bridgend
CF31 4LN
Tel: (01656) 753025

Mr Robert Searle
Trainee Clinical Psychologist
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT
Tel: (02920) 874007

Raising a concern:

Any concerns about the way you have been dealt with during the study would be treated very seriously. If you were to have a concern about any aspect of this study, please address them to us (details above) and we would do our best to answer them.

If you were still unhappy and wished to raise a concern formally, you could do any of the following.

- Obtain the NHS '*Putting Things Right*' procedure from the Department of Investigations and Redress.
- Contact the Community Health Council: -
  Abertawe Bro Morgannwg University Health Board, First floor, Cimla Hospital, Neath, SA11 3SE

  Tel: 01639 683490
  email: ofice.abm@waleschc.org.uk
  website: http://www.wales.nhs.uk/sitesplus/902/home

Thank you!

Thank you very much for taking the time to read this information leaflet. Please keep it for your own records. To provide your consent to be interviewed, please sign the attached consent form.

Kind regards,

Robert Searle (Trainee Clinical Psychologist)

PARTICIPANT INFORMATION

PHASE 2

Study Title: **Impact of masculinity upon psychosis**

	**Hi, my name is Robert Searle. I am a Trainee Clinical Psychologist.**
	**I would like to invite you to take part in a research study. Before you decide if you would like to be involved, we want to provide you with the information you need to understand why the research is being done and what it would involve for you. This means you can make an informed choice about whether or not you wish to participate.**

	**It is up to you to decide whether you would like to be involved. If after reading this document you believe that you would like to take part, we will then ask you to sign a consent form to show you have agreed to take part.**
	**I am currently completing some research into males' experiences of psychotic phenomena, and would like to know more about your beliefs about what it is to be a man.**
	**This would involve you sorting and rating information cards about masculinity and psychosis considering how the ideas relate to your own experience.**
	**All research in the National Health Service (NHS) is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and agreed by them.**
	**The card sort will be done in a private place on your ward.**

	**The card sort would last approximately 45 minutes. You can have a break or stop at any time.**
	**Anything you say will be private and anonymous. This means that no one will know what you have said except the researcher. We will only tell your clinical team and your responsible clinician that you will be involved in the study, not what you have said.**
	**The only time in which I would not be able to keep what you say private is if you say that you or someone else has/will come to harm.** **I will need to tell someone else if this were to happen. However, I will try to tell you first if I was going to tell someone else.**
	**The card sort data would be recorded on a Dictaphone and notes will be taken to ensure I remember all your important points.**
	**You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.**

	**When I have written down what you said during your interview I will delete the recording. The written interview will then be stored in a locked drawer and will not have your name on it.**
	**You will not receive any payment for your involvement in the project**
	**We cannot promise the study will help you but by participating in the study, you may find that you learn more about yourself and understand more about some of your difficulties. The information we get from this study will try to help improve the treatment of men with psychosis.**
	**I care about your safety and wellbeing. Therefore, if you were to become at all distressed during the card sort, I could stop the interview and arrange for a staff member to provide you with some support**
	**If you have a concern about any aspect of this study, you should ask to speak to the researchers (details below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the Caswell Clinic.**

	**Information about the outcomes of the research study could be provided to you if you like, please let the researcher know if this is the case. Any personal information that could identify you would be removed from the typed data and stored securely while the study is written up.**
	**Thank you very much for taking the time to read this information leaflet. Please keep it for your own records.**
	**If you have any questions about the research project, please let us know!**
	**If you would be happy to be involved in this research project, please sign the consent form provided.**
 Dr Bronwen Davies Robert Searle	**Please contact myself (Cardiff University - 02920 870582) or Bronwen (Caswell Clinic - 01656 753025) if you have any questions, or ask a staff member to help you contact us.** **Thank you!**

41.0 APPENDIX N - PARTICIPANT CONSENT FORM (PHASE 2)

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

ID:_____

CONSENT FORM

PHASE 2

Study Title: **Impact of masculinity upon males with psychosis**

If you would like to participate in the research study, please read the following information and sign your name as indicated below:

- I have read and understood the Participant Information sheet for Phase 2 of the study.
- I understand what is being asked of me during the project.
- I have no questions or have asked all the questions which I had, which have been adequately answered by the researcher.
- I understand that I can withdraw my consent at any time.
- I understand that all the information I disclose will be kept confidential unless the researcher is worried about mine or someone else's safety.
- I am happy that all the information I disclose will be kept anonymized and written up in a report which may be submitted for publication.
- I would be happy to meet with the researcher and participate in the rating exercise.

If you do not want to take part, do not sign your name.

I agree to the above:

_____ _____ _____

Name (printed) *Signature* *Date*

_____ _____

Countersigned by researcher *Date*

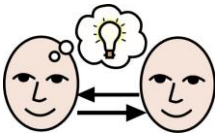
ID:_____

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

CONSENT FORM

PHASE 2

Study Title: **Impact of masculinity upon psychosis**



	Yes 	No 
Have you read (or had read to you) 'Participant Information Phase 2'?	[ ]	[ ]
Do you understand what you have been told about the project?	[ ]	[ ]
Have you asked all the questions you want?	[ ]	[ ]
Do you understand that you can stop taking part at any time?	[ ]	[ ]
Do you understand that everything you say will be confidential unless Rob is worried about someone's safety?	[ ]	[ ]
Would you like to meet Rob and participate in rating ideas of masculinity? Your responses will be recorded.	[ ]	[ ]
Do you agree to the things you say and do being written up in a report (anonymised)?	[ ]	[ ]

If you do not want to take part, do not sign your name.

I agree to the above:

_____ _____ _____

Service User's name (printed) *Signature* *Date*

_____ _____

Countersigned by researcher *Date*

42.0 APPENDIX O – Q-SORT ANALYSIS

PQMethod2.35 Masculinity & Psychosis PAGE 1

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Correlation Matrix Between Sorts

SORTS	1	2	3	4	5	6	7	8	9	10
1 AP	100	32	22	12	33	19	24	20	16	13
2 KJ	32	100	32	47	46	59	29	48	30	44
3 SG	22	32	100	29	43	52	43	25	27	26
4 AT	12	47	29	100	28	23	13	29	37	17
5 AG	33	46	43	28	100	22	34	25	27	51
6 WF	19	59	52	23	22	100	25	19	25	30
7 JM	24	29	43	13	34	25	100	31	24	11
8 JH	20	48	25	29	25	19	31	100	23	27
9 KH	16	30	27	37	27	25	24	23	100	21
10 JR	13	44	26	17	51	30	11	27	21	100

Unrotated Factor Matrix

Factors

	1	2	3	4	5	6	7	8
SORTS								
1 AP	0.4514	0.3942	0.1194	-0.4506	-0.1690	0.6001	0.0628	0.1121
2 KJ	0.7964	-0.2315	0.1008	0.0255	-0.3486	0.0759	0.0047	-0.2746
3 SG	0.6711	0.3271	-0.1973	0.3636	0.1463	-0.0602	-0.2157	0.4139
4 AT	0.5502	-0.5340	-0.3181	-0.1212	0.0761	0.1479	-0.4706	-0.0488
5 AG	0.6902	0.1325	0.3880	-0.1346	0.3743	-0.0136	-0.2266	-0.0648
6 WF	0.6414	0.0398	-0.0869	0.6024	-0.3084	0.1863	0.1671	-0.0595
7 JM	0.5399	0.5405	-0.3211	-0.1340	0.0725	-0.3509	0.0001	-0.3719
8 JH	0.5699	-0.1474	-0.0681	-0.4043	-0.4038	-0.4524	0.1179	0.2986
9 KH	0.5247	-0.2700	-0.3773	-0.1048	0.4706	0.1304	0.5040	0.0342
10 JR	0.5740	-0.1784	0.6468	0.1219	0.1696	-0.1806	0.1552	0.0221
Eigenvalues	3.7000	1.0389	0.9911	0.9388	0.8311	0.8037	0.6433	0.4986
% expl.Var.	37	10	10	9	8	8	6	5

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Cumulative Communalities Matrix

Factors 1 Thru ....

	1	2	3	4	5	6	7	8
SORTS								
1 AP	0.2038	0.3592	0.3734	0.5765	0.6050	0.9652	0.9691	0.9817
2 KJ	0.6343	0.6879	0.6980	0.6987	0.8202	0.8260	0.8260	0.9014
3 SG	0.4504	0.5574	0.5963	0.7285	0.7499	0.7535	0.8000	0.9713
4 AT	0.3027	0.5879	0.6891	0.7037	0.7095	0.7314	0.9529	0.9553
5 AG	0.4764	0.4940	0.6445	0.6626	0.8027	0.8029	0.8543	0.8585
6 WF	0.4114	0.4130	0.4205	0.7834	0.8785	0.9133	0.9412	0.9447
7 JM	0.2915	0.5837	0.6868	0.7047	0.7100	0.8331	0.8331	0.9714
8 JH	0.3248	0.3465	0.3511	0.5146	0.6776	0.8823	0.8962	0.9853
9 KH	0.2754	0.3483	0.4906	0.5016	0.7231	0.7401	0.9941	0.9953
10 JR	0.3295	0.3613	0.7797	0.7945	0.8233	0.8560	0.8800	0.8805
cum% expl.Var.	37	47	57	67	75	83	89	94

Factor Matrix with an X Indicating a Defining Sort

Loadings

QSORT	1	2	3
1 AP	-0.0274	0.5299X	0.3031
2 KJ	0.5776	0.2427	0.5527
3 SG	0.3058	0.6877X	0.1725
4 AT	0.8230X	-0.0185	0.1064
5 AG	0.1452	0.3882	0.6875X
6 WF	0.4096	0.4173	0.2804
7 JM	0.1561	0.8134X	-0.0273
8 JH	0.4721X	0.2259	0.2780
9 KH	0.6744X	0.1888	0.0127
10 JR	0.1369	0.0101	0.8723X
% expl.Var.	20	19	18

Path and Project Name: C:\Users\pre setup\Downloads\pqm235win\PQMethod/rob Mar 28 17

Free Distribution Data Results

QSORT	MEAN	ST.DEV.
1 AP	0.000	2.858
2 KJ	0.000	2.858
3 SG	0.000	2.858
4 AT	0.000	2.858
5 AG	0.000	2.858
6 WF	0.000	2.858
7 JM	0.000	2.858
8 JH	0.000	2.858
9 KH	0.000	2.858
10 JR	0.000	2.858

Path and Project Name: C:\Users\pre setup\Downloads\pqm235win\PQMethod/rob Mar 28 17

Factor Scores with Corresponding Ranks

No.	Statement	No.	Factors 1		2		3	
1	Sometimes you need to use physical violence to defend	1	0.34	17	-0.90	37	-0.55	34
2	Sometimes youve got to fight or people will walk all o	2	0.83	11	0.66	16	0.78	10
3	Men should watch football games instead of soap operas	3	0.52	16	-1.03	40	-0.20	28
4	A man should prefer watching action movies to reading	4	-0.07	28	0.92	11	0.18	21
5	Men should be tough	5	-0.13	30	-0.21	27	0.00	24
6	A man talks his way out of trouble	6	0.07	20	1.48	4	-1.23	44
7	A man does not go looking for trouble	7	2.23	1	0.11	23	1.55	4
8	Men should be physically strong	8	0.77	13	-0.28	28	0.39	19
9	Men should stop others from being hurt	9	1.19	8	0.80	14	0.70	12
10	Ignoring voices who belittle you is the right thing to	10	0.56	14	1.35	5	-0.88	39
11	Arguing back with voices who belittle you is the right	11	1.30	6	-1.33	46	-1.45	47
12	Men should protect and provide for their families	12	0.83	12	1.26	7	1.94	1
13	Men should be muscular	13	0.53	15	-0.32	30	-0.10	27
14	Men should be competitive	14	1.91	2	-0.30	29	0.08	22
15	Men should be smartly dressed	15	0.32	18	1.24	8	1.92	2
16	The best men are at the top of the pecking order	16	0.05	21	0.99	9	0.67	15
17	Being dominant stops others from attacking you	17	0.31	19	-0.02	24	0.67	15
18	A man should be in charge	18	-0.06	26	-0.60	33	-0.10	27
19	The more masculine you are the better others will trea	19	-0.38	33	1.48	3	0.96	8
20	Men should be in control	20	-0.44	34	0.32	21	0.76	11
21	A man should prefer to be ill than ask for help	21	-1.73	48	-1.14	42	0.29	20
22	Men who cry are weak	22	-1.79	49	-0.69	34	-2.23	49
23	Men should cope with difficulties on their own	23	-0.19	31	0.34	20	-1.35	46
24	Men should not talk about their emotions	24	-0.51	35	-1.80	49	-0.80	36
25	Men should not be vulnerable	25	1.53	3	0.43	18	-1.47	48
26	Men should not show that they are upset	26	-0.64	36	-1.03	39	-0.78	35
27	Men should not show any emotion	27	-1.15	43	-0.06	25	-0.98	41
28	Men should use drugs to cope with their emotions	28	-1.45	45	-1.24	44	-1.04	42
29	A man should not tell his problems to other people	29	-1.14	42	-0.73	36	0.86	9
30	A man should go to the gym and lift weights	30	-0.05	25	0.88	12	0.67	15
31	A man should have sex with as many women as possible	31	-1.14	41	-1.33	46	-0.29	30

32	Antipsychotics lessen my sex drive which makes me less	32	-0.01	22	0.15	22	-0.88	39
33	A man should be able to get errections	33	1.47	4	2.28	1	0.61	16
34	Men should not allow women to pay the bills	34	-1.03	39	0.69	15	-0.29	30
35	A man should be sexually active and have sexual relait	35	-0.31	32	0.82	13	-0.86	37
36	A man should not be reliant upon other people	36	-0.01	23	0.92	10	-1.12	43
37	Men should be able to solve problems on their own	37	-1.48	46	1.57	2	0.49	18
38	A man is too proud to get help	38	-0.12	29	-0.37	31	0.57	17
39	A man makes his own decisions	39	-0.65	37	0.48	17	1.45	5
40	Men should be confident	40	1.34	5	1.31	6	-0.39	32
41	Men should look after their family	41	1.26	7	0.36	19	1.37	6
42	I would think less of another man if I were to find ou	42	-1.09	40	-1.12	41	-0.31	31
43	A man should never compliment another man	43	-1.02	38	-0.71	35	-0.10	27

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Factor Scores with Corresponding Ranks

No.	Statement	Factors No.	1		2		3	
44	Men should never hold hands or show affection towards	44	-0.02	24	-1.20	43	-0.49	33
45	I would be uncomfortable to be with a gay man on my ow	45	-1.16	44	-1.35	47	-0.98	41
46	It is important for a man to take risks even if he mig	46	1.01	10	-1.03	38	1.35	7
47	Pain is temporary glory is forever	47	-0.07	27	-0.48	32	1.84	3
48	A man should break the rules occasionally	48	1.01	10	-0.11	26	0.02	23
49	Men should rebel against society	49	-1.58	47	-1.46	48	-1.27	45

Correlations Between Factor Scores

	1	2	3
1	1.0000	0.3360	0.3025
2	0.3360	1.0000	0.3058
3	0.3025	0.3058	1.0000

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Factor Scores -- For Factor 1

No.	Statement	No.	Z-SCORES
7	A man does not go looking for trouble	7	2.226
14	Men should be competitive	14	1.912
25	Men should not be vulnerable	25	1.528
33	A man should be able to get errections	33	1.471
40	Men should be confident	40	1.344
11	Arguing back with voices who belittle you is the right thing	11	1.298
41	Men should look after their family	41	1.265
9	Men should stop others from being hurt	9	1.191
46	It is important for a man to take risks even if he might get	46	1.014
48	A man should break the rules occasionally	48	1.014
2	Sometimes youve got to fight or people will walk all over yo	2	0.832
12	Men should protect and provide for their families	12	0.826
8	Men should be physically strong	8	0.774
10	Ignoring voices who belittle you is the right thing to do	10	0.562
13	Men should be muscular	13	0.528
3	Men should watch football games instead of soap operas	3	0.524
1	Sometimes you need to use physical violence to defend what y	1	0.342
15	Men should be smartly dressed	15	0.320
17	Being dominant stops others from attacking you	17	0.314
6	A man talks his way out of trouble	6	0.069
16	The best men are at the top of the pecking order	16	0.051
32	Antipsychotics lessen my sex drive which makes me less of a	32	-0.007
36	A man should not be reliant upon other people	36	-0.010
44	Men should never hold hands or show affection towards anothe	44	-0.020
30	A man should go to the gym and lift weights	30	-0.051
18	A man should be in charge	18	-0.064
47	Pain is temporary glory is forever	47	-0.066
4	A man should prefer watching action movies to reading romant	4	-0.069
38	A man is too proud to get help	38	-0.117
5	Men should be tough	5	-0.131

23	Men should cope with difficulties on their own	23	-0.194
35	A man should be sexually active and have sexual relaitionshi	35	-0.306
19	The more masculine you are the better others will treat you	19	-0.375
20	Men should be in control	20	-0.437
24	Men should not talk about their emotions	24	-0.506
26	Men should not show that they are upset	26	-0.639
39	A man makes his own decisions	39	-0.651
43	A man should never compliment another man	43	-1.018
34	Men should not allow women to pay the bills	34	-1.030
42	I would think less of another man if I were to find out he w	42	-1.094
31	A man should have sex with as many women as possible	31	-1.140
29	A man should not tell his problems to other people	29	-1.142
27	Men should not show any emotion	27	-1.145

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Factor Scores -- For Factor 1

No.	Statement	No.	Z-SCORES
45	I would be uncomfortable to be with a gay man on my own	45	-1.158
28	Men should use drugs to cope with their emotions	28	-1.451
37	Men should be able to solve problems on their own	37	-1.484
49	Men should rebel against society	49	-1.582
21	A man should prefer to be ill than ask for help	21	-1.725
22	Men who cry are weak	22	-1.794

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Factor Scores -- For Factor 2

No.	Statement	No.	Z-SCORES
33	A man should be able to get errections	33	2.283
37	Men should be able to solve problems on their own	37	1.570
19	The more masculine you are the better others will treat you	19	1.482
6	A man talks his way out of trouble	6	1.479
10	Ignoring voices who belittle you is the right thing to do	10	1.348
40	Men should be confident	40	1.311
12	Men should protect and provide for their families	12	1.258
15	Men should be smartly dressed	15	1.236
16	The best men are at the top of the pecking order	16	0.993
36	A man should not be reliant upon other people	36	0.922
4	A man should prefer watching action movies to reading romant	4	0.916
30	A man should go to the gym and lift weights	30	0.882
35	A man should be sexually active and have sexual relaitionshi	35	0.817
9	Men should stop others from being hurt	9	0.803
34	Men should not allow women to pay the bills	34	0.692
2	Sometimes youve got to fight or people will walk all over yo	2	0.656
39	A man makes his own decisions	39	0.483
25	Men should not be vulnerable	25	0.431
41	Men should look after their family	41	0.355
23	Men should cope with difficulties on their own	23	0.336
20	Men should be in control	20	0.321
32	Antipsychotics lessen my sex drive which makes me less of a	32	0.149
7	A man does not go looking for trouble	7	0.111
17	Being dominant stops others from attacking you	17	-0.021
27	Men should not show any emotion	27	-0.057
48	A man should break the rules occasionally	48	-0.111
5	Men should be tough	5	-0.206
8	Men should be physically strong	8	-0.276
14	Men should be competitive	14	-0.298
13	Men should be muscular	13	-0.319

38	A man is too proud to get help	38	-0.371
47	Pain is temporary glory is forever	47	-0.482
18	A man should be in charge	18	-0.598
22	Men who cry are weak	22	-0.690
43	A man should never compliment another man	43	-0.713
29	A man should not tell his problems to other people	29	-0.733
1	Sometimes you need to use physical violence to defend what y	1	-0.897
46	It is important for a man to take risks even if he might get	46	-1.029
26	Men should not show that they are upset	26	-1.031
3	Men should watch football games instead of soap operas	3	-1.032
42	I would think less of another man if I were to find out he w	42	-1.121
21	A man should prefer to be ill than ask for help	21	-1.143
44	Men should never hold hands or show affection towards anothe	44	-1.203

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Factor Scores -- For Factor 2

No.	Statement	No.	Z-SCORES
28	Men should use drugs to cope with their emotions	28	-1.237
31	A man should have sex with as many women as possible	31	-1.330
11	Arguing back with voices who belittle you is the right thing	11	-1.330
45	I would be uncomfortable to be with a gay man on my own	45	-1.348
49	Men should rebel against society	49	-1.463
24	Men should not talk about their emotions	24	-1.796

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Factor Scores -- For Factor 3

No.	Statement	No.	Z-SCORES
12	Men should protect and provide for their families	12	1.943
15	Men should be smartly dressed	15	1.922
47	Pain is temporary glory is forever	47	1.841
7	A man does not go looking for trouble	7	1.554
39	A man makes his own decisions	39	1.452
41	Men should look after their family	41	1.370
46	It is important for a man to take risks even if he might get	46	1.350
19	The more masculine you are the better others will treat you	19	0.961
29	A man should not tell his problems to other people	29	0.859
2	Sometimes youve got to fight or people will walk all over yo	2	0.777
20	Men should be in control	20	0.756
9	Men should stop others from being hurt	9	0.696
16	The best men are at the top of the pecking order	16	0.675
17	Being dominant stops others from attacking you	17	0.675
30	A man should go to the gym and lift weights	30	0.675
33	A man should be able to get errections	33	0.614
38	A man is too proud to get help	38	0.572
37	Men should be able to solve problems on their own	37	0.491
8	Men should be physically strong	8	0.389
21	A man should prefer to be ill than ask for help	21	0.286
4	A man should prefer watching action movies to reading romant	4	0.184
14	Men should be competitive	14	0.082
48	A man should break the rules occasionally	48	0.021
5	Men should be tough	5	0.000
13	Men should be muscular	13	-0.102
18	A man should be in charge	18	-0.102
43	A man should never compliment another man	43	-0.102
3	Men should watch football games instead of soap operas	3	-0.205
31	A man should have sex with as many women as possible	31	-0.286
34	Men should not allow women to pay the bills	34	-0.286

42	I would think less of another man if I were to find out he w	42	-0.307
40	Men should be confident	40	-0.389
44	Men should never hold hands or show affection towards anothe	44	-0.491
1	Sometimes you need to use physical violence to defend what y	1	-0.552
26	Men should not show that they are upset	26	-0.777
24	Men should not talk about their emotions	24	-0.798
35	A man should be sexually active and have sexual relaitionshi	35	-0.859
32	Antipsychotics lessen my sex drive which makes me less of a	32	-0.879
10	Ignoring voices who belittle you is the right thing to do	10	-0.879
27	Men should not show any emotion	27	-0.982
45	I would be uncomfortable to be with a gay man on my own	45	-0.982
28	Men should use drugs to cope with their emotions	28	-1.043
36	A man should not be reliant upon other people	36	-1.124

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Factor Scores -- For Factor 3

No.	Statement	No.	Z-SCORES
6	A man talks his way out of trouble	6	-1.227
49	Men should rebel against society	49	-1.268
23	Men should cope with difficulties on their own	23	-1.350
11	Arguing back with voices who belittle you is the right thing	11	-1.452
25	Men should not be vulnerable	25	-1.473
22	Men who cry are weak	22	-2.229

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Descending Array of Differences Between Factors 1 and 2

No.	Statement	No.	Type 1	Type 2	Difference
11	Arguing back with voices who belittle you is the right thing	11	1.298	-1.330	2.628
14	Men should be competitive	14	1.912	-0.298	2.210
7	A man does not go looking for trouble	7	2.226	0.111	2.115
46	It is important for a man to take risks even if he might get	46	1.014	-1.029	2.044
3	Men should watch football games instead of soap operas	3	0.524	-1.032	1.556
24	Men should not talk about their emotions	24	-0.506	-1.796	1.290
1	Sometimes you need to use physical violence to defend what y	1	0.342	-0.897	1.239
44	Men should never hold hands or show affection towards anothe	44	-0.020	-1.203	1.183
48	A man should break the rules occasionally	48	1.014	-0.111	1.126
25	Men should not be vulnerable	25	1.528	0.431	1.097
8	Men should be physically strong	8	0.774	-0.276	1.050
41	Men should look after their family	41	1.265	0.355	0.909
13	Men should be muscular	13	0.528	-0.319	0.847
18	A man should be in charge	18	-0.064	-0.598	0.535
47	Pain is temporary glory is forever	47	-0.066	-0.482	0.416
26	Men should not show that they are upset	26	-0.639	-1.031	0.391
9	Men should stop others from being hurt	9	1.191	0.803	0.388
17	Being dominant stops others from attacking you	17	0.314	-0.021	0.335
38	A man is too proud to get help	38	-0.117	-0.371	0.254
45	I would be uncomfortable to be with a gay man on my own	45	-1.158	-1.348	0.190
31	A man should have sex with as many women as possible	31	-1.140	-1.330	0.190
2	Sometimes youve got to fight or people will walk all over yo	2	0.832	0.656	0.177
5	Men should be tough	5	-0.131	-0.206	0.076
40	Men should be confident	40	1.344	1.311	0.033
42	I would think less of another man if I were to find out he w	42	-1.094	-1.121	0.027
49	Men should rebel against society	49	-1.582	-1.463	-0.119
32	Antipsychotics lessen my sex drive which makes me less of a	32	-0.007	0.149	-0.156
28	Men should use drugs to cope with their emotions	28	-1.451	-1.237	-0.214
43	A man should never compliment another man	43	-1.018	-0.713	-0.305
29	A man should not tell his problems to other people	29	-1.142	-0.733	-0.409
12	Men should protect and provide for their families	12	0.826	1.258	-0.432

23	Men should cope with difficulties on their own	23	-0.194	0.336	-0.530
21	A man should prefer to be ill than ask for help	21	-1.725	-1.143	-0.582
20	Men should be in control	20	-0.437	0.321	-0.758
10	Ignoring voices who belittle you is the right thing to do	10	0.562	1.348	-0.786
33	A man should be able to get errections	33	1.471	2.283	-0.812
15	Men should be smartly dressed	15	0.320	1.236	-0.916
36	A man should not be reliant upon other people	36	-0.010	0.922	-0.932
30	A man should go to the gym and lift weights	30	-0.051	0.882	-0.933
16	The best men are at the top of the pecking order	16	0.051	0.993	-0.941
4	A man should prefer watching action movies to reading	4	-0.069	0.916	-0.985
27	Men should not show any emotion	27	-1.145	-0.057	-1.088
22	Men who cry are weak	22	-1.794	-0.690	-1.105

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Descending Array of Differences Between Factors 1 and 2

No.	Statement	No.	Type 1	Type 2	Difference
35	A man should be sexually active and have sexual rel	35	-0.306	0.817	-1.123
39	A man makes his own decisions	39	-0.651	0.483	-1.135
6	A man talks his way out of trouble	6	0.069	1.479	-1.409
34	Men should not allow women to pay the bills	34	-1.030	0.692	-1.722
19	The more masculine you are the better others will treat you	19	-0.375	1.482	-1.858
37	Men should be able to solve problems on their own	37	-1.484	1.570	-3.054

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Descending Array of Differences Between Factors 1 and 3

No.	Statement	No.	Type 1	Type 3	Difference
25	Men should not be vulnerable	25	1.528	-1.473	3.001
11	Arguing back with voices who belittle you is the right thing	11	1.298	-1.452	2.750
14	Men should be competitive	14	1.912	0.082	1.830
40	Men should be confident	40	1.344	-0.389	1.733
10	Ignoring voices who belittle you is the right thing to do	10	0.562	-0.879	1.441
6	A man talks his way out of trouble	6	0.069	-1.227	1.296
23	Men should cope with difficulties on their own	23	-0.194	-1.350	1.155
36	A man should not be reliant upon other people	36	-0.010	-1.124	1.114
48	A man should break the rules occasionally	48	1.014	0.021	0.994
1	Sometimes you need to use physical violence to defend what y	1	0.342	-0.552	0.894
32	Antipsychotics lessen my sex drive which makes me less of a	32	-0.007	-0.879	0.873
33	A man should be able to get errections	33	1.471	0.614	0.857
3	Men should watch football games instead of soap operas	3	0.524	-0.205	0.729
7	A man does not go looking for trouble	7	2.226	1.554	0.671
13	Men should be muscular	13	0.528	-0.102	0.631
35	A man should be sexually active and have sexual relaitionshi	35	-0.306	-0.859	0.553
9	Men should stop others from being hurt	9	1.191	0.696	0.495
44	Men should never hold hands or show affection towards anothe	44	-0.020	-0.491	0.471
22	Men who cry are weak	22	-1.794	-2.229	0.435
8	Men should be physically strong	8	0.774	0.389	0.386
24	Men should not talk about their emotions	24	-0.506	-0.798	0.292
26	Men should not show that they are upset	26	-0.639	-0.777	0.138
2	Sometimes youve got to fight or people will walk all over yo	2	0.832	0.777	0.055
18	A man should be in charge	18	-0.064	-0.102	0.039
41	Men should look after their family	41	1.265	1.370	-0.106
5	Men should be tough	5	-0.131	0.000	-0.131
27	Men should not show any emotion	27	-1.145	-0.982	-0.163
45	I would be uncomfortable to be with a gay man on my own	45	-1.158	-0.982	-0.176
4	A man should prefer watching action movies to reading romant	4	-0.069	0.184	-0.253
49	Men should rebel against society	49	-1.582	-1.268	-0.314
46	It is important for a man to take risks even if he might get	46	1.014	1.350	-0.335

17	Being dominant stops others from attacking you	17	0.314	0.675	-0.361
28	Men should use drugs to cope with their emotions	28	-1.451	-1.043	-0.409
16	The best men are at the top of the pecking order	16	0.051	0.675	-0.623
38	A man is too proud to get help	38	-0.117	0.572	-0.690
30	A man should go to the gym and lift weights	30	-0.051	0.675	-0.726
34	Men should not allow women to pay the bills	34	-1.030	-0.286	-0.744
42	I would think less of another man if I were to find out he w	42	-1.094	-0.307	-0.787
31	A man should have sex with as many women as possible	31	-1.140	-0.286	-0.853
43	A man should never compliment another man	43	-1.018	-0.102	-0.915
12	Men should protect and provide for their families	12	0.826	1.943	-1.117
20	Men should be in control	20	-0.437	0.756	-1.193
19	The more masculine you are the better others will treat you	19	-0.375	0.961	-1.336

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Descending Array of Differences Between Factors 1 and 3

No.	Statement	No.	Type 1	Type 3	Difference
15	Men should be smartly dressed	15	0.320	1.922	-1.603
47	Pain is temporary glory is forever	47	-0.066	1.841	-1.907
37	Men should be able to solve problems on their own	37	-1.484	0.491	-1.975
29	A man should not tell his problems to other people	29	-1.142	0.859	-2.001
21	A man should prefer to be ill than ask for help	21	-1.725	0.286	-2.011
39	A man makes his own decisions	39	-0.651	1.452	-2.103

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Descending Array of Differences Between Factors 2 and 3

No.	Statement	No.	Type 2	Type 3	Difference
6	A man talks his way out of trouble	6	1.479	-1.227	2.705
10	Ignoring voices who belittle you is the right thing to do	10	1.348	-0.879	2.227
36	A man should not be reliant upon other people	36	0.922	-1.124	2.046
25	Men should not be vulnerable	25	0.431	-1.473	1.904
40	Men should be confident	40	1.311	-0.389	1.700
23	Men should cope with difficulties on their own	23	0.336	-1.350	1.685
35	A man should be sexually active and have sexual rel	35	0.817	-0.859	1.675
33	A man should be able to get errections	33	2.283	0.614	1.669
22	Men who cry are weak	22	-0.690	-2.229	1.539
37	Men should be able to solve problems on their own	37	1.570	0.491	1.079
32	Antipsychotics lessen my sex drive which makes me less	32	0.149	-0.879	1.028
34	Men should not allow women to pay the bills	34	0.692	-0.286	0.979
27	Men should not show any emotion	27	-0.057	-0.982	0.924
4	A man should prefer watching action movies to reading ro	4	0.916	0.184	0.732
19	The more masculine you are the better others will treat y	19	1.482	0.961	0.521
16	The best men are at the top of the pecking order	16	0.993	0.675	0.318
30	A man should go to the gym and lift weights	30	0.882	0.675	0.207
11	Arguing back with voices who belittle you is the right thing	11	-1.330	-1.452	0.122
9	Men should stop others from being hurt	9	0.803	0.696	0.108
2	Sometimes youve got to fight or people will walk all over	2	0.656	0.777	-0.121
48	A man should break the rules occasionally	48	-0.111	0.021	-0.132
28	Men should use drugs to cope with their emotions	28	-1.237	-1.043	-0.194
49	Men should rebel against society	49	-1.463	-1.268	-0.195
5	Men should be tough	5	-0.206	0.000	-0.206
13	Men should be muscular	13	-0.319	-0.102	-0.216
26	Men should not show that they are upset	26	-1.031	-0.777	-0.253
1	Sometimes you need to use physical violence to defend	1	-0.897	-0.552	-0.346
45	I would be uncomfortable to be with a gay man on my o	45	-1.348	-0.982	-0.366
14	Men should be competitive	14	-0.298	0.082	-0.379
20	Men should be in control	20	0.321	0.756	-0.435
18	A man should be in charge	18	-0.598	-0.102	-0.496

43	A man should never compliment another man	43	-0.713	-0.102	-0.611
8	Men should be physically strong	8	-0.276	0.389	-0.664
12	Men should protect and provide for their families	12	1.258	1.943	-0.685
15	Men should be smartly dressed	15	1.236	1.922	-0.687
17	Being dominant stops others from attacking you	17	-0.021	0.675	-0.696
44	Men should never hold hands or show affection towards a	44	-1.203	-0.491	-0.712
42	I would think less of another man if I were to find out he	42	-1.121	-0.307	-0.814
3	Men should watch football games instead of soap operas	3	-1.032	-0.205	-0.827
38	A man is too proud to get help	38	-0.371	0.572	-0.944
39	A man makes his own decisions	39	0.483	1.452	-0.969
24	Men should not talk about their emotions	24	-1.796	-0.798	-0.998
41	Men should look after their family	41	0.355	1.370	-1.015

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Descending Array of Differences Between Factors 2 and 3

No.	Statement	No.	Type 2	Type 3	Difference
31	A man should have sex with as many women as possible	31	-1.330	-0.286	-1.043
21	A man should prefer to be ill than ask for help	21	-1.143	0.286	-1.429
7	A man does not go looking for trouble	7	0.111	1.554	-1.443
29	A man should not tell his problems to other people	29	-0.733	0.859	-1.591
47	Pain is temporary glory is forever	47	-0.482	1.841	-2.323
46	It is important for a man to take risks even if he might get	46	-1.029	1.350	-2.379

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Exact Factor Scores (á la SPSS) in Z-Score and T-Score units

No.	Statement	Factors No.	1		2		3	
1	Sometimes you need to use physical violence to defend	1	-0.27	47	-0.60	44	-0.25	48
2	Sometimes youve got to fight or people will walk all o	2	0.05	51	0.37	54	-0.01	50
3	Men should watch football games instead of soap operas	3	0.71	57	-1.63	34	-0.32	47
4	A man should prefer watching action movies to reading	4	-0.31	47	0.96	60	-0.07	49
5	Men should be tough	5	0.07	51	-0.13	49	-0.13	49
6	A man talks his way out of trouble	6	0.15	51	1.54	65	-0.99	40
7	A man does not go looking for trouble	7	2.13	71	-0.65	44	1.24	62
8	Men should be physically strong	8	0.68	57	-0.31	47	0.25	53
9	Men should stop others from being hurt	9	1.31	63	0.65	57	0.60	56
10	Ignoring voices who belittle you is the right thing to	10	0.95	60	1.64	66	-1.27	37
11	Arguing back with voices who belittle you is the right	11	1.67	67	-1.21	38	-0.51	45
12	Men should protect and provide for their families	12	0.47	55	1.27	63	1.77	68
13	Men should be muscular	13	0.59	56	-0.73	43	-0.60	44
14	Men should be competitive	14	2.45	74	-1.02	40	-0.34	47
15	Men should be smartly dressed	15	-0.19	48	0.61	56	1.20	62
16	The best men are at the top of the pecking order	16	0.20	52	0.75	57	0.53	55
17	Being dominant stops others from attacking you	17	0.22	52	-0.43	46	0.49	55
18	A man should be in charge	18	0.06	51	-0.80	42	-0.16	48
19	The more masculine you are the better others will trea	19	-0.35	46	1.23	62	0.53	55
20	Men should be in control	20	-0.59	44	0.09	51	0.50	55
21	A man should prefer to be ill than ask for help	21	-1.45	35	-0.97	40	0.30	53
22	Men who cry are weak	22	-0.92	41	0.05	51	-2.53	25
23	Men should cope with difficulties on their own	23	-0.18	48	1.06	61	-0.91	41
24	Men should not talk about their emotions	24	0.14	51	-1.72	33	-0.16	48
25	Men should not be vulnerable	25	2.03	70	-0.15	49	-2.30	27
26	Men should not show that they are upset	26	-0.27	47	-0.70	43	-0.65	44
27	Men should not show any emotion	27	-1.16	38	0.44	54	-1.21	38
28	Men should use drugs to cope with their emotions	28	-1.69	33	-0.92	41	-0.46	45
29	A man should not tell his problems to other people	29	-1.68	33	-0.95	40	1.44	64
30	A man should go to the gym and lift weights	30	-0.15	49	0.77	58	0.40	54
31	A man should have sex with as many women as possible	31	-1.40	36	-0.84	42	0.53	55

32	Antipsychotics lessen my sex drive which makes me	32	-0.38	46	0.19	52	-0.83	42
33	A man should be able to get errections	33	0.64	56	2.07	71	-0.01	50
34	Men should not allow women to pay the bills	34	-0.63	44	1.11	61	-0.15	49
35	A man should be sexually active and have sexual relait	35	-0.99	40	0.85	59	-0.36	46
36	A man should not be reliant upon other people	36	0.25	52	1.30	63	-1.25	37
37	Men should be able to solve problems on their own	37	-1.37	36	1.98	70	1.02	60
38	A man is too proud to get help	38	0.07	51	-0.44	46	0.74	57
39	A man makes his own decisions	39	-0.95	40	0.85	59	1.76	68
40	Men should be confident	40	1.29	63	1.08	61	-0.48	45
41	Men should look after their family	41	1.28	63	0.36	54	1.51	65
42	I would think less of another man if I were to find ou	42	-0.96	40	-0.84	42	-0.44	46
43	A man should never compliment another man	43	-1.00	40	-0.58	44	-0.21	48

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Exact Factor Scores (á la SPSS) in Z-Score and T-Score units

			Factors					
No.	Statement	No.	1		2		3	
44	Men should never hold hands or show affection towards	44	-0.02	50	-1.14	39	-0.27	47
45	I would be uncomfortable to be with a gay man on my ow	45	-0.83	42	-1.13	39	-0.90	41
46	It is important for a man to take risks even if he mig	46	0.84	58	-1.37	36	1.50	65
47	Pain is temporary glory is forever	47	0.35	54	-0.61	44	2.47	75
48	A man should break the rules occasionally	48	0.46	55	-0.24	48	-0.29	47
49	Men should rebel against society	49	-1.35	37	-1.10	39	-0.70	43

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Factor Q-Sort Values for Each Statement

No.	Statement	No.	Factor Arrays 1	2	3
1	Sometimes you need to use physical violence to defend what y	1	1	-2	-1
2	Sometimes youve got to fight or people will walk all over yo	2	2	1	3
3	Men should watch football games instead of soap operas	3	1	-3	0
4	A man should prefer watching action movies to reading romant	4	0	2	1
5	Men should be tough	5	-1	0	0
6	A man talks his way out of trouble	6	1	4	-4
7	A man does not go looking for trouble	7	6	0	4
8	Men should be physically strong	8	2	0	1
9	Men should stop others from being hurt	9	3	2	2
10	Ignoring voices who belittle you is the right thing to do	10	2	4	-2
11	Arguing back with voices who belittle you is the right thing	11	4	-4	-5
12	Men should protect and provide for their families	12	2	3	6
13	Men should be muscular	13	2	-1	0
14	Men should be competitive	14	5	-1	0
15	Men should be smartly dressed	15	1	3	5
16	The best men are at the top of the pecking order	16	1	3	2
17	Being dominant stops others from attacking you	17	1	0	2
18	A man should be in charge	18	0	-1	0
19	The more masculine you are the better others will treat you	19	-1	5	3
20	Men should be in control	20	-1	1	2
21	A man should prefer to be ill than ask for help	21	-5	-3	1
22	Men who cry are weak	22	-6	-1	-6
23	Men should cope with difficulties on their own	23	-1	1	-4
24	Men should not talk about their emotions	24	-2	-6	-2
25	Men should not be vulnerable	25	5	1	-5
26	Men should not show that they are upset	26	-2	-2	-2
27	Men should not show any emotion	27	-3	0	-3
28	Men should use drugs to cope with their emotions	28	-4	-4	-3
29	A man should not tell his problems to other people	29	-3	-2	3
30	A man should go to the gym and lift weights	30	0	2	2

31	A man should have sex with as many women as possible	31	-3	-4	-1
32	Antipsychotics lessen my sex drive which makes me less of a	32	0	0	-2
33	A man should be able to get errections	33	4	6	1
34	Men should not allow women to pay the bills	34	-2	2	-1
35	A man should be sexually active and have sexual relaitionshi	35	-1	2	-2
36	A man should not be reliant upon other people	36	0	3	-3
37	Men should be able to solve problems on their own	37	-4	5	1
38	A man is too proud to get help	38	-1	-1	1
39	A man makes his own decisions	39	-2	1	4
40	Men should be confident	40	4	4	-1
41	Men should look after their family	41	3	1	4
42	I would think less of another man if I were to find out he w	42	-3	-3	-1
43	A man should never compliment another man	43	-2	-2	0
44	Men should never hold hands or show affection towards anothe	44	0	-3	-1

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Factor Arrays

No.	Statement	No.	1	2	3
45	I would be uncomfortable to be with a gay man on my own	45	-4	-5	-3
46	It is important for a man to take risks even if he might get	46	3	-2	3
47	Pain is temporary glory is forever	47	0	-1	5
48	A man should break the rules occasionally	48	3	0	0
49	Men should rebel against society	49	-5	-5	-4

Variance = 8.000 St. Dev. = 2.828

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Factor Q-Sort Values for Statements sorted by Consensus vs. Disagreement (Variance across Factor Z-Scores)

		Factor Arrays			
No.	Statement	No.	1	2	3
2	Sometimes youve got to fight or people will walk all over yo	2	2	1	3
5	Men should be tough	5	-1	0	0
49	Men should rebel against society	49	-5	-5	-4
45	I would be uncomfortable to be with a gay man on my own	45	-4	-5	-3
26	Men should not show that they are upset	26	-2	-2	-2
28	Men should use drugs to cope with their emotions	28	-4	-4	-3
9	Men should stop others from being hurt	9	3	2	2
18	A man should be in charge	18	0	-1	0
17	Being dominant stops others from attacking you	17	1	0	2
13	Men should be muscular	13	2	-1	0
42	I would think less of another man if I were to find out he w	42	-3	-3	-1
43	A man should never compliment another man	43	-2	-2	0
16	The best men are at the top of the pecking order	16	1	3	2
38	A man is too proud to get help	38	-1	-1	1
30	A man should go to the gym and lift weights	30	0	2	2
4	A man should prefer watching action movies to reading romant	4	0	2	1
8	Men should be physically strong	8	2	0	1
32	Antipsychotics lessen my sex drive which makes me less of a	32	0	0	-2
31	A man should have sex with as many women as possible	31	-3	-4	-1
41	Men should look after their family	41	3	1	4
12	Men should protect and provide for their families	12	2	3	6
27	Men should not show any emotion	27	-3	0	-3
44	Men should never hold hands or show affection towards anothe	44	0	-3	-1
20	Men should be in control	20	-1	1	2
48	A man should break the rules occasionally	48	3	0	0
1	Sometimes you need to use physical violence to defend what y	1	1	-2	-1
24	Men should not talk about their emotions	24	-2	-6	-2
3	Men should watch football games instead of soap operas	3	1	-3	0
22	Men who cry are weak	22	-6	-1	-6
15	Men should be smartly dressed	15	1	3	5

33	A man should be able to get errections	33	4	6	1
35	A man should be sexually active and have sexual relaitionshi	35	-1	2	-2
23	Men should cope with difficulties on their own	23	-1	1	-4
34	Men should not allow women to pay the bills	34	-2	2	-1
19	The more masculine you are the better others will treat you	19	-1	5	3
40	Men should be confident	40	4	4	-1
36	A man should not be reliant upon other people	36	0	3	-3
21	A man should prefer to be ill than ask for help	21	-5	-3	1
39	A man makes his own decisions	39	-2	1	4
29	A man should not tell his problems to other people	29	-3	-2	3
7	A man does not go looking for trouble	7	6	0	4
10	Ignoring voices who belittle you is the right thing to do	10	2	4	-2
14	Men should be competitive	14	5	-1	0
47	Pain is temporary glory is forever	47	0	-1	5

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Factor Arrays

No.	Statement	No.	1	2	3
46	It is important for a man to take risks even if he might get	46	3	-2	3
6	A man talks his way out of trouble	6	1	4	-4
25	Men should not be vulnerable	25	5	1	-5
37	Men should be able to solve problems on their own	37	-4	5	1
11	Arguing back with voices who belittle you is the right thing	11	4	-4	-5

Factor Characteristics

	Factors		
	1	2	3
No. of Defining Variables	3	3	2
Average Rel. Coef.	0.800	0.800	0.800
Composite Reliability	0.923	0.923	0.889
S.E. of Factor Z-Scores	0.277	0.277	0.333

Standard Errors for Differences in Factor Z-Scores

(Diagonal Entries Are S.E. Within Factors)

Factors	1	2	3
1	0.392	0.392	0.434
2	0.392	0.392	0.434
3	0.434	0.434	0.471

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Distinguishing Statements for Factor 1

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

Both the Factor Q-Sort Value (Q-SV) and the Z-Score (Z-SCR) are Shown.

Factors

		1		2		3	
No. Statement	No.	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR
14 Men should be competitive	14	5	1.91*	-1	-0.30	0	0.08
25 Men should not be vulnerable	25	5	1.53*	1	0.43	-5	-1.47
33 A man should be able to get errections	33	4	1.47	6	2.28	1	0.61
11 Arguing back with voices who belittle you is the right thing	11	4	1.30*	-4	-1.33	-5	-1.45
48 A man should break the rules occasionally	48	3	1.01	0	-0.11	0	0.02
10 Ignoring voices who belittle you is the right thing to do	10	2	0.56	4	1.35	-2	-0.88
1 Sometimes you need to use physical violence to defend	1	1	0.34	-2	-0.90	-1	-0.55
15 Men should be smartly dressed	15	1	0.32	3	1.24	5	1.92
6 A man talks his way out of trouble	6	1	0.07*	4	1.48	-4	-1.23
36 A man should not be reliant upon other people	36	0	-0.01	3	0.92	-3	-1.12
19 The more masculine you are the better others will treat you	19	-1	-0.38*	5	1.48	3	0.96
39 A man makes his own decisions	39	-2	-0.65*	1	0.48	4	1.45
37 Men should be able to solve problems on their own	37	-4	-1.48*	5	1.57	1	0.49

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Distinguishing Statements for Factor 2

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

Both the Factor Q-Sort Value (Q-SV) and the Z-Score (Z-SCR) are Shown.

Factors

		1		2		3	
No. Statement	No.	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR
33 A man should be able to get errections	33	4	1.47	6	2.28	1	0.61
37 Men should be able to solve problems on their own	37	-4	-1.48	5	1.57	1	0.49
6 A man talks his way out of trouble	6	1	0.07	4	1.48*	-4	-1.23
10 Ignoring voices who belittle you is the right thing to do	10	2	0.56	4	1.35	-2	-0.88
36 A man should not be reliant upon other people	36	0	-0.01	3	0.92	-3	-1.12
35 A man should be sexually active and have sexual relaiti	35	-1	-0.31	2	0.82*	-2	-0.86
34 Men should not allow women to pay the bills	34	-2	-1.03	2	0.69	-1	-0.29
39 A man makes his own decisions	39	-2	-0.65	1	0.48	4	1.45
25 Men should not be vulnerable	25	5	1.53	1	0.43*	-5	-1.47
41 Men should look after their family	41	3	1.26	1	0.36	4	1.37
7 A man does not go looking for trouble	7	6	2.23	0	0.11*	4	1.55
27 Men should not show any emotion	27	-3	-1.15	0	-0.06	-3	-0.98
22 Men who cry are weak	22	-6	-1.79	-1	-0.69*	-6	-2.23
46 It is important for a man to take risks even if he might	46	3	1.01	-2	-1.03*	3	1.35
24 Men should not talk about their emotions	24	-2	-0.51	-6	-1.80	-2	-0.80

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Distinguishing Statements for Factor 3

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

Both the Factor Q-Sort Value (Q-SV) and the Z-Score (Z-SCR) are Shown.

Factors

		1		2		3	
No. Statement	No.	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR
47 Pain is temporary glory is forever	47	0	-0.07	-1	-0.48	5	1.84*
39 A man makes his own decisions	39	-2	-0.65	1	0.48	4	1.45
29 A man should not tell his problems to other people	29	-3	-1.14	-2	-0.73	3	0.86*
33 A man should be able to get errections	33	4	1.47	6	2.28	1	0.61
37 Men should be able to solve problems on their own	37	-4	-1.48	5	1.57	1	0.49
21 A man should prefer to be ill than ask for help	21	-5	-1.73	-3	-1.14	1	0.29*
31 A man should have sex with as many women as possibl	31	-3	-1.14	-4	-1.33	-1	-0.29
40 Men should be confident	40	4	1.34	4	1.31	-1	-0.39*
32 Antipsychotics lessen my sex drive which makes me	32	0	-0.01	0	0.15	-2	-0.88
10 Ignoring voices who belittle you is the right thing to do	10	2	0.56	4	1.35	-2	-0.88*
36 A man should not be reliant upon other people	36	0	-0.01	3	0.92	-3	-1.12
6 A man talks his way out of trouble	6	1	0.07	4	1.48	-4	-1.23*
23 Men should cope with difficulties on their own	23	-1	-0.19	1	0.34	-4	-1.35*
25 Men should not be vulnerable	25	5	1.53	1	0.43	-5	-1.47*

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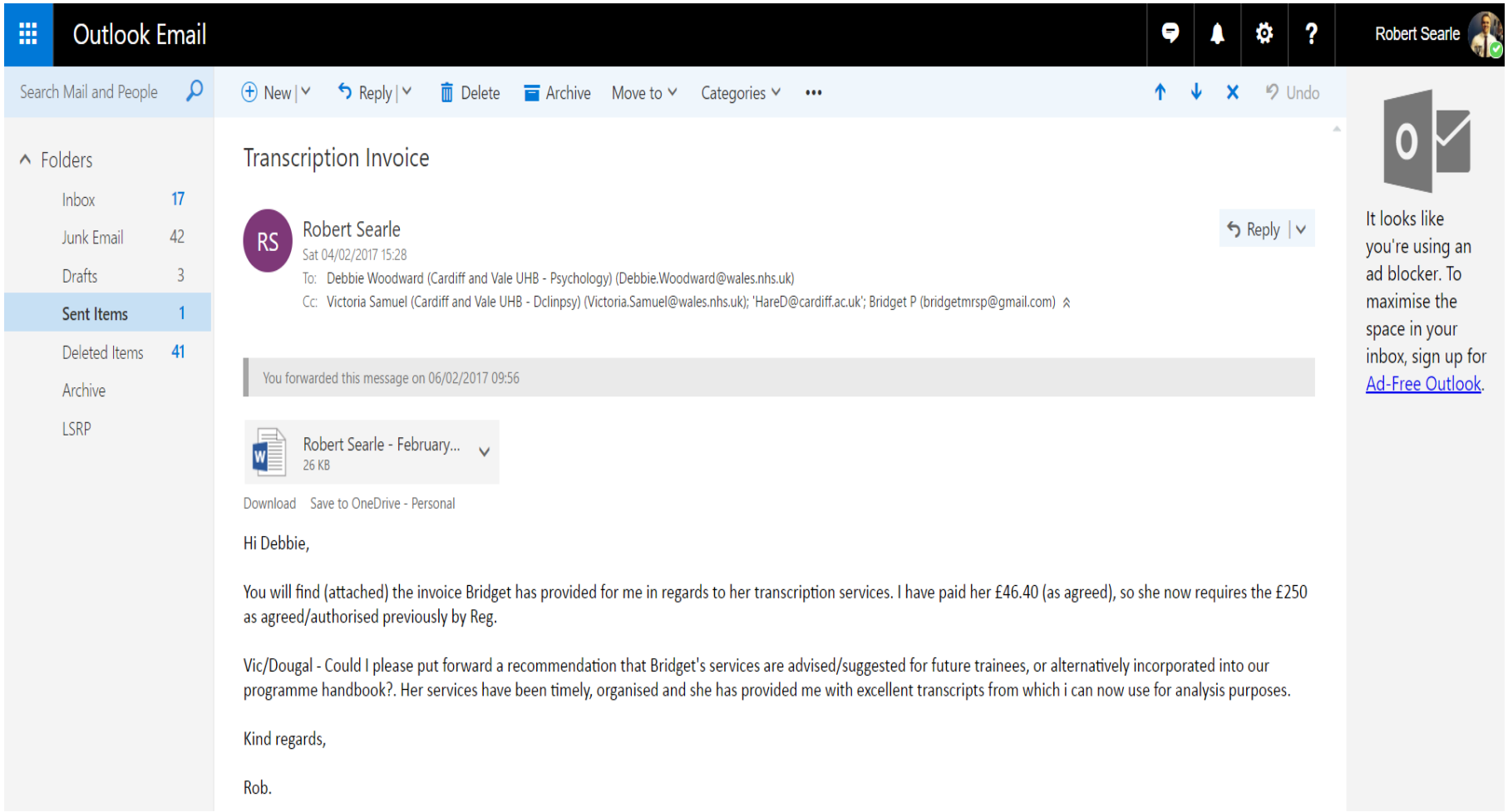
Consensus Statements -- Those That Do Not Distinguish Between ANY Pair of Factors.

All Listed Statements are Non-Significant at P>.01, and Those Flagged With an * are also Non-Significant at P>.05.

		Factors					
		1		2		3	
No.	Statement	No.	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR
2*	Sometimes youve got to fight or people will walk all over yo	2	2	0.83	1	0.66	3	0.78
4	A man should prefer watching action movies to reading	4	0	-0.07	2	0.92	1	0.18
5*	Men should be tough	5	-1	-0.13	0	-0.21	0	0.00
9*	Men should stop others from being hurt	9	3	1.19	2	0.80	2	0.70
12	Men should protect and provide for their families	12	2	0.83	3	1.26	6	1.94
13	Men should be muscular	13	2	0.53	-1	-0.32	0	-0.10
16	The best men are at the top of the pecking order	16	1	0.05	3	0.99	2	0.67
17*	Being dominant stops others from attacking you	17	1	0.31	0	-0.02	2	0.67
18*	A man should be in charge	18	0	-0.06	-1	-0.60	0	-0.10
26*	Men should not show that they are upset	26	-2	-0.64	-2	-1.03	-2	-0.78
28*	Men should use drugs to cope with their emotions	28	-4	-1.45	-4	-1.24	-3	-1.04
30	A man should go to the gym and lift weights	30	0	-0.05	2	0.88	2	0.67
31	A man should have sex with as many women as possible	31	-3	-1.14	-4	-1.33	-1	-0.29
32	Antipsychotics lessen my sex drive which makes me less	32	0	-0.01	0	0.15	-2	-0.88
38	A man is too proud to get help	38	-1	-0.12	-1	-0.37	1	0.57
41	Men should look after their family	41	3	1.26	1	0.36	4	1.37
42*	I would think less of another man if I were to find out he w	42	-3	-1.09	-3	-1.12	-1	-0.31
43	A man should never compliment another man	43	-2	-1.02	-2	-0.71	0	-0.10
45*	I would be uncomfortable to be with a gay man on my own	45	-4	-1.16	-5	-1.35	-3	-0.98
49*	Men should rebel against society	49	-5	-1.58	-5	-1.46	-4	-1.27

QANALYZE was completed at 16:21:07

43.0 APPENDIX P – RECOMMENDATION OF TRANSCRIBER



44.0 APPENDIX Q – EXAMPLE FEEDBACK FROM TRAINING SESSION

Feedback report on teaching sessions

Cohort:	Facilitator:
Date: 26 January 2017	Subject: Ethics workshop

1. **Please circle (and include any additional comments below)**

Were key references identified?	Yes	No
Were adequate handouts given?	Yes	~~No~~
Were a variety of teaching methods used?	~~Yes~~	No
Was the content relevant to clinical practice?	Yes	No
Was service user perspective included?	Yes	No
Any Comments?		

2. **How useful was the teaching at this stage of training?**
   0 =not at all ,5=extremely useful?

   0 1 2 3 4 (5)

3. **Did the session include content relevant to the domains of the syllabus (circle all that apply)**

   Clinical Cycle Skills for services (Research/Audit) Personal/professional

4. **Best things about the teaching were?**

   Reassuring of process
   info about what to do from 3rd yrs
   Varied experiences/types of study.

5. **Least satisfactory things about the teaching?**

   N/A.

   Thank you :)

6. **Suggested improvements?**

   This be offered as standard to everyone so people don't get put off doing NHS Ethics!

S:\Psy_Tng\FORMS\Feedback report on teaching sessions August2016.docx

45.0 APPENDIX R: INSTRUCTIONS FOR AUTHORS – JOURNAL OF PSYCHOSIS

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

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Contents list

About the journal

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Preparing your paper

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Word limits

Please include a word count for your paper.
A typical paper for this journal should be no more than 5000 words; this limit includes tables; references; figure captions; endnotes.
A typical First Person Account for this journal should be no more than 3000 words.
A typical Brief Report for this journal should be no more than 1000 words.
A typical Opinion Piece for this journal should be no more than 750.
A typical Letters to Editor for this journal should be no more than 400 words.
A typical Book Review for this journal should be no more than 750 words.

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Please use any spelling consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.

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Checklist: what to include

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In order to be published in a Taylor & Francis journal, all clinical trials must have been registered in a public repository at the beginning of the research process (prior to patient enrolment). Trial registration numbers should be included in the abstract, with full details in the methods section. The registry should be publicly accessible (at no charge), open to all prospective registrants, and managed by a not-for-profit organization. For a list of registries that meet these requirements, please visit the WHO International Clinical Trials Registry Platform (ICTRP). The registration of all clinical trials facilitates the sharing of information among clinicians, researchers, and patients, enhances public confidence in research, and is in accordance with the ICMJE guidelines.

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Please ensure that all research reported in submitted papers has been conducted in an ethical and responsible manner, and is in full compliance with all relevant codes of experimentation and legislation. All papers which report in vivo experiments or clinical trials on humans or animals must include a written statement in the Methods section. This should explain that all work was conducted with the formal approval of the local human subject or animal care committees (institutional and national), and that clinical trials have been registered as legislation requires. Authors who do not have formal ethics review committees should include a statement that their study follows the principles of the Declaration of Helsinki.

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Updated August 2016

46.0 APPENDIX S: INSTRUCTIONS FOR AUTHORS – JOURNAL OF FORENSIC STUDIES

Author Guidelines

AUTHOR RESOURCES

JFS Information for Authors
English Language Editing Resource
Electronic Artwork (Figures) Guidelines
Optimizing Abstracts for Search Engines Guide

INFORMATION FOR AUTHORS

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JFS requires that authors submitting manuscripts for peer review (Papers, Technical Notes, Case Reports and Reviews) have obtained required approval(s) for submission from authorized principals and/or internal reviews in their laboratories and/or organizations.

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Acknowledgements of financial support should appear as footnotes to the title of the paper on the title page

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The abstract should be no more than 150 words. *JFS* uses unstructured abstracts; however, the abstract should include the following – background, brief description of methods and results (give specific data and their statistical significance, if possible), and conclusions. Emphasize new and important aspects of the study or observations. The word **ABSTRACT** should be in all capital letters and bold.

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The text of observational and experimental articles is usually – but not necessarily – divided into sections with headings. *JFS* does not use an "Introduction" heading. The introductory text begins on the first text page. Other typical headings include Methods (or Materials and Methods), Results, and Discussion. Long articles may need subheadings within the sections to clarify their content, especially the Results and Discussion sections. Other types of articles, such as Case Reports, are likely to need different headings and subheadings. Generally, avoid overuse of subheadings, especially in the Methods section. Headings should be in upper and lower case and bolded, subheadings should be in upper and lower case and un-bolded and italicized, and sub-sub-headings should be in upper and lower case and normal text (no bold or italicize).

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Put a general description of methods in the Methods section. When data are summarized in the Results section, specify the statistical methods used to analyze them. Restrict tables and figures to those needed to explain the argument of the paper and to assess its support. Use graphs as an alternative to tables with many entries; do not duplicate data in graphs and tables.

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Results

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47.0 APPENDIX T – REJECTION EMAIL FROM THE JOURNAL OF FORENSIC PSYCHIATRY AND PSYCHOLOGY