A reflexive thematic analysis of the experiences of psychotherapy of adult men with a history of suicidality

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A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Adult Men with a History of Suicidality.

Alastair Coomes

Middlesex University and Metanoia Institute

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Abstract

Male suicide is an ever-pressing issue that presents a unique challenge to society. The impact of male suicide in the UK is considerable, and for every female suicide death, there are approximately 3.5 male deaths. For every successful suicide attempt, researchers speculate that there are twenty unsuccessful attempts and attempting suicide increases the likelihood of further attempts by up to 45 times. Despite significant research into the phenomenon, the number of successful suicides remains stubbornly high in the UK amongst men. Ultimately, a middle-aged man who has had a previous suicide attempt is at a very high risk of death by suicide. Despite the wide acknowledgement of the severity of male suicide, its disproportionate impact on families and society, and the encouragement of men to access formal and informal mental health support, there is minimal research on the experience of help-seeking for men recovering from a suicide attempt.
This research aimed to explore the experience of therapy of men aged between 25 and 65 who had a history of suicidality to generate much-needed information on their experience of help-seeking and how best to help men who have an arrested or unsuccessful suicide attempt.

Six male participants/co-researchers who had previously had an unsuccessful or arrested suicide attempt and had participated in individual long-term therapy (of at least 20 weeks) took part in the research. Data was collected through semi-structured interviews and analysed using reflexive thematic analysis within a critical realist paradigm. From this, three themes were identified: (1) Creating a safe space in therapy, (2) The push and pull of gender proximity, and (3) Iatrogenic harm in institutional care. Innovative methods of scriptwriting, acting, and filming were used to consolidate and display findings.

The data revealed the necessity for time and resources to develop safe therapeutic relationships to fully meet clients' needs and facilitate and support possible traumatic history revelations. Findings highlight a complex dynamic between the client's and therapist's gender, in the form of maternal representation, avoidance of competitiveness masculine traits and erotic transference within the therapeutic dyad. The experience of ineffective therapeutic help and high levels of bureaucracy from institutions, such as the NHS and their over-reliance on psychiatric medication, highlighted a significant issue and constituted a level of iatrogenic harm, which was a considerable influence in them seeking alternative provision in the form of private therapy or alternative medication.

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List of Abbreviations

A & E	Accident and Emergency
ACT-D	Acceptance and Commitment Therapy for depression
BACP	British Association for Counselling and Psychotherapy
BDSM	Bondage Domination Sadism and Masochism.
BHS	Beck Hopelessness scale
BPD	Borderline Personality Disorder
BPS	British Psychological Society
CALM	Campaign Against Living Miserably
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
CBSP	Cognitive Behavioural Suicide Prevention
CGT	Constructivist Grounded Theory
CPTSD	Complex Post-Traumatic Stress Disorder
CR	Critical Realism
DBT	Dialectical Behaviour Therapy
DCoP	Division of Counselling Psychology
DNS	Did Not Show
EMDR	Eye Movement Desensitisation and Reprocessing
GP	General Practitioner
IPA	Interpretative Phenomenological Analysis
LGBTQAI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, And Asexual
MT	Man Therapy
NA	Narcotics Anonymous
NHS	National Health Service
NSC	no suicide contracts
PE	Prolonged Exposure
PHQ-9	Patient Health Questionnaire
POMS	Profile of Mood States
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PTSD	Post-Traumatic Stress Disorder
RTA	Reflexive Thematic Analysis
SNRI	Serotonin And Norepinephrine Reuptake Inhibitors
SSRI	Selective Serotonin Reuptake Inhibitors
TA	Thematic Analysis
TMD	Total Mood Disturbance
UK	United Kingdom
UKCP	United Kingdom Council for Psychotherapy

Introduction and Background

On my first day working as a volunteer in a low-cost counselling service, as a trainee counselling psychologist, I sat across Michael, my first-ever client. Client one. Hour one. I nervously reviewed the questionnaires he had filled in at his assessment with the clinical lead of the service the previous week—a new experience of what would become a weekly ritual. A requirement of the centre was to track clients' progress session by session. Although familiar with the questions on the Patient Health Questionnaire-9 (Kroenke & Spitzer, 2002) (PHQ-9), I tried to look authoritative, as if I had viewed this material a thousand times before, but as I surveyed each of his nine responses, my anxiety once again rose.

My gaze alighted on his reply to the ninth statement: "thoughts that you would be better off dead or of hurting yourself in some way", a crossed-out number two indicating *more than half the days* and a firmly ringed number 3 indicating that Michael, a professional, and healthy man of considerable intelligence and independent wealth, had thoughts of killing himself or self-harming *nearly every day*. It transpired that he had, unbeknownst to the outside world, tried to end his own life on three separate occasions. Feeling ill-equipped and, like Bambi on ice, I stuttered through the suicide protocols I had rehearsed in triads the week before. Something like: 'Are you feeling suicidal now?', 'Do you have a plan in mind to end your life?', 'Do other people know you are feeling like this?' and 'What would you do if you continued to feel like this?' I am not sure if I asked him if he owned a loaded gun or had been stockpiling painkillers. Michael looked bemused or perhaps a touch embarrassed, and I am not sure my cack-handed attempt at making him feel safe worked particularly well. Over the coming months and years, I partook in similar, confessional-like affirmations of suicidality from the widest collection of often desolate individuals that beat a path to my therapy door. In that initial year of being a student practitioner, seven out of my first ten clients had attempted suicide or come very close to at one time or another. I never do feel wholly equipped to deal with this common occurrence, though I do know that there are people alive today despite or maybe because of my cack-handedness.

Perhaps the most basic premise of psychotherapy, psychology and psychiatry is to help people live better lives, unburdened them of the weight of mental health disorders and be happy. Sometimes the first step on that very subjective and broad path is to keep clients alive, not die at their own hands and offer them the hope to, at least, make it to the next appointment. Client suicide is an ever-present danger; it hovers, spectre-like, over every therapeutic consulting room and grasps the heart of many professionals, causing no end of anxiety in our profession. We, as psychotherapists and psychologists, have a duty, a fundamental tenant, to ameliorate clients' metaphorical and literal self-destruction and often, particularly when in our career infancy, this anxiety is heightened. When we are confronted with the potential or real loss of a client by suicide, it is devastating. It seems indiscriminate, the ultimate leveller and no one appears immune. In the past few years, some prominent men in the prime of their lives have taken their own lives, some closer to home than could be imagined. Keith Flint, whose band, The Prodigy, were signed to the same record label during my very short-lived music career, and Graham Thorpe, the Surrey and England Cricketer who took his own life at the train station of my childhood home. My old school friend Dyl.

There is a genuine impetus in the Western world and the UK to improve men's mental health in the hope that this will reduce the stubbornly high male suicide rate. Innovative campaigns in print and social media seem to have had some traction (Brown et al., 2019). In particular '#Project 84' by Campaign Against Living Miserably (CALM) and 'Real People Real Stories' by The Samaritans (Wyllie et al., 2012). However, despite these efforts, the ratio of 1:3 female to male successful suicide endures (Kennelly & Connolly, 2012) , and suicide continues to be one of the biggest killers of men of all ages in the UK (Withers, 2016). Little research has focused on the experience of suicidal men and **how** therapy promotes recovery. A confluence of factors accounts for that lack of research. It is hard to do, to find participants who feel happy to talk about suicide, to sit with the topic and for researchers to wrestle with the ethical concerns of research.

How often do we psychologists look for more accessible topics to engage with? The first tenant in research is *do no harm*. Having completed this research journey, I am not surprised that there is such little research that interrogates the view from the

other chair. Whilst engaging with this topic, I have often wondered why I did not choose to talk to therapists or elect to study something much simpler; using air fresheners in the counselling room was a title that often sprung to mind as I struggled with this project. I have always been clear that the 'So what?' test of my research has always propelled me forward. At the heart of this research is the voice of the men who could very quickly not be with us. One of the things that struck me the most when meeting the six men you will hear from was the randomness of why and how they survived. What they all had in common was an extended period of psychotherapy, at least a year, and I was curious what their experience was. I hope that this study does them and their stories justice. This research aims at representing their voice, giving the profession a view from the other chair.

Definitions and Terms Used.

I have decided to adopt De Leo et al., (2006, p. 14) definition of attempted suicide:

> "The nonhabitual act with nonfatal outcome that the individual, expecting to, or taking the risk to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes."

This means in my study, I recruited men who carried out an act of suicidal self-harm intending to end their lives. To avoid confusion, the term 'suicide survivor' in the psychological literature refers most often to people left behind after suicide (the loved ones, friends and family, colleagues and health professionals who knew the individual who died by suicide). These studies examine the trauma and aftermath of successful suicides. They do not, for obvious reasons, convey the direct views of suicidal individuals. However, I have adopted the term suicide recoveree to demarcate the distinct group studied individuals who have displayed suicidal behaviours.

I am also aware that the nomenclature of suicide is potentially highly stigmatising. Padmanathan et al. (2019) suggest the language used around the suicide discourse can add to that stigma. Consequently, I am thoughtful about the terms and definitions I use throughout my research. Padmanathan et al. found that the most preferred phrase to use for a non-fatal suicide was attempted suicide and to avoid

near misses. That the terms: *took their own life, died by suicide* and *ended their life* were most acceptable when referring to a fatal suicide. As Nielsen et al., (2016, p. 21) notes the term *committed suicide* is avoided as a "stigma-laden term", recommending it be "expunged from the scientific literature." Throughout this study, I will use language in the spirit of hope, respect, and compassion.

Death by suicide has various subsets, and it is essential to note that in this study, when talking about suicide and suicidality, I am referring to those acts that are intended to end a person's severe emotional distress, which I may refer to as psyche-ache, through acts of self-violence or harm. I am distinguishing this from other types of suicides, most notably suicide, due to wanting to create suffering on adversaries, such as suicide bombings or Kamikaze pilots during the Second World War. I am not referring to suicide to end physical suffering through organisations such as Dignitas, nor suicides as an alternative to torture or death by enemy forces. Suicide in this document refers to the means to end severe emotional distress.

Reflexivity 1

My position as an insider researcher

I will, I am studying, reading and researching mid-aged men and their experience of long term therapy. I am a mid-aged man who has experienced therapy. I started therapy properly on the 31st March 2014, my son's 13th birthday. This was not the coaching I had as part of the senior management team as a schoolteacher, but proper long-term therapy with a male clinical psychologist. I was doing an MSc in psychology and had become interested in men and why and how they were represented in terms of toxic masculinity, and having unhelpful traditional masculine traits and was wondering how that fitted with me. I am a man but do not particularly see myself as having traditional male traits and find the term toxic masculinity frankly insulting. I have done most of the childcare in my family, cook all the meals, and worked in a female dominated industry, but also enjoy going to the pub, and shouting at sport on the TV and dancing badly. I specifically wanted a male therapist – I worked in a female dominated industry (Special needs education) and perhaps wanted support from someone who would appreciate the tension if that. On the 14th March 2014 when responding to their question about what I was looking for from therapy – I wrote

> *1 …I have some training and experience of coaching (CBC) but often I find myself in the foothills of therapy without crampons.... I don't get supervision or for that matter much 'managing' which often leaves me without a support network.*
> *2 - I am doing a MSc Psychology course with a view to move into either counselling or clinical psychology and as such I would find it very valuable to have time with someone in the process so to speak.*

3 - I have faced or am facing a great deal of change in my personal/family life and want to make the best of the opportunity that this is presenting and may not be seeing the wood for the trees...

Reflexivity 2

My position as an outsider researcher

Reading this I can see the isolation and pressure I was under. I was shouldering a lot and had just learnt of one of my school friend's successful suicide – vicariously – no one had told me, it had been hushed up.
from my participants is I have not had a suicide attempt, or self-harmed, I have not walked through that door that marks me out as a more likely future candidate for suicide. I have not been hospitalised, had time off work because of mental health needs. I haven't even been to my GP to ask for a sick note or any anti-depressants, though in the early 2000s I should have after counting 23 stress ulcers in my mouth and almost being incapable to drag myself out of my car and face my year 4 class. Unlike the men I will interview I did not reach out in that crisis. Perhaps if I did, I might have got some help…perhaps not…maybe someone else did instead.
I wonder how I am to remain cognisant of these positions. Will I either take a schizoid position and be too uninvolved in this processs, or let my narcissistic side be too involved – The key will be reflexivity.

Literature Review

This section of the work will systematically identify, review and assess the main academic studies about post suicidal men and their experience of therapy. In doing so, I will ascertain what research has uncovered and identify gaps in the literature to guide my quest for knowledge. The review will be split into two main sections to offer both a wide social and academic context of the subject and to provide a more focused account of research within the specific psychotherapeutic and counselling psychology domain. To do that, I initially offer a *general* review to frame the phenomenon of male suicide and men's help-seeking in the context of society and the academic world, noting the pan-discipline scholarship that suicidality embraces. Space does not permit as comprehensive a review as I would like, as it is such a vast arena. As an illustration, a simple search of Web of Science (on 07/05/2023,16:42) using the keywords "suicide* study" had over 61,000 results, including over 200 academic journals and publications with at least 50 articles in their back catalogue. This indicates not just the volume of research that has been undertaken and the enduring interest of the subject matter but also of the need which lies behind it.

In this review, I consider work from psychology and psychotherapy, as well as other disciplines, such as psychiatry, nursing, and social work, as a *general* review. I then present a more detailed, *specific* review that considers the qualitative research on male suicide and psychotherapy from the client's position, focusing more on idiopathic and experiential research. To identify relevant qualitative studies, I have employed the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) protocols. In following this rubric, I contextualise my research and justify it.

Suicide in Literature and Popular Culture

> There is but one truly serious philosophical problem, and that is suicide.
>
> (Camus & Camus, 2005, p. 1)

These opening lines from Camus's Myth of Sisyphus encapsulate the enormity of studying suicide. This topic is more considerable than psychology, psychotherapy, biology, or medicine. Szasz, in his treatise against the medicalisation of suicide,

Suicide Prohibition, remarks that “As a phenomenon, suicide is ancient. As a medical problem, it is recent.” (2011, p. 9) as a psychological issue, one could argue that it is even newer. It would be foolish to think that psychology had anything like the full picture of suicide. Like a Dickensian London peasouper, it seeps unwanted into almost all areas of society and history. Curling around the hearts and minds of us all. Like other uncomfortable phenomena, it filters deftly into art, where it can be explored differently, perhaps safer, more sanitised, and at arm’s length. Perhaps not so easily; art and literature may give us the words that we find difficult to voice or make us aware of the problematic unconscious existential angst that our time on earth is limited and can be halted at any time if we want to. Art knows suicide well. Ignoring the teenage suicide and tragic happening of Romeo and Juliet that somehow has become the hallmark of romance or the demise of Cleopatra clasping an asp to her breast to avoid being subject to Roman hands, her desperate choice between servitude and slavery, or death. In Hamlet's soliloquy in ACT 3, Shakespeare captures something close to what Camus talks of, the nature of being or not being.

In the realm of more recent literature, among the writers who have delved into the depths of suicidal ideation is Sylvia Plath, whose own struggles with mental health and, perhaps because her suicide writing foreshadowed her end of life, has become the subject of extensive scholarly analysis in psychoanalysis (Gerisch, 1998; Potamites et al., 2014). In Plath’s "The Bell Jar" and poetry collection "Ariel," she adeptly and poignantly explores the inner turmoil of suicidal ideation and contemplation. Her poetry gets far closer to the lived experience of suicide than any research could ever hope to and offers a nuanced and deeply personal perspective on the topic of suicide (Gerisch, 1998). Perhaps, for me, two more recent novels, Nick Hornsby’s *A Long Way Down* (Hornby, 2014) and Julian Barnes’s *The Sense of an Ending* (Barnes, 2012) capture what this research tries to capture is the clarity and solidarity of male suicide recovery and

General Literature Review

This section of the review analyses what I believe to be the most influential literary texts surrounding suicide and contend with how the arts hold a mirror up to society. Throughout this study I lean into the performing and theatrical arts as a reflexive device to help create meaning, so it seems fitting to include a short reflection on the phenomenology of suicide as reflected in culture. More prescient is that this contemplation of major literature works, foreshadows my study, in that although it is often a narrative device by authors to add drama to their work, the voice of the suicidal character is often absent in much of what has been written.

I then proceed to examine influential academic writing in two more positivist orientated areas, epidemiology and larger-scale quantitative research. These are of interest as they paint both a global and national picture of male suicide. In the UK they influence public policy on prevention, identify risk factors and help direct resources to the most pressing areas. These have been systematically chosen through careful consideration of several factors: citation statistics, quality of publication, influence of author and the relationship of those studies to my UK based study of males aged 25 to 65, including the impact on therapeutic help. I also consider popular movements that have arisen supporting men's mental health.
My specific literature review covers qualitative research on the lived experience of therapy of men who have a history of suicidality, something which is of particular relevance to the present study. Together this gives a more focused understanding of what we know about these phenomena and how they interact.

Dominant Psychological Paradigms in Suicide Research

Perhaps the most influential theory to emerge from the extensive body of epidemiological research is Joiner's (2007) interpersonal theory of suicide. After Durkheim, this is the second most cited work by a suicidality theoretician (Bhatia et al., 2023). The theory moves away from the impact of post-industrial society, social disintegration, and the resultant loss of group identification that Durkheim proposed drove suicidality. Joiner posits that suicidality resides at the individual, inter and intrapsychic levels. In his seminal work *Why People Die by Suicide* (2007), he suggests that three factors interact to increase suicidality - thwarted belongingness, and perceptions of burdensomeness, combined with the acquired capability of self-

harm (Van Orden et al., 2010). Hejemeland and Loa (2020) argue that while this theory has dominated the research landscape, they consider it reductionist, over-simplistic, and factually incorrect. Roger and Soyka (2004) contend that it is biased towards Western cultural and gendered norms. Nevertheless, it has proved popular and provides a framework for clinicians to undertake assessment, prevention and treatment, as well as inspiring further opportunities for scientific research (Stellrecht et al., 2006).

As a result of the acceptance of grand theories, such as Joiner's, that psychology often endorses (Gergen, 2015), quantitative research in suicide is also dominant in suicidology. The impact of this shapes the design, implementation and assessment of mental health interventions. It would be remiss, therefore, not to include findings from quantitative and epidemiological scholarship that aligns with that paradigm as it adds context to my study.

Epidemiological and Quantitative Research in Suicidology

World Health Organization (2018) statistics estimated that in 2017, over 800,000 people died by their own hands and, that for every successful suicide, there may be up to 20 unsuccessful attempts. Expansive epidemiological quantitative studies dating back to Durkeim's 1897 *Le Suicide* (Shneidman, 2001) have highlighted the complexity and inequality of the phenomena. Scholars have revealed links between suicide and various risk factors, most notably socio-economic factors (Kennelly & Connolly, 2012; Rehkopf & Buka, 2006), sexuality (Blosnich et al., 2016; Mayer & McHugh, 2016; McAndrew & Warne, 2010), gender dysphoria (Marshall et al., 2016; Peterson et al., 2017), professional career (Blachly et al., 1963; Mościcki, 1997), incarceration (Hampson et al., 2024) and mental disorders (Brådvik, 2018; Harris et al., 2023; Mortensen et al., 2000). However, two interacting risk factors that are almost uniformly noted across the globe are age (Kim et al., 2011a) and gender. Bachmann (2018) noted that globally, except for in China and Bangladesh, males are more likely to die by suicide than females. They contend that for every female death, there are, on average 1.7 male deaths. However, in some areas of the world, the rate for males may be up to twelve times that for females. Of male suicide death

a sizable proportion is made up of people aged between 25 and 60 age (Kim et al., 2011b).

It is important to consider further epidemiological findings on male suicidality. One outcome pertinent to this study, is the sizable increased probability of future suicide attempts once suicide has been attempted or arrested (Lewinsohn et al., 1994; Ribeiro et al., 2016). A meta-analysis of 121 studies by Wang et al. (2019), which examined suicidality in individuals released from non-psychiatric settings after a suicidal incident, estimated that the risk of suicide death of post-suicidal individuals rises to around 30 times that of the global rate. They also suggest that post-suicidal men are twice as likely as females to complete a successful suicide attempt. This identifies this group of men as the most vulnerable sector in society at risk of death by suicide.

United Kingdom statistics reflect the same gender inequality. Men were three and a half times more likely to die by suicide than women in 2015 (Withers, 2016). Recent figures (Office for National Statistics (ONS), 2023) indicate that this ratio has not changed. Despite national administrative recognition of the risk to public health of male suicide, and the launch of various formal and informal initiatives, male suicide numbers remain stubbornly high. Arowasegbe and Oyelade (2023) contend that male suicide rates have actually exhibited a statistically significant increase - from 15.4 per 100,000 in 2020 to 16.0 in 2021. Further insight into the issue comes from Appleby et al., (2021). In their comprehensive study of the antecedents of 242 suicides of middle-aged men (40-55 years), 20% of the suicides are characterised by a complex interaction of factors, counselling caution in attributing male suicide to one single cause. However, four things stand out. Almost two-thirds (66%) had a mental health diagnosis, rising to 80% if suspected but undiagnosed mental health needs were added; most men did seek help (91%) from agencies, almost half were on psychiatric medication (44%) and 36% had been in contact with agencies the week prior to their suicide, mainly mental health services.

It is clear that an enduring gender disparity remains (Canetto & Sakinofsky, 1998; Kennelly & Connolly, 2012) which is evident in the UK (Hawton, 2000). Additional non-epidemiologically based quantitative research in this area reveals other

important phenomena. While identifying qualitative research, which was painfully thin, twelve quantitative studies were recognised as adding insight. Accordingly, I considered it appropriate to consider these and highlight what they add to the literature.

Many studies looked at the efficacy of cognitive behavioural therapy (CBT) and various iterations of it. In a narrative review of adaptions of CBT for a more effective treatment for depressed men, Spendelow (2015) speculated that there is little empirical evidence of success in modifying treatment to be more male-friendly. He also questioned assumptions around traditional masculine traits, noting that men are gaining psychological flexibility. He intimated that the need to reframe therapy may not be as called for as once was thought. Findings suggested the importance of therapeutic engagement and rapport when working with men and that this specifically needed more study.

A fair volume of research exists looking at specific male populations: prisoners, military veterans and hospitalised men suffering from mental health disorders such as schizophrenia, bipolar and psychosis. Research into the usefulness of an adapted cognitive behavioural suicide prevention (CBSP) by Pratt et al., (2015) which was delivered in prisons, indicated that it was both feasible and efficacious in preventing suicide. Participants at risk of suicide showed a marked improvement in symptomatology and personal functioning. Hampson et al., (2024) further developed this work and reported on a pilot study based on an intensive version of the CBSP programme. They noted that by the end of the intervention, there was a significant statistical impact on suicidal behaviour and ideation. However, this was a short-term evaluation of just one month, and the long-term effects remain unknown. Interestingly, some participants expressed distress at ending therapy. The intervention was only five sessions delivered over three weeks. Other studies outside the UK have examined the impact of mindfulness on prisoners' suicidality: a modified behavioural and mental health programme, START NOW +, in American penitentiaries (DiSciullo et al., 2023) and indigenous Australian male prisoners with access to therapeutic Aboriginal art workshops therapy (Rasmussen et al., 2018). Rasmussen et al., found an indirect inverse correlation between the number of days attending art workshops and the suicidality of participants. DiSciullo et al. found their

8-month, twice-weekly prison group intervention based on dialectical behavioural therapy and a behaviour modification program (START NOW+) had mixed results, with no significant differences in mental health referrals compared to a control group. Unfortunately, the COVID-19 pandemic impacted the study, which may have affected their findings. Many people, particularly inmates, were disproportionately impacted by the global COVID-19 outbreak. One may also wonder what a reduction in mental health referrals indicates of a therapy's effectiveness. Seeking help could be seen as a positive outcome of a study rather than an indication of failure. Having trouble during the therapeutic process is often observed in many psychological therapies and by practitioners. According to Interian et al., (2024), therapeutic difficulty can offer an opportunity for acquiring coping skills such as insight and improved emotional regulation and help to develop trust with the therapeutic process and therapist.

Both An et al., (2019) and Xu et al., (2016) considered the impact of mindfulness programmes on suicidality within a population of long-term prisoners in Beijing. Xu et al., indicated that a 6-week mindfulness-based intervention enhanced the mindfulness level and all measures of mental health well-being according to measurements made using the Profile of Mood States (POMS), and Total Mood Disturbance (TMD). Researchers presented significant effects, both post-intervention and when compared to the control group. From this it may be assumed that suicidality would have been reduced, although it was not explicitly measured. The report did not comment on how or why this may have happened or what mechanisms drove the change, other than being more mindful. The studies presented statistical efficacy for mindfulness and long-term prisoners' mental health. Interestingly, the effects were not replicated with short-term prisoners in a later trial (An et al., 2019). Other studies evaluating the reduction of men's suicidality by therapeutic methods have examined male veteran populations (Walser et al., 2015), those with both post-traumatic stress disorder PTSD and borderline personality disorder (BPD) (Meyers et al., 2017), as well as hospitalised groups showing significant mental health issues, such as psychosis, and increased suicidality (Gooding et al., 2020).

As with the prison studies, further work has shown the impact of therapeutic interventions on reducing suicidality acts and or ideation. Research by Walser et al., (2015) described a drop in the severity of participant depression and a reduction in suicidal ideation following a 12-16 weeks course of Acceptance and Commitment Therapy for depression (ACT-D). Meyers et al., (2017) examined the impact on suicidality of a 12-week intervention integrating dialectical behaviour therapy (DBT) and prolonged exposure (PE) therapy, with veterans of mixed gender (51% male) presenting with PTSD and BPD. Although they report a moderate effect size in the decrease of suicidal ideation, it is not known if any gender differences were considered. It was also not reported what the gender mix of the 33% dropout rate was, making it difficult to examine in finer detail what was going on. Gilgoff et al., (2023) considered the impact of Man Therapy (MT), an online therapeutic tool to facilitate help-seeking and intervention for suicidal men. Their study intimated an increase in professional help-seeking compared to participants who received just the screening and referral intervention.

Other online interventions aimed at suicidal individuals, particularly men, have attracted interest. As with MT, other bodies around the world have been at the forefront of developing methods to increase men's mental health engagement and novel treatments. Contrary to Spendlow, Pirkis et al., (2022) argued that mental health care professionals should seek to normalize help-seeking and challenge unhelpful masculine traits. There has also been a rise in the intended use of more informal settings and methods to lessen men's loneliness and isolation, which has strong links with depression (Franklin et al., 2019) and anxiety (Fisher et al., 2024) and engagement with mental health services. One initiative is the Men's Sheds movement (Golding, 2021). Their mission, to break the stigma around men's help-seeking by offering men peer support through the construction and restoration of household objects, has been relatively successful. The tagline "shoulder to shoulder" (Golding, 2021, p. i) was devised as men don't engage as easily face to face. The movement started in the 1980s, was formalised as a charity in 1993, and has been adopted in many Western countries, including Canada, New Zealand, Ireland, and the United States. In the UK, there are over 900 affiliated programs. Although they have a wide well-being remit in their 'health by stealth' methodology, a significant part includes increasing men's mental health engagement. However, there is a tacit

acknowledgement that men taking part as helpers are not seen as mental health professionals.

Organisations employing similar tactics have appeared in the UK. The campaign against living miserably **(**CALM**)** utilises a more specific suicide abatement remit. CALM was originally an NHS helpline pilot project in Liverpool before becoming a national charity in 2006. The work specifically undertaken by these new organisations in Australia and the UK is welcome, but, as with the Man Therapy initiative, they are movements that primarily aim to educate and raise awareness. They are not, and have never claimed to be, organisations delivering professional therapeutic interventions.

The findings of researchers conducting epidemiological and quantitative studies do point to the gender disparity in suicide. They recognise the need for men to access mental health providers and offer ideas on how that may be achieved. Research also indicates that different iterations of psychotherapeutic interventions have a positive effect on reducing male suicidality across many other groups. What is not apparent from these studies, big and small, is how and why these interventions work and when they do not, why not. The voice of the suicidal man is drowned out and dominated by that of the researcher. Much of the research is narrowly focused and does not engage with the specifics of why interventions have the effect they do. This means that little is learned to aid the future development of effective interventions. This may be a limitation of quantitative research in this area and points to the need for more in-depth work.

Qualitative studies

The Voice of the Participants

In a comprehensive and impactful Delphi review, Seidler et al., (2019), considered what has influenced the course of psychotherapy from the lived experience of psychotherapy clients. Putting the clients in the position of experts instead of being orientated from the therapist's point of view. Findings include that men need support in both moments of crisis and to find meaning in life; men are help-seeking but have a negative experience in that venture; informal community and family-based interventions are important; framing suicide as a biomedical issue narrows the

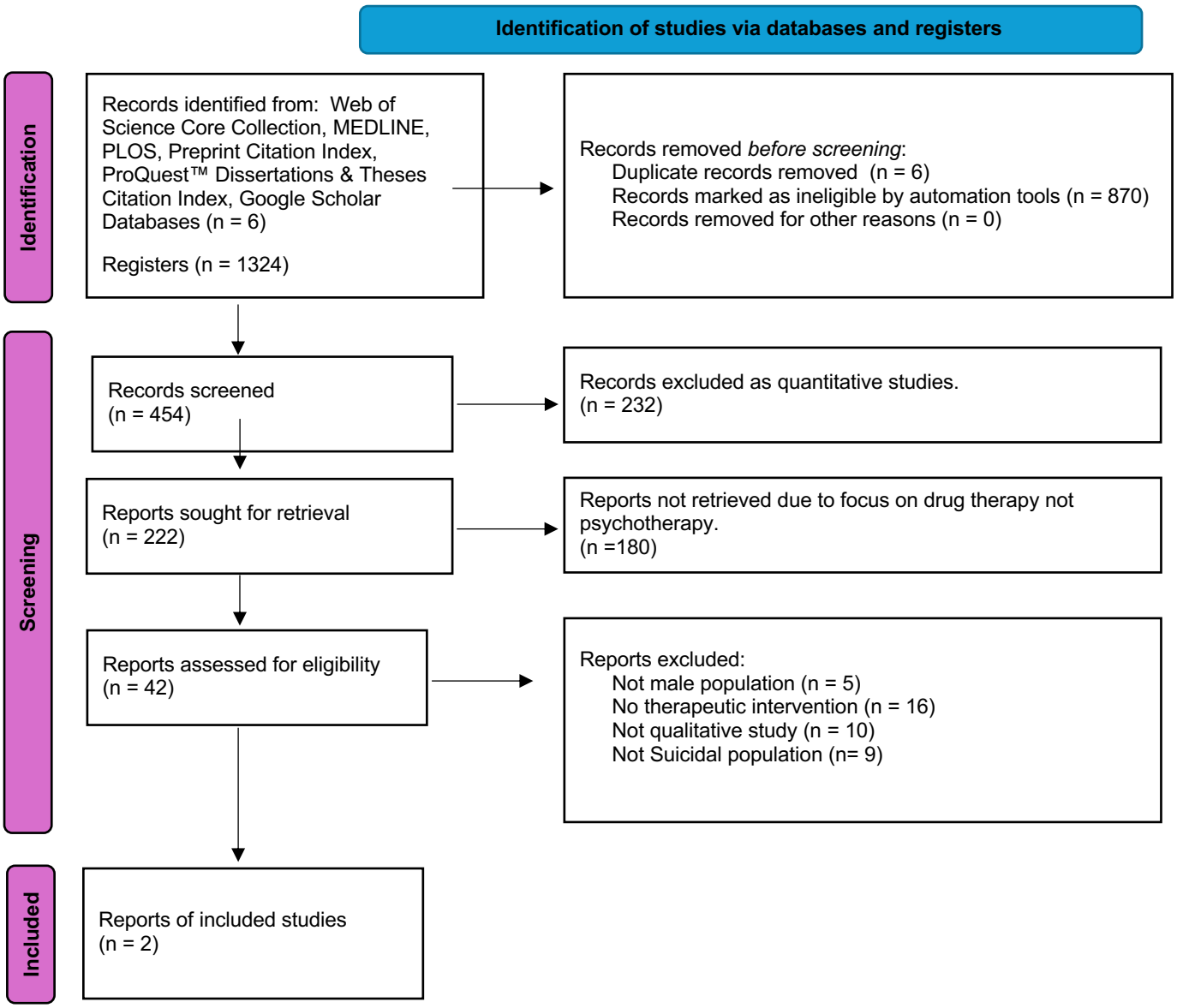
causes of suicidal pain which limits remission options; and, finally, involving diverse communities and healthcare providers is essential.

Search and Decision-making Criteria for Qualitative Studies

Fenaughty and Harré (2003) have identified a scarcity of qualitative studies on suicide, a tendency in academia also highlighted by Hjelmeland and Knizek (2010), who state that in the period between 2005 and 2007 only 3% of the studies in the three leading suicide journals were qualitative investigations. An extensive search was undertaken, following PRISMA guidelines for qualitative studies into the experience of psychotherapy for homogenous masculine groups who have had an attempt on their life. This employed all databases of Web of Science on 02/08/2024, using the search terms (male OR Masculine OR Male) AND (Suicid* OR Suicidality OR Life attempt) AND (Counselling OR Psychology OR Psychotherapy OR Therapy) NOT (Female OR Girl OR Woman) NOT (Boy OR Adolescent OR Youth OR Young) see figure 2.1. This search initially resulted in 1324 potential papers. Numbers were reduced to 454 by excluding duplicates, biochemical and medical research (except psychiatry and nursing), non-English language reports, and publication quality. Further screening for eligibility reduced the number to 222 papers. These were further screened by reading abstracts and often full papers. Research studies were rejected for several reasons. They were based on drug therapy, health and smoking (97), management of drugs overdose (25) COVID-19 (3), risk or prevention of suicide (22), duplicates (3), bereavement (3), predominantly female populations (4), autopsy studies (2), non-suicidal population (7), legal papers (2) or were the wrong age group (12). Each of the remaining 42 papers were read in totality and screened for eligibility. To be included in the qualitative research review, they needed to display all of the following features: employ qualitative methodology, comprise male or predominately male participants who had had experience with psychotherapy and had at one time shown suicidal behaviours as an antecedent to therapy. Additionally, it was desired that data came from the lived experience of psychotherapy clients rather than the views of the ‘expert’ therapist. Only two were retrieved for the qualitative review indicating the paucity of studies present in academic annals, confirming Hjelmeland and Knizek’s observation. However, 12 of the quantitative studies were included in the general review. I also considered

studies from outside of psychology. A MEDLINE search that included areas such as mental health nursing and psychiatry using the exact keywords did locate some relevant studies, which will be considered first.

Figure 0-1 PRISIM Qualitative Literature Search



General Qualitative Research

Qualitative Health Care Professional Research

Cross-cultural qualitative studies examining the lived experience of those recovering from suicide suggest there is a relationship between recovery and the degree of support from healthcare professionals (Chi et al., 2014; Cutcliffe, McKenna, Keeney, Stevenson, & Jordan, 2013; Obando Medina, Dahlblom, Dahlgren, Herrera, & Kullgren, 2011). Chi et al. (2014) examined the lived experience of recoverees. This grounded theory study of 14 Taiwanese participants aged 35-57 (12 women and two men) in a psychiatric setting concluded that recovery did not take a linear path and that patients required 'help from many sources' (p.1757), with talking to healthcare professionals (psychiatrists, therapists and psychiatric nurses) an important part of their recovery. However, the study only had two male participants and provided little information on the patients' contact with therapeutic professionals. Studies of Nicaraguan (Obando Medina et al., 2011) and South African (Meissner et al., 2016) young men highlighted the importance of gender-specific prevention strategies and identified that talking freely about their suicide attempt aided recovery. In a study of young (18-34) Northern Irish men, Cutcliffe et al. (2013) corroborated this finding, showing a similar connection between recovery and support from mental health professionals. Their findings also pointed to the therapeutic relationship as an essential factor in recovery: 'person-to-person, therapeutic closeness and engagement remain central and vital to the psychiatric nursing care of suicidal people' (p. 470).

These contributions from nursing and health science offer insights into the interpersonal needs of recoverees. They stress the importance of being proactive and widening access to therapeutic help for men and highlight the challenges for men in the 21st century. They further suggest that recovery from suicidal acts is made more accessible when men can express themselves to trained mental health care providers, and therapeutic understanding has a benefit. This is a somewhat nebulous finding, and it is unclear whether these findings would be reproduced in an older, male, UK-based population of suicide recoverees.

Qualitative Research into Older Suicidal Men

Two influential studies regarding older suicidal men's experiences of and therapy were identified. Each examined an extreme population: Australian farmers and military personnel, respectively. In his study of Australian men, Alston (2012) connects the poor help-seeking behaviour of farmers in rural extremities with masculine gender norms, concluding that 'masculinity must be exposed and interrogated… and its shortcoming revealed' (p. 522). Similarly, while exploring US servicemen's suicidality, (Mahalik et al., 2007) also posit that adherence to masculine gender norms contributes to the risk of suicide and stops men from accessing mental health services. Both studies have raised an important issue, expressed in recent research: that of a growing interest in the connection between masculine gender norms and male suicide, suggesting that suicidal men are less likely to seek help and die more frequently because of their rigidly held, hegemonic views of masculinity (Bolster & Berzengi, 2019). It is important here to consider the social construct of masculinity, and it is helpful to have a definition of what is often referred to but seldom questioned. Men who adhere to traditional masculine gender norms are often described as being emotionally restrictive, being driven by success, power and competition, showing restrictive affectionate behaviour toward men, and having a drive towards dominance at work and within the family, both of which often lead to conflict (Granato et al., 2015). However, these studies charting men's interactions with health and mental health services stem from data extracted from extreme male populations (Australian farmers, veterans, prison populations and emergency service personnel). They may not be universally representative of men's experiences.

Player et al., (2015) studying a less homogeneous group of suicide recoverees in Australia, with lower rates of hyper-masculine archetypes, confirmed the importance of having trust in expert help. They found that because of their experience of shame, some men only felt comfortable in the hands of trained professionals, who could play a crucial role in critical periods of risk. However, large numbers of participants reported being dissatisfied with mental health professionals and reported having bad experiences with them. Unfortunately, the authors did not elaborate on this crucial

finding but acknowledged that more research was needed. This leaves me to speculate on the precise nature of that dissatisfaction and how it was co-created.

Qualitative Research Based on Suicidal Men's Experience of Therapy.

Finally, the two studies were identified as meeting all the relevant criteria for inclusion in this review section. Table 2-1 displays each study and its authors. As this is an interdisciplinary review, all studies identified have been taken from the field of psychology or psychotherapy. Each study was identified individually because they illuminate and comment on therapeutic work with men with suicidality. A key distinguishing aspect of these studies is that they are either based upon raw data or reviews of literature taken from the client's point of view - rather than, or in addition to, the therapist, researcher or counsellor's opinion. All are qualitative, as this study is, bringing new insights to the field.

Table 0-1- Chosen Titles for Qualitative Literature Review

Review number	Authors	Article Title & DOI	Source Title	Publication Date & Pages
1	Shepherd, G; Astbury, E; Cooper, A; Dobrzynska, W; Goddard, E; Murphy, H; Whitley, A	The challenges preventing men from seeking counselling or psychotherapy DOI:10.1016/j.mhp.2023.200287	MENTAL HEALTH & PREVENTION	SEPT 2023
2	Sigal, N; Rob	Dual perspectives on art therapy and EMDR for the treatment of complex childhood trauma DOI:10.1080/17454832.2021.1906288	INTERNATIONAL JOURNAL OF ART THERAPY	APR 2021 37-46

The Challenges Preventing Men from Seeking Counselling or Psychotherapy

Shepherd et al., (2023) conducted a scoping review of literature on men's mental health and help-seeking, using a thematic analysis methodology. They identified 45 articles that fit their rubric. Over three-quarters (78%) of the articles focused on men with depression (21) and on suicidality (16), which gave pertinence to this literature review. They identified three themes from the literature around men's mental health and help-seeking. The first two centred around attitudes around masculine identity

and male attitudes towards help-seeking (which are summarised below). The third theme, particularly pertinent to the present study, contends with psychological services and therapists and is considered in more depth.

The first theme identified that masculine identity conflicted with help-seeking. Several subthemes were identified:

- The activity of help-seeking conflicts with masculine behaviour.
- Masculinity creates fear, stigma and shame in men.
- The public and social stigma regarding help-seeking with mental health issues.
- Fear of isolation and withdrawal from society adds to the challenge of help-seeking.
- Masculine identity is a barrier to help-seeking.
- Men who struggle with psychological connection to others are challenged in seeking or continuing counselling or psychotherapy.

The second theme, concerning male attitudes & behaviours, depicts how men position themselves in relation to help-seeking and how their poor consideration and knowledge of mental health impacts their ability to cope with a mental health crisis. The subthemes identified were:

- Unhelpful attitudes exist because of masculine socialisation.
- Self-reliance results in lower mental health help-seeking.
- Men have poor mental health literacy, which creates barriers to seeking help.
- Help-seeking is seen as a feminine activity.
- Men adopt masculine behaviours to masque authentic emotion.
- Men adopt dysfunctional coping strategies such as using alcohol or drugs to self-medicate (Shepherd et al., 2023, p. 5).

These two themes and their resultant subthemes help position my work. What is particularly informative in this context are the observations that help-seeking was viewed as a feminine activity and that the public and social stigma of being socially overlooked causes an arrest in help-seeking. Further examination of the source

articles indicates factors that facilitated help-seeking and reduced its positioning as a feminine entity, such as having a female listener and trust in the person listening (Mahalik & Dagirmanjian, 2019).

In the theme of psychological services and therapists, the authors highlight the significant challenges for men accessing psychotherapy effectively. The subthemes of their findings can be summed up as follows:

- Lack of specific health promotion, coverage and provision of male mental health.
- Men are less likely to seek help from friends, family or mental health services.
- The presence of economic barriers to help-seeking.
- Lack of trust in the medical model of healthcare.
- Fear or reluctance to engage in counselling or therapy.
- Men's lower utilisation of healthcare services.
- Health professionals' poor attitudes to masculine help-seeking.
- Mental health services are seen as feminised.
- Poor mental health service awareness.
- Professional health care training is needed around men and men's mental health.

For this study, it is helpful that the issue of therapeutic access and attitudes of men suffering from poor mental health is highlighted. Both the findings and the language used to express them are key. Although male suicide has been and remains a public health emergency, men seeking help reported their experience as being laborious. It is fraught with difficulty on several levels, be that of an intrapersonal conflict in accepting or seeking help because of reported maladaptive masculine socialisation, the monetary cost of therapeutic help, the attitude of service providers or the framing of mental health as a medical issue. Mental health services were reported to be feminised. This citation was traced back to three other meta reviews and further investigation revealed one of the sources to be from an article published ten years ago in *The Psychologist*, the British Psychological Society's magazine (Morison et al., 2014). They concluded that men are put off from seeking help because there

was an absence of male service providers, confirming “that around 80 per cent of those who provide psychological services are women” (2014, p. 415) and a resultant overly feminised therapeutic style prevails. They call for better gender awareness in the NHS and in training organisations to redress the balance, intimating that having more men in therapeutic situations would facilitate more men (and more suicidal men) seeking help. A comparison can be drawn to ethnic minorities being in aspirational roles that inspire generational change by increasing ethnic minority engagement in society. However, the authors do point out that service shaping and decision-making positions in government were male-dominated (85% in 2014), so perhaps the more significant problem is one of male domination, and the disproportionate numbers are symbolic of a larger macro issue of inherent systemic sexism.

What perhaps is important to note is the narrative switch from men themselves being the main block to accessing mental health help to the role that services play in preventing men from getting help. Many articles berate men for not accessing help because they adhered to maladaptive masculine traits. However, here we see a tacit acknowledgement that services themselves bear a responsibility for the provision of care that is gender sensitive and that this has failed in several ways.

Although helpful, Shepherd et al., (2023) have taken us to the point of why men don’t engage in therapy, and the qualitative nature of their review helps to highlight attitudinal and systemic issues in suicidal men’s help-seeking. What they do not do, or what is not apparent, is comment on what the experience of therapy is like. We now know more about the experience of access and the barriers to access, but we are left outside the gates of entry to the therapeutic experience.

Dual Perspectives on Art Therapy and EMDR for the Treatment of Complex Childhood Trauma

My second and final qualitative article for review (Sigal & Rob., 2021) is a piece of co-produced research that combines and illuminates the work of therapist Nili Sigal, an art psychotherapist and accredited Eye Movement Desensitisation and Reprocessing (EMDR) practitioner, and her client Rob* (pseudonym). It covers the three years they worked together after Rob was diagnosed with complex post-traumatic stress disorder (CPTSD) following his arrested suicide attempt. Identifying demographics were removed from the writings. However, Rob’s details match with

my intended study focus as his approximate age and gender can be inferred from the text: a man over 25 years of age who displayed suicidality and so fulfils the brief for inclusion in this literature review. The article places the voice of the participant/co-researcher centre stage and examines the therapy process from both points of view, using novel and artistic methods of reflexivity throughout.

The first section of the article provides Rob's account of the antecedents to his meeting with Sigal. He describes his experience of the journey to the meeting and his therapeutic experience, which includes a rich level of experiential learning. Of note was his history as a survivor of childhood sexual abuse, his flashbacks, dissociation and sleep disturbance and how his 'maladaptive' coping mechanisms manifested in drug and alcohol abuse, addiction, social isolation, self-harm, and ultimately an arrested suicide attempt. He details how he found the NHS a twenty-year "shit-show" (2021, p. 37). His prescription of selective serotonin reuptake inhibitors (SSRI) was ineffectual, as was NHS talking therapy.
Trust was a theme that he and Sigal emphasised throughout. He alludes to the unsuccessful earlier therapeutic endeavour where he engaged with six months of weekly talking therapy with a "lovely therapist" (2021, p. 38). However, he found there was not the time to build the trust needed for him to share and begin to address his sexual and psychological abuse. After his suicide attempt, he was referred by his GP for art therapy. Speaking further on trust, he recounts, "It took a long time for a clear, strong bridge of trust and security to be built between myself and Nili (Sigal)" (2021, p. 38), judged in years as opposed to months or weeks. Apart from the impact and effectiveness of finding a therapeutic language in art, for Rob, the foundation of their work was trust, which took considerable time and skill to develop.

Sigal recounted how she and her therapy room represented safety for Rob. She emphasised the importance of psychoeducation around concepts such as interception, bodily re-attunement, and safety, posited by many traumatologists (Damasio, 2006; Herman, 2015; Rothschild, 2000; Stellrecht et al., 2006). Skilled use of EMDR in the here and now, setting the pace of therapy, and integration of parts was equally important and was dictated to by need rather than economics. Of interest was the implied transference and counter-transferential matrix of his

apparent need for a protective maternal figure and her anxiety at being good enough for him. These mirror the child-mother dyad found in many seminal psychological texts (Bion, 1985; Bowlby, 2008; Fonagy et al., 2002; Schore, 2011; Winnicott & Rodman, 2010). I wonder if, in her visualisation work to help him connect to "safe, wise, protective, and nurturing figures" (2021, p. 42), she was describing their therapeutic relationship. Other elements were essential, not least finding his own language through art to represent and process unconscious traumatic memories of child abuse, which included the utilisation of imagery to integrate cut-off parts of self as well as the application of humour. Difficulties arose when the process went too fast, and Rob was re-traumatised. During these times, he experienced between-session difficulty and occasionally did not show (DNS) for his scheduled sessions. This further underlines the importance of establishing therapeutic safety and offering therapeutic flexibility, which other services did not provide.

Although an inspiring piece of work, this client-led research has difficulties. Retelling his therapeutic journey and the very slight possibility of being identified carries the risk of client re-traumatisation, though Rob refutes this, finding the research process therapeutic. The subject matter is based on one worked example with a client, and so the necessity for replication cannot be avoided.
Criticisms could also be levelled at the lack of methodological structure or rigour, and no indication of Sigal's philosophical positioning is evident in the paper. However, the fact remains that this is perhaps the only paper or research that I could identify that has attempted to put the participant/co-researcher as an expert in the arena of male suicide. For this, the author and her client should be applauded. In the present study, I will attempt the same focus, and in my data analysis, I will use an innovative, rigorous method and methodology.

Gaps in the Literature

This study aims to build on and contribute to work in psychotherapy, psychology, and specifically counselling psychology. Although studies in suicidology have examined and predicted how, why, and what demographic of men make attempts on their own life and what social, inter and intra-psychological drivers exist, there has not been a

thorough examination of the experience of talking therapy from the client's point of view. As such, this study provides additional insight into what is effective and what is to be avoided in treatment for these men. The analytic focus on the protagonist's experience enables a further contribution to the academic literature from a voice seldom present in research. This study aims to analyse what impact long-term therapy has on suicidal men, how they interact and build a solid therapeutic relationship with their therapist, and what actions have contributed to a poor experience. Although numerous studies have identified risk factors, considered suicide demographics, antecedents, suicidal crisis management, and suicidal bereavement, as well as looked at preventative measures of past suicidal men, little analytic attention has been paid to the experience of help and psychotherapy of men following a suicide attempt. The fact that so few studies examining this area could be found attests to that fact. I attempt to address this issue and highlight the experience of post-suicidal men through in-depth interviews and rigorous analysis, shedding light on the processes that these men go through when they seek healing and how they find a way to continue to live through the liminal space of suicide recovery.

I contend that this study is vital. We know from quantitative research many factors and variants influence men to take their own lives. We understand that there is a view that men are not as help-seeking as society would like and that great effort has been made to reframe help-seeking as a strong masculine trait. We know that, on the surface, preventative measures and therapeutic input can be helpful in identifying risk, arresting, and recovering from suicide. We know that establishing good therapeutic bonds is vital in that regard. What we lack is knowledge of the interpersonal processes underpinning that help. Qualitative research in this area is painfully thin, and almost no studies have examined this topic. Researchers have either engaged with protagonists from afar and drawn conclusions from this distance, or their observational writings lack methodological credibility. As a result, what has not been established in research is the granular detail of how post-suicidal men experience therapy and what they think is valuable. We can assume that what works for other populations also works for them or draw inferences from grand theories. However, assumptions and grand theories can be dangerous in psychological research.

I have shown that research in this area tends to stem from a medical perspective, focuses on extreme populations, neglects to explore the specific impact of therapy on male suicide survivors, or, when examining the inner workings of therapy, does so primarily from the therapist's viewpoint, potentially overlooking the crucial impact on the client, who is ultimately the most important part of any therapeutic relationship. This is why my research is more than vital in the present age.

Reflexivity 3

Standing on the shoulder of giants…or are they standing on me?
It is with some trepidation I step into the area that so many have and my leaning to the existential has proven both illuminating and a time vampire. Attributed to Confucius, one of my guiding principles recently has been *If you are the smartest person in the room, then you are in the wrong room*. In the metaphorical and real library that I now sit. After completing my literature review and communing with such intelligence, I certainly feel I am not the smartest in the room. I can feel the authority and ominous academic weight. It feels oppressive. So many researchers with such resources behind them, with seemingly so many answers delivered. This research is just me (with some excellent support from my supervisors). So, while I wait for a clipboard wielding bureaucrat to ask for my pass back to escort me from the budling. I will persevere by reminding myself that Foucault had to retake every single exam he sat, Einstein did not learn to read until he was 9, and that Nelson Mandela was expelled from school and failed half of his law exams whilst at university. They were alone and they struggled on. This gives me hope that my struggle is one I share with others in this virtual library.

Research Aims, Methodology and Ethics

Research Aims

This research aims to explore what contributes to the therapeutic experience of men who have displayed suicidal behaviours. It is a client-focused study rather than from the professional's perspective. Therefore, I aim to interview clients rather than therapists about their experiences. I used a reflexive thematic analysis method, employing a critical realist methodology, to investigate the phenomena. Philosophically, I situate this work within a critical realist paradigm that accounts for the social construction of experience and the epistemological relativism of that experience.
In the following section, I outline the thought processes that led me to this choice of methodology and how I undertook my qualitative research using an adapted version of Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2006, 2021; Byrne, 2021) . I will also account for myself as a researcher, consider the ethical issues involved in a study with such a potentially precarious group and the steps I will take to ensure the quality of this study.

My objective is to undertake flexible research where the voices of the participants can be clearly heard and expanded upon. With that in mind, following from Given (2008), I made the decision of using the term co-researcher(s) rather than participant(s) to acknowledge their part in the creation of this work. To capture their stories I collected my research data using a qualitative idiographic approach. Ensuring that the findings develop from real-life experiences of the studied phenomena. Through my involvement with the current literature in the subject and by reflecting on what gaps exist in the field, I chose the research question(s):

- What is the lived experience of psychotherapy for suicidal recoveree men?
- How has that experience influenced their recovery?
- How can therapists be aware of that experience and be more aware of the needs of recovering men?

To that end, I propose the study title to be: **A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Adult Men with a History of Suicidality.**

Methodology

Philosophical Underpinning

In this section, I present my philosophy of scientific enquiry and clarify my ontological and epistemological position in relation to my research question and aims. I believe, after Bhaskar, the founder of critical realism, that the philosophical paradigm I adopt has an important influence on my research practice (Gorski, 2013). Echoing Mills et al., (2006) it is paramount that my research design stems from the compatibility of the research paradigm and my own beliefs about the nature of reality. This will add coherence to my study, improve the reliability of my discoveries, add weight to recommendations, and ensure the study will contribute to the ongoing debate in suicidality academia and further influence it.

Ontological and Epistemological Position

I hold a critical realist (CR) ontology associated with the work of Bhaskar (2013; 2016; 2017) and expanded upon within the realm of psychology by Pilgrim (2019), Collier (1994) and Gorski (2013). In my consideration of CR, I subscribe to the assumptions laid out by Bhaskar and Hartwig (2016), that our experiences and decisions take place in a laminated, open world. Our choices and actions are influenced by four different planar:

1. Within our bodies, and how we react to the physical world.
2. Relationally with others.
3. Socially, within the hermeneutic framework of where and when we live.
4. Within the stratification of our own embodied personality.

From this standpoint, a multiplicity of determined reality exists with no single driver of events. Reality exists, but our ability to fully grasp and explain it is restricted and mediated by our socially constructed knowledge. The concept of *lost in translation* is helpful; the act of translating one language to another may give a degree of

understanding of what is being said; however, the translated version will only partially grasp the meaning in its entirety. As Fletcher (2017, p. 185) explains, "human knowledge captures only a small part of a deeper and vaster reality". Furthermore, fundamental truths exist in the world, but our ability to access and express them using just language is limited. Fletcher argues that knowledge is fallible to varying degrees and open to modification and reappraisal.

My research philosophical position must be able to hold the paradox of structure and agency, understanding that human nature is voluntary but acts within the constraints of reality.

Reflexivity 4

From reflexivity journal 7/07/2022

As I engaged in research, the phrase "persuading an octopus into a jar" (Kamler & Thomson, 2014, p. 30) has become a constant reference earworm. I was curious of my own understanding and my struggles with what and how knowledge is produced. I consider that what I know is fallible and incomplete. But the gradual transformation of moving from a relatively scientific background and a positivistic view of research to adopting my subjective phenomenological epistemology has been taken a circuitous route. It is also a relief not to have to be 100% right and in so doing I can relax and temper my language and acknowledge that reality cannot be fully understood but **can** be hinted all the while remembering that human nature acts within the constraints of reality. I have found myself chasing the ideas of many different theorists and philosopher and they have allowed me to explore and generate knowledge of my own, knowing that interpretation, development and conjecture of material will be needed to understand what may be said to me at a deep level. Shneidman (1996, p. 5) suggests that suicide is a "multi-faceted event – that biology, biochemistry, culture, sociological, interpersonal, intrapsychic, logical, philosophical, conscious and unconscious elements are always present". Adoption my old positivist approach to this complex matter will only offer, as Pilgrim (2019) notes, a superficial explanations for what I will observe and experience. I will need a methodology that develop themes as fully as possible: areas such as the interpersonal, intrapsychic, unconscious, and philosophical are important. A methodology that allows phenomenology to co-exist with more straight forward syntactic observation of what is said. This seems like the academic octopus that swirls around my head and wonder if I have the academic dexterity to coax it into the jar and I wonder why I keep opening it.

Other Philosophical Approaches

Positivist Naïve Realistic Approach

The field of psychology has long grappled with whether a quantitative, positivistic approach is the most appropriate way to investigate the nuanced and subjective realm of human experience, particularly in the context of psychotherapy. I want to underline the shortcomings of taking a naive orthodoxy, the go-to position of the Natural Sciences, in trying to uncover and appreciate the phenomenology of the therapeutic experience of men who have tried to take their own life. Pilgrim (2019) states that because psychology is a social rather than a natural science, it needs an underlying philosophy to accommodate participant agency. Because humans have reflexivity and facts and values are so intertwined, humans cannot be reduced to subjects to study objectively. While the scientific rigour and objectivity associated with quantitative research hold significant appeal, there are compelling arguments for exploring alternative philosophical and methodological approaches that may be better suited to capturing the complexities of the therapeutic experience.

A positivistic view of psychology, rooted in the belief that human behaviour can be studied through objective, empirical observation and measurement, has yielded valuable insights into various psychological phenomena (Shepard et al., 1993). However, when it comes to the subjective and often deeply personal experiences of individuals undergoing therapy, a purely quantitative approach will fail to capture the depth and richness of these experiences fully.

Social Constructivist/ Constructivist

A constructivist approach that adopts tenets that are in contrast to traditional quantitative psychology (Burr, 2003) would be more appealing and suited to answer my research question. Emphasising the co-creation of the production of meaning between co-researcher and researcher would allow me to recognise my involvement in the research rather than act as a passive, objective observer. It would permit a critical stance towards taken-for-granted knowledge and embrace ‘a very strong form of epistemic relativism’ (Gorski, 2013, p. 661), emphasising the linguistic

construction of social reality. However, I would want to go beyond a collection of stories and world views. According to Gorski (2013), reality is part of the world and taking a constructionist position would ignore that. As my literature review indicated, the phenomena of the gendered imbalance of suicide is one found across almost all cultures, religions, ages and socioeconomic groups. I hope my generated knowledge will have a more extensive reach and translate into these areas rather than be reduced to a narrow set of social constructs. I do believe that the world is real, that social structures and causes are real and can be studied, but that knowledge production is fallible and "not theory determined but theory dependant" (Pilgrim, 2019).

Choosing a methodology that acknowledges the existence of different planar the world, as Bhasker suggests, that recognises the social practices of research is required. As such, my study will sit in a context that reflects my norms, history, values and cultural position. Consequently, embracing a qualitative approach frees me to consider reality as being more than the observed and measurable. It is happy with the chaos of real-life (Hennink et al., 2019). In addition, considering myself as a researcher and a reflexive human agent with influence on the research also chimes with my work as a reflexive therapeutic practitioner, where I remain curious about the co-created experience and its values. My aim in taking this stance is to enable a richer, fuller and more reflective understanding of the experiences of therapy for post-suicidal men.

Method and Methodology Choice

Methodological Choice

Through the pursuit of internal validity, quantitative studies have not and cannot, by design, reflect all co-researcher's subjective experiences in the detail I would like. They have and can capture a vital surface understanding of my subject, "the what" of a phenomenon. However, using a qualitative method would give depth to the inquiry, considering the' why' and 'how' of the issues under examination. A qualitative research design would better capture the nuance of experience. Furthermore, as a scientist-practitioner, my mode of being is one of active participation in the production of my research field (Galbraith, 2017); an objective,

neutral position would not be tenable. I will produce and use theoretical and research knowledge. Only adopting a research method and methodology that acknowledges my influence as a co-producer of the research that aligns with my philosophical stance will sufficiently address my research questions. I am not a neutral observer and, as Willig (2013) suggests, I consider my subjectivity positively as a researcher from the onset of the enquiry.

Rejected Methodologies

When choosing an appropriate methodology for this study, I initially considered using constructivist grounded theory (CGT) (Charmaz, 2006) and Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009; Smith & Eatough, 2016). Both were well suited to the complexity of my research topic and hold a tacit acknowledgement of knowledge co-creation. I intend to reflect upon my part in the co-construction during this research. So, CGT would fit with my desire to focus on the voice of co-researchers and develop and generate theory based on their experience whilst taking account of my part in the process. However, on reflection and through consultation with colleagues, choosing CGT may not align with my research question as I aim to explore experience rather than generate theory.

I also considered an Interpretative Phenomenological Analysis (IPA) methodology, the central tenets of IPA research (Smith et al., 2009; Smith & Eatough, 2016), which advocates for placing the significance of co-researchers' experience at the heart of research. This again chimes with my philosophical stance. However, as it relies heavily on the recorded words of interviews, it lacks some flexibility; I believe it cannot fully account for the implicit experience of the researcher. This would reduce the freedom to explore researcher-generated data that could allude to a deeper understanding of the phenomena. This methodological focus would, I believe, reduce sources of insight.

Although both offer the allure of a complete methodology that I could easily subscribe to and follow, they need more researcher flexibility, which I value in an explorational enquiry. To gain as much richness as possible in researching a subject matter that has, up until now, had little investigation, I wanted to remain as open and unfettered as possible. Choosing either IPA or CGT may not do that. For these

reasons, I decided on the methodological agnostic thematic analysis method to conduct my research and imposed my own methodology.

Thematic Analysis

In adopting an atheoretical method such as thematic analysis (TA) there needs to be clarity in methodology and theoretical stance. Braun and Clarke (2021) describe TA as a collection of qualitative research methods for exploring and interpreting patterned meaning across datasets. Three main methods of TA exist: coding reliability, codebook, and reflexive (RTA). All have a different methodological position and offer various levels of flexibility. In my choice of methodology, I considered both coding reliability and a codebook approach. Still, as they tend towards early adoption of themes based on prior theory for data collection (Byrne, 2021), and are somewhat positioned within a positivist framework (Braun & Clarke, 2006), they were incompatible with my research question. I am not convinced that simply harvesting themes from the data set to either concur with or diverge from what has been studied before would fulfil my research objectives.

Furthermore, coding reliability and a codebook approach would not attune to my desire to recognise my active role in knowledge production. Although not strictly a quantitative approach because inclusion and exclusion criteria are developed early in the analytic process, it is a method that distances my role as a researcher and offers an overly objective perspective. My subjectivity is a resource when interviewing and analysing data (Gough & Madill, 2012) , and a codebook methodology would potentially negate this.

I have employed the more fully qualitative RTA approach developed by Braun and Clarke (Braun & Clarke, 2006; Byrne, 2021). It does not use a framework, as coding is open and organic; it recognises that themes do not emerge but are teased out by the researcher and that themes are the outcome of the coding process through iterative development rather than having them forced upon them as in code reliability and codebook approaches. In the context of this research project, RTA fits because it helped me explore, more fully, the experiential data about post-suicidal men's lived experience of therapy. This research method enabled not only an exploration of how my co-researchers made sense of their lived experiences and uncovered meaning but also considered the active and dynamic role I would have in the meaning-making

process. It allowed creativity to be part of that process. RTA offered a double hermeneutic, that of the co-researcher making sense of their world whilst I tried to make sense of them making sense of their world. Richer analysis, according to Smith and Eatough (2016), comes from taking a critical yet empathic position and leads to a fuller, if more complex, understanding of the phenomena. In this way, I will retain my subjectivity while engaging with my reflexive practice as a co-researcher. To aid me, I will approach coding and analysis inductively and focus on semantic coding while attuning to my data's latent meaning. Braun and Clarke (2021) argue that the coding approach can combine semantic and latent levels and does not present it as a binary choice. This fits my personal and professional stance as a psychotherapist and counselling psychologist trainee. I consider my subjectivity a significant strength in how I make sense of my client's experience and, as such, cannot approach research that I am part of any differently. It is also important to note and recognise that the research process is a very different scenario to the therapeutic encounter and will guard against entering that realm.

RTA offers a systematic and transparent analysis while permitting an acknowledgement of my ever-present epistemological framework. It offered me flexibility in capturing this phenomenon's complexity while recommending clear data analysis guidelines.

I have gone beyond summaries to represent and give voice to co-researchers and locate their stories within their broader social, cultural, historical, political, and ideological contexts. Through my interpretation and contextual analysis, I hope to have made the argument for further evolution of the therapeutic understanding of suicidal men.

The research questions for this study have been addressed within a paradigmatic framework of interpretivism and constructivism. I have adopted Byrne's (2004) principle, of faithfully reflecting on co-researchers' accounts of their attitudes, opinions, and experiences while also reflexively accounting for my interpretative influence as the researcher. RTA is a highly appropriate research method in the context of this study's underlying theoretical and paradigmatic assumptions.

Method

Data Collection

In line with Willig's (2013) recommendations for doctoral thesis studies, I decided to recruit between five and eight men to interview. I succeeded in recruiting 6 co-researchers and conducted individual, semi-structured interviews, each one lasting between 81 and 125 minutes. In total, I collected over eight hours of interview material. Participants were men over the age of 25 who had had a prior suicidal event and had subsequently experienced long-term therapy of at least twenty weeks. The group was heterogenous save my selection criteria:

- They no longer self-reported suicidal behaviours.
- Their last suicidal behaviour was more than 12 months ago (this significantly reduced the risk of suicidal behaviours being present)
- They had psychological support to draw from before, during and after our interviews: they were in therapy, attended a support group or had easy identifiable access to professional psychological help.
- They defined their gender and sex as male.
- They had therapy of at least 20 sessions to help them recover from their suicidality or from the phenomena that led them to be suicidal.
- They were over 25 and were able to give informed consent.

An ethical stipulation was that interviews take place at a named therapy centre Phoenix counselling in Feltham, SW London (see Appendix 7.3) or an agreed-upon neutral place provided by a therapeutically aware organisation. The interview dyads were never conducted in an isolated building, and help, if needed, was always on hand.

Recruitment

Although my research was originally scheduled for the summer of 2020, it was severely impacted by the COVID-19 pandemic. Although it was mooted that interviews could take place online, I felt uncomfortable with that and delayed recruitment until interviews in person were viable. Once I had achieved ethical clearance on the 21st of April 2022 (see Appendix 7.1& 7.2), I commenced recruitment.

Recruitment was challenging both due to lingering COVID-19 anxiety and connecting with such a hard-to-reach population. I engaged with organisations that had a specific remit to supporting men psychologically, such as Men Speak and the Male Psychology section of the British Psychological Society, but they were unable to help with recruitment. I also contacted suicide support communities that I had previously engaged with at psychological conventions and social media, such as Andy's Club, Males Allowed, and the charities CALM and Support After Suicide Partnership. My initial contact with these organisations was promising; however, they were reluctant to offer help due to ethical considerations around anonymity. Following consultation with my supervisor, other avenues for recruitment were identified and approved. I publicised my study through various electronic notice boards, Metanoia Institute and Middlesex University, Call for Participants (a research-specific recruitment website) and a physical advert at Phoenix counselling service in South-West London, as well as reaching out to my professional psychotherapist community.

(Ethical steps and considerations are outlined later in this document, which stipulates the exact procedures of this research.)

Initially, twelve respondents contacted me. All were emailed to arrange an initial phone call. Seven replied to my email, and a phone call was scheduled. During the call, I explained my study, checked if they aligned with the selection criteria, and went through a screening procedure (Appendix 7.5) based on protocols devised by Draucker et al. (2009). Of the seven contacted, two did not fulfil the selection criteria, one did not experience individual therapy, and one was not old enough. Whilst I went through this process, I started collecting data. I conducted 5 interviews over four months (from 16th August 2022 to 13th November 2023, during which time I was recommended to recruit a sixth co-researcher. They were identified, contacted and

engaged through my association with a charity, who was made aware of my research through a colleague. Although I did not offer any payment to co-researchers, I did provide travel expenses. All co-researchers were emailed and given a participation sheet (see Appendix 7.6) prior to interviews.

Co-researchers

Table 0-1 Co-researcher Information

Co-researcher pseudonym	***Age***	***Number of suicide attempts***	***Number of years of weekly therapy***	***Ethnicity***	***Sexuality***	***Number of Therapists***	***Main Therapist Gender***
Nathaniel	*60s*	*2*	*10+*	*White British*	*Homosexual*	*3*	*Male*
Ravi	*40s*	*7+*	*7*	*Asian British*	*Heterosexual*	*5+*	*Female*
Eric	*20s*	*3*	*2*	*Indian Asian*	*Heterosexual*	*3*	*Female*
John	*40s*	*1*	*1.5*	*White British*	*Heterosexual*	*2*	*Both Male*
Kyle	*30s*	*1*	*9*	*White British*	*Homosexual*	*3*	*Female*
Victor	*40s*	*3*	*2*	*White Irish*	*Heterosexual*	*4*	*Female*

Interview Protocols

Co-researchers were allotted a randomly generated identification code, completed a consent form (see Appendix 7.8) and completed two psychometric screeners to check their psychological well-being at the time of their interview, the Beck Hopelessness scale (BHS) and the short version of the patient health questionnaire (PHQ 9). These documents were made available to my supervisor, who confirmed that all Co-researchers consented to the interview and had indicated from the psychometric tests that each was within the no or mild range for the psychometric tests, and interviews proceeded as planned. My research questions were developed into three sections: Initial, intermediate, and ending questions, which are detailed in Appendix 7.6. These questions were formulated following the guidelines expressed

by Vos (2023). I was conscious of my desire to stimulate Co-researchers to talk freely whilst being mindful of my assumptions, bias and influence as a researcher, so I was sensitive and respectful to co-researchers when they opted to remain silent, being aware at all times that they were volunteers. After introductions and completing paperwork, I endeavoured to guide them in expressing their therapy experience. I collected their and known therapist demographic information.
To answer my research objectives, I asked more focused questions about their suicide and therapy experience, using probes, prompts and follow-up questions to elucidate what impacted the quality of their therapeutic experience, the dyadic relationship, and how ruptures were negotiated. I also asked if and how their gender and that of their therapists had influenced therapy and help-seeking. I referred to a schedule of open-ended questions illustrated below in Table 3-3.

My ontological position guided my questions regarding the need to obtain data that substantially illuminated the interviewee's experience rather than one that reflected my own held beliefs, fears or expertise. Positioning myself in the critical realist tradition, I was aware that research offers a construction created under specific seen and unseen conditions. I aimed to be mindful of my part in this. As such, the reflective use of gentle guidance helped elicit an as authentic as possible phenomenological representation of the co-researchers' lived experiences. Questions were dynamically shaped to facilitate dialogue, stimulate memories of therapy, and illuminate the experience within the therapeutic dyad. Developing a flexible schedule helped me respond with curiosity to my co-researchers and capture richer data. Continuing to take a reflexive stance throughout the process, questioning what I want to become aware of and if my schedule of questions fulfils that objective, helped me revise, emphasise and change questions before, during and after each interview. I ensured that all interviews were comparable and reliable; however, I used the schedule of questions as a guide rather than a set text. Modifications were made between interviews, for example, adding questions about pharmaceutical drugs and the journey to and from therapy and I retained these for all interviews. Considering the nature of the subject matter and the potential for re-traumatisation of co-researchers, I paid particular attention to questions that may be too intrusive. I devised the schedule with both the co-researcher's and interviewer's safety in the

foreground. My initial questions were designed to put the co-researchers at ease, whilst potentially tricky questions were asked at appropriate moments when I felt I had built enough safety and rapport with my co-researchers. This resulted in an accurate representation of their lived experience. I was also aware that I was acting as a researcher, not a therapist, and I drew a distinction reminding each co-researcher of that. These questions helped me answer my research question because they were open and elicited responses about how they experienced therapy.

The schedule was split into three sections, and I used my skill to decide when I thought I had rich enough material to move on to the next section:

Table 0-2 Schedule of Questions

	Possible Questions
Initial questions	Can you tell me a little about why you started therapy/ Can you tell me about how you found your therapist? What was the first experience of therapy?
Intermediate questions	Can you tell me something about how felt you may have changed during therapy? In relation to your suicide attempt? How has it helped you/what was not so useful? Can you tell me about your experience with your therapist? Did you ever disagree or fall out? What affected your work together? How did your therapist gender impact therapy? Can you tell me how your views about suicide have changed since having therapy? What services did you engage with (NHS GP Psychiatrist) – what was that experience like?
Ending Questions	Are there any thoughts that you have had during our time together that you may not have thought about previously? Is there anything that you would like me to know to help me understand what it was like having therapy? Is there anything you would like to ask me? How has this interview been?

At the end of each interview, I included questions about how they found our time together and whether they wanted to add more details. During interviews, I checked that co-researchers were feeling psychologically composed and not distressed. I

ensured all co-researchers were in a safe emotional state before concluding the interview. At the end of our time, I thoroughly debriefed co-researchers, giving each a copy of debrief information (see Appendix 7.9), which included contact details of support organisations.

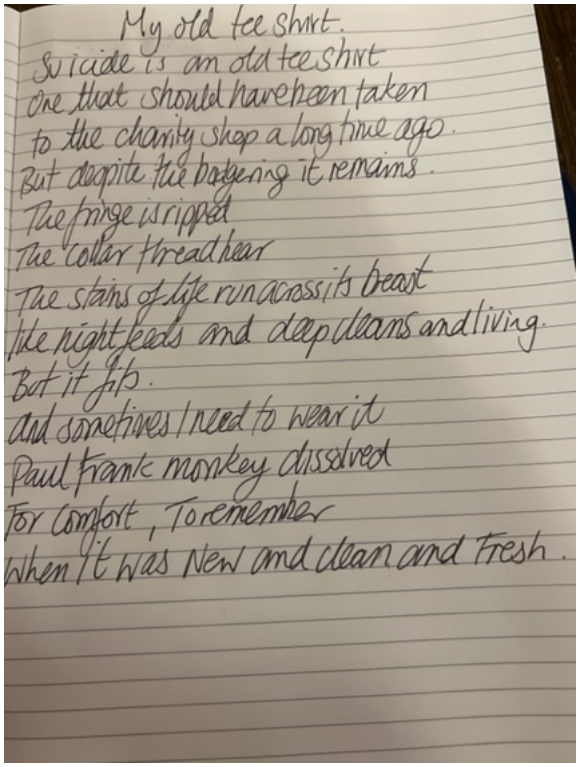
I found all co-researchers garrulous and happy to talk for over sixty minutes. Interviews were recorded using a digital recording device and transferred to a password-protected computer with specialist security software using 256-bit AES encryption. No identifying material was retained from recordings. All data was anonymised, and each co-researcher was allotted a random name. I noted any interpersonal processes and implicit information not clearly elaborated by their spoken words alone.

Participants were reminded that they were free to stop at any point and were permitted to withdraw from the research with no adverse effects, confirming that their contributions would be struck from the record up to two months from the interview date. Thankfully, none did. I was aware that co-researchers could have experienced difficulties and may have needed to contend with anxiety, depression or shame-based issues that may not have been apparent before they participated in the study. Although this did not happen, I had prepared a set of distress protocols based on Haigh & Witham's (2013) published procedures, detailed in Appendix 7.11.

Reflexivity 5

Insights into my first interview - taken from my reflexive journal 16/08/22 I have just finished my first interview and am struck by a number of things, firstly I am elated to have finally have my first interview in the bag. It has taken almost a year since I first started my ethics application. Although I was concerned that talking about suicidal history could be upsetting and difficult Nathaniel (Pseudonym) was very happy to talk about his experience, it had been over ten years since his last suicidal act and had completed a lot of therapeutic work since then – not least training as a therapist. I am not sure that tiptoeing around the issue is helpful – he did know what to expect and he was more than happy to talk about it. Because we shared a therapeutic language together I felt we sometimes slipped in to shop talk. I was very keen though for this NOT to be a theoretic conversation and made sure we focused on his experience rather shop talk and a couple of times had to check myself and my natural curiosity of the ingroup therapists' view

of suicidality and take him back to his life before training. This helped show me that recovery is not a simple case of moving from being suicidal seeking help get help and recover, it is a much more undulating path. There were so many different layers we discussed, sexuality, spirituality, gender and erotic transference. The discussion about his journey and time after therapy was very illuminating and I will remember to add that into the question schedule He had gotten caught up in conversion therapy which, because of my past religious experiences, made me want to research that. What was really helpful was how he described how therapy had not taken away his suicidality but had helped him turn the dial down, that therapy was sometimes a very unsettling experience. I wrote this poem to help me process that thought that suicide is something that never leaves us.



Phases of Reflexive Thematic Analysis

I followed Braun and Clarke's (2021) the six distinct phases of RTA. However, cognisant that they represent guidelines rather than a rigid set of rules (Braun et al., 2019). At each step, I was aware of and responded to my own intrapersonal reaction to co-researcher material. I also designed a novel way of theme development which aided my clarity. By being so aware, I became very conscious of my contribution to the data and how the intersubjective field was co-created.

Data Familiarisation

From the first interview, continuing throughout all interviews, to the transcription stage and beyond, I immersed myself in the data. I transcribed all interviews verbatim, leaving at most 48 hours after interviews. I included all utterances and words, adding punctuation marks and ensuring their accuracy by listening back to each recording at least four times. No transcription software was used in this process, as I could engage more fully with the material by employing this method. Where there was a pause, I included an ellipse …In addition to listening to the recordings, producing transcripts and reading through them to check accuracy. At this stage, I started to develop some initial thoughts around themes and noting them in my reflective journal, an essential process of reflexivity, Braun and Clarke (2021). Appendix 7.13 provides examples. This facilitated my reflective process and helped me identify what I might be bringing to the material, what areas I might want to explore with other co-researchers, and what initial themes I might start to create. I also found this an essential part of my self-care as there were times when I needed to process some of the profoundly emotive topics that co-researchers brought up. Much of my writing took the form of poetry and visual art.

Reflexivity 6

Extract from my reflexive journal Saturday 17th September 2022
After interview 2 had been transcribed

Interview 2 was very different to my first, in fact they could hardly be more different. Ravi (pseudonym) was manual labourer, an ex-addict (alcohol, drugs and sex) and was refreshingly very straight talking, almost abrupt. He also had a genuine want to help me, and other men who are suicidal. So, I have just finished my second transcription and am struck by a number of things that I took for granted but am having to question them now. First of all his openness was magnificent and the way he questioned what he was saying and I could feel him work out what he thought about the topic – his meaning making process shone through as he spoke, often remarking that he was having realisations as we spoke together, and the honesty that he had about covering up his first attempt, perhaps for the first time admitting to himself that he purposefully drove his car off the road at high speed rather than the official police report of it being an accident. I wonder how many suicides are missed that way?

I was also struck by his openness about his childhood sexual trauma and his insistence of that being the underlying reason for his suicidality. I was very interesting listening to my reaction to him talking about his psychiatric prescription

and how it had saved him. I am not a fan of SSRIs and the ilk however they seemed to save his life at the time so perhaps I need to get off my hubristic throne! This is something that I will include in future interviews as I think it is an important aspect to his help seeking, I have worries that it isn't about therapy per say but certainly impacts his life very much. I was also the humour we shared about him having so many (9) suicide attempts - the gallows humour and how that eased the difficulty in talking about this subject – although at the time I did wonder if I had over-stepped the mark but this was a genuine moment of meeting and a SHARED joke.

Generating Initial Codes

Initial code generation was started as soon as the first interview was transcribed. I did this with each interview, generating initial codes soon after each interview was transcribed. I chose this time scale as I wanted involvement with the data set to inform my interviews. For example, during the first interview, the idea of journeys to and from therapy was highlighted as an issue and the prescription of psychometric drugs in the second. Consequently, I purposefully amended my schedule of questions if matters referred to by previous co-researchers were not presented unprompted (see reflexivity 6). Using Microsoft Word to help me keep engaged easily with my data, I coded each transcript free hand purposefully at a more semantic level. I wanted to have a good appreciation of the data at a surface level, and I was keen not to be too present in the data set too early in the process, bracketing off my wants so that I would not miss significant ideas and make them available for theme generation later in the process. I was cognizant of how I reacted to the data and the differences and tensions within and across the interviews; I noted these inconsistencies and was aware that qualitative research can and should highlight minority voices and took note of ideas that did not follow the dominant narrative in the coding.

I completed my first round of coding and then coded each of the interviews again, looking for inconsistencies in my coding and adding code that captured more latent meaning. I later transferred the transcripts and these codes to a three-column electronic version (see Appendix 7.12). During this process, I began to build connections and reuse or tweak other initial codes to generate patterns across the entire data set.

After all transcripts had been manually transcribed and coded twice, I decided to recode them a third time using computer-assisted qualitative data analysis software (CAQDAS) (NVivo 12). This gave me a more organised central depository and allowed me to be more dexterous in comparing across different co-researchers' interviews; it also allowed me to pay more attention to emerging clusters of codes that I began to organise into groups of codes. During this third coding, I checked the generated codes and again considered if I could develop more latent meaning within the data set. As my research was based on therapy experience, I wanted to stay relatively close to my co-researchers' semantic meanings and honour their words. However, to balance the tension of that desire with the psychological curiosity that I have developed over years of being a full-time psychotherapist, I was mindful of my projections of the data set. I worked in collaboration with my supervisor, looking at various codes at different levels of interpretation to manage the internal consistency and accuracy of my codes in line with recommendations from Clarke and Braun (2021). During this time, I had frequent weekly discussions with my peer supervision group and presented my initial coding and the direction I could take my research. I also ensured with their help that I was bracketing off my own beliefs and desires regarding the findings of my developing analysis. To help build trustworthiness, I continued to document my feelings and initial ideas, showing my process as an auditable and transparent process (Lincoln & Guba, 1985).

I checked codes for their stand-alone reasoning and modified where appropriate. Once the third coding had been completed, I started collating codes into similar code sets, checking back with recordings and transcripts for any disparity between raw data, codes and code sets. Because of my scrutiny in coding, I became aware of ideas contrary to my belief patterns, particularly of what a good therapeutic experience is, which reminded me of work by Prall (2009) on what is good. What may be “good” therapy to me may not be what is experienced as “good” for the co-researchers. I found some data uncomfortable as it showed some ethically questionable practices. I also knew where my psychological and theoretical beliefs conflicted with my co-researchers. John’s assertion was that it was a ‘fool’s errand’ to look at his past in therapy, preferring to stay in the here and now. Being a psychodynamically informed therapist, I recognise the importance and impact of

childhood but also recognise that therapy needs to be concerned with change, meeting clients where they are and offering a service they want.
Throughout the process, I developed a fluid and organic process that built up a dialogue between my raw materials and refined my code set (see Appendix 7.14 & 7.15). I began to use them to knit meaning within and between them. Rich possibilities with resonant, complex, and subtle ideas started to be produced.

Generating Initial Themes

After my third coding using NVivo 12, I listened back to all interviews, meticulously taking notes to check the accuracy of initial code sets represented in each or at least most interviews. I then collated codes that had shared meaning. At first, I used NVivo faculties but found them unwieldy. I exported all codes and code sets and reverted to using Microsoft Excel. I began a meticulous categorisation and shifted my analytic attention to larger patterns of meaning (see Appendix 7.16). After this process and my migration from NVivo to Microsoft Excel, I still felt disconnected to the data set and not a little overwhelmed. I decided to go back to engaging with my data physically.
Being particularly dyslexic, I got disorientated and overwhelmed by the information, codes and initial theme ideas. I also needed to see and become physically engrossed with my data –to appreciate it together rather than in discrete, separate bundles on a screen (see Appendix 7.17). I recognised that I could not do this using a computer screen, either NVivo or Excel. I used different physical, rather than micro-processed, tables to collate and cluster codes around emergent themes, placing codes together that shared similarities. I was then able to see subjects and topics in my data more clearly and engage with my data at a deeper level. I generated my first set of themes and subthemes. These were checked through with my supervisor and my research support group. This created an excellent thematic map of my data and continued and facilitated the dynamic dialogue between themes and data sets. I reminded myself (with help from my supervisor) not to be too attached so I could fully enter the next phase of the analysis process.

Reviewing Themes

In a review of my first attempts at creating themes (see Appendix 7.16.1.-7.16.6), I considered how well it represented the original data and cross-referenced and checked back with the original data sets. The themes I initially created (Sitting in a difficult position, Inside out, outside in and in between, The Cycle of Therapy, Good drugs bad drugs, Power and Choice) did make sense. Still, in consultation with my research support group and supervisor, I realised they needed more complexity and were more descriptive rather than in-depth analysis. I could justify my themes; they made sense. However, they needed to be thicker and have more clarity between themes and subthemes. I was unhappy that they did not quite capture what was represented in the data set but held in mind advice from Braun and Clarke (2021, p. 100) that "I might need to discard my initial themes and start over". Subsequently, I went through a cycle of collapsing, renaming themes and subthemes and separating and amplifying others into new themes (Appendix 7.17-7.20). Some themes were discarded, partly because they did not relate to the research questions. Others were present across the data set but did not have enough extracts to support their inclusion. They were too anecdotal, with only a few examples. I was reminded that the main point of this important phase was to maintain the reliability and overall tone of the data in relation to my research question. I returned to the code set and approached them differently, theoretically robustly. To do this, I took my codes and produced two creative pieces: a theatre monologue and a short film.

Refining, Defining and Naming Themes

Elsner (2003) contends that using creative-based processes and traditions has honed our understanding of what it is to be human and how we cope with the world. Psychology and psychoanalysis have a long history of leaning into creativity, and as Finlay attests, using a creative embodied research practice helps researchers understand the world as expressed by those in it. I found that by connecting to my data differently and collaborating with an actor, I could see the underlying currents of meaning more clearly. This allowed me to draw out and pull together more robust themes and subthemes as I more fully immerse myself in the data set.

During this refining phase of analysis, I made sure that I kept a well-documented account of the process and noted that this development in my research methods was not an endeavour of my imagination but based upon the words, latent codes and my reaction to them hierarchies of themes. Supervision support helped me stay focused on linking my script to material from my data. Braun and Clarke state that phases of analysis do not have to be followed religiously; stages of analysis are a guide (2021). I was keen to see if this would clarify my thoughts. I was heartened to come across material about creative research by Helen Kara (2020), who attests to the role of creativity as both a way to unify existing components in research and free researchers from restrictive conventional fixed methods. She notes that "even authors who make a point of championing reflexivity express it in a cognitive way" (2020, p. 36). I used my creative writing to generate more precise topic summaries and comprehensive overviews. At this point, I established their efficacy and confirmability by demonstrating that each theme had been established and embedded in the original data (Ryan et al., 2010) (see Appendix 7.23). Once my themes were demarcated and built around a strong core concept, I focused on giving them an informative, concise and memorable name. Again, my creativity aided this and gave me the focus to provide a brief synopsis of themes and check that each had a singular focus related to and directly addressing my research questions.

Reflexivity 7

A copy of the video I produced can be viewed online via this link. https://vimeo.com/1003254260?share=copy

Writing-up

My writing-up process has not been non-linear. As a knowledge production process, I began collating my informal reflective journal into a more formal iteration of my research. I engaged with the themes and accounted for the active decisions I made through the reflexivity section in this thesis. As a seasoned writer of therapeutic processes, I appreciated that writing enhanced and catalysed the analysis of the

themes present in the data. Both are mutually inclusive and not just a barren description of my steps.

Trustworthiness

I have conducted this research project rigorously and methodically so that the results are trustworthy, meaningful and valuable (Lincoln & Guba, 1985). I refer to a widely accepted and understood criteria for testing trustworthiness created by Lincon and Guba (1989). This research meets their trustworthy criteria, covering credibility, transferability, dependability, and confirmability.

Credibility

A vital part of the success of this research rests on the credibility, believability and, ultimately, trustworthiness of my findings. In my aim to understand the experience of therapy of post-suicidal men, I define credibility as a measure of the "fit" between the co-researcher's views and the researcher's portrayal of them (Tobin & Begley, 2004). Lincoln and Guba (1985) suggest several ways to increase credibility, some of which I could not oblige given the singular source of data (data collection triangulation). I was the sole researcher. However, I undertook other activities, such as examining referential adequacy (Lincoln & Guba, 1985). I used multiple readings and reflexivity to locate my findings in the context of my data whilst keeping an appreciation of my bias and position as an outside entity on the influence on interpretations of the data.

Transferability

Transferability refers to the generalisability of the research findings. Here, generalisability did not apply as much as other studies might. The subject matter precluded half of the population due to gender, and suicide is still an infrequent occurrence, resulting in findings specific to that group. However, to facilitate those who wish to refer to this study as a helpful tool to understand the experience and perspective of men who have had a suicide attempt and engaged in therapy, I provided as detailed and thick a description of the research process and findings as possible.

Dependability

By making the process as easy to follow and traceable as possible, I confirmed the dependability of my research. By providing clear documentation, in line with Janis (2022), I have shown systematic and transparent methods and provided readers with a complete audit trail as evidence of all my decisions and choices during this research's planning, carrying out, and writing up. Furthermore, I include explicit references to the rationale of my choices. Throughout this process, I engaged with my supervisor(s) to safeguard any blind spots that may have influenced my decisions and checked for any unexplored areas in my data. My audit trail confirms the credibility of my findings, and following my research rubric, others would be able to clearly see how and why I come to the decisions I have.

Confirmability

I can confirm that the findings from this study originate from the data collected and understand that this confirmability is vital to building confidence with the reader. Throughout this study, I have built confirmability through a transparent commitment to Gaba and Lincoln's (1989) aim that qualitative research has credibility, transferability and dependability. I have acknowledged my impact on the research process, the double hermeneutic phenomenon (Smith & Eatough, 2016), and displayed this both in my reflexive journaling and through my reflexive writing, which led to my creative endeavours, namely the use of film and stage. I used the experience of creating a filmed version of my findings and the experience of being interviewed to learn, reflect on and understand what I brought of myself to the study. How that influenced the study's findings is an acknowledgement of the inevitable fact of my involvement in that co-creation.

Ethical considerations and procedures

General Ethical Considerations

To execute my research, I followed the guidance of Shaw and Carroll (Shaw & Carrol, 2016) and adopted an ethically mature position, balancing the ethics of duty

with the ethics of relational fidelity. Although, as Haverkamp (2005) stipulates, there is no universal form of ethically responsible research, I have embraced ethics of responsibility within the context of diverse relationships and shifting settings. I held in mind that student research is expected to comply with the British Psychological Society's four principles of ethics. I held by their principles of "respecting the autonomy, privacy and dignity of individuals and communities; conducting research with scientific integrity; acting in a socially responsible manner and maximising benefit and minimising harm" (British Psychological Society, 2014, p. 27). However, as with therapy itself, research into therapy can be emotionally messy (Hanley et al., 2013), and informed consent can never be 100% accurate, so risk cannot conversely be 100% avoided, particularly in consideration of the present subject matter. I endeavoured to reduce risk as much as possible. I fully briefed the co-researchers on the aims of my research. To achieve this, I ensured that the research aims were fully explained in my flyer and that other mental health professionals involved in helping me recruit co-researchers were fully briefed. To ensure that co-researchers felt capable of taking part and remained safe, I conducted an initial phone call explaining the process and how I ensured their safety.

During this phone call, I ran through a checklist with potential co-researchers to ensure that they were no longer reporting suicidal behaviour and sufficiently recovered from suicide attempts, self-harm, or psychotic disorders. This was to minimise the likelihood of harm by participating in this study. I also sent a follow-up email with the same information. When I made contact, I checked the co-researchers understood what taking part involved, allowing them to ask any questions about the process. In that manner, they verified they understood the aims and extent of their contribution to the research both orally and via email. Before each interview, also assessed current levels of risk by undertaking a suicidal ideation and a self-harm checklist assessed levels of mood measured with the PHQ-9 (Kroenke & Spitzer, 2002) and Beck's Hopelessness Scale (Beck et al., 1974), excluding individuals with severe levels of depression or hopelessness.

Participants were recruited voluntarily, and I only used professional email and social media accounts. This kept my personal online presence separate from my

professional life and minimised any potential boundary violations. I also recruited by placing an advert on bulletin boards and online professional networks of organisations supporting psychologists and psychotherapists: Metanoia, UKCP, BACP and the BPS. I did not recruit co-researchers I knew in any way, thereby eliminating dual relationships and their implied complexity. All co-researchers knew that their involvement was voluntary, and they retained the right to withdraw from the study at any time up to the start of the analysis process. None did. All co-researchers were notified that their involvement was anonymised. All material relating to them remains confidential by using pseudonyms and redacting any identifying information.

Specific Ethical Considerations

As my study centred around suicide and recovery, it was likely to evoke strong emotions within the co-researchers before, during and after the interviews. To this end, I devised a clear set of reproducible research protocols specific to this study.

Operationalised Research Protocols

I ensured that I maintained my professional boundaries by adhering to these clear operationalised protocols, which covered my recruitment procedures, initial inclusion, exclusion criteria and interview procedures. I also considered the location of interviews and how and where I recruited interview candidates.

Ethical Suicidal Research Literature

Gibson et al., (2014), identified a quandary in that, although qualitative suicide studies based on the experience of protagonists are needed, a particular ethical stumbling block arises that needs to be addressed when working with a potentially vulnerable population such as suicide survivors. A tautology exists: research is needed on vulnerable populations, but, as ethically, we are bound to ensure research does no harm. It may not be possible to do meaningful research because of the very vulnerability in question. My main consideration in studying suicide recoverees experience of therapy is the risk that co-researchers' suicidality (suicide ideation and behaviours) is increased. Dazzi et al (2014), contend that there has been a common perception in psychology that talking about suicide, in both a

research and clinical setting, increases the risk of suicidality. This apprehension, they believe, is not supported by empirical evidence. In their review of 13 published papers on adults, adolescents, at-risk groups and the general population, they found no statistical evidence to support the view that enquiring about suicidal ideation increased risk. Evidence indicated that the process of enquiry into suicidality reduced risk.

Furthermore, recent qualitative studies ratify that finding. Papers examining the role of dialogue (Sheehan et al., 2019; Stoewen, 2015) and collaboration Jobes (2023), points to the reduction of risk when disclosure of suicidal ideation is made. It increases the well-being of co-researchers. Halliwell and Hoskin (2005, p. 398) state that 'there is ample evidence that bringing these issues out in the open...is of great assistance'. Dazzi et al., (2014) affirm that ethical concerns about the suicidality of co-researchers would improve and encourage research. Although the exact mechanism of harm reduction is unclear (Sheehan et al., 2019), talking about suicide does not increase risk of suicide.

However, it is not enough to suggest, in this context, that it's good to talk. I believe that dialogue is both an implicit and explicit process. Gibson et al., (2014) identifies other issues that present themselves as problematic. When conducting qualitative research that is interpretive, co-researchers' words form the raw material from which the researcher creates their findings, albeit tentative. This further ethical issue, in anonymised portrayal, runs the risk of presenting a caricature and an inaccurate representation. Engaging in this emergent research method cannot foresee the risks that co-researchers may be exposed to in the future due to the researcher's practice at the point of consent. It begs the question: Are co-researchers, and for that matter researchers, able to assess the level of risk fully in advance? Work by Cukrowicz et al.,(2010) allays those fears. Judging the impact of research suicide on the suicidality of vulnerable co-researchers, they conducted 3-month follow-up interviews that showed that taking part in this type of research had no increase in the suicidality of co-researchers and, in some cases, a reported reduction in suicidality. As such, although informed consent is a difficult issue, it can be assumed that it has efficacy in this scenario.

Findings

In this chapter, I present my themes derived from the analytic process described in the previous chapter. Each theme, derived from the experience of psychotherapy co-researchers in this study, is exemplified by direct quotes from interviews. I provide a detailed introduction to my co-researchers and give a diagrammatic representation of my themes before explaining each of my themes and sub-themes in detail. My analysis produced three themes:

1) Creating a safe space in therapy.
2) The push and pull of gender proximity in therapy; and
3) Iatrogenic harm in institutional care.

The implications of these themes are discussed in the next chapter (5).

Presentation of Findings

Each of my co-researchers will be represented by a first name pseudonym (these were randomly assigned to the co-researchers as the original idea of identifying each person with a number felt too impersonal). My voice is represented by my initials AC. Transcripts were transcribed verbatim to retain meaning and appear in that form in this section. Grammatical errors, profanities and colloquial words and phrases remain as spoken. As presented in the recorded material, punctuation has been used to demarcate sentences, clauses, and lists. However, to avoid confusion, long pauses were represented with an ellipse … and remain in situ, but where text has been removed, an ellipse with a square bracket has been utilised […] to differentiate. Material may have been removed for one of three reasons: either to protect the co-researcher's anonymity or that of any third party, where co-researchers repeat a point before exemplifying it, or where they return to the discussed topic.
I use as broad a range of co-researchers as possible to illustrate each theme, endeavouring to demonstrate the ubiquity of the themes and sub-themes across the whole data set. This details a comprehensive illustration of the topics' complexity

whilst retaining the balanced and nuanced views expressed in interviews. As far as possible, accuracy and meaning are retained, and care has been taken not to alter or misrepresent a co-researcher's thoughts. All quotes are in italics, and any emphasised words (from the recordings) are in bold. More extended quotes are kept separate, but some shorter quotes, such as words and phrases below ten words, are within the narrative. Some themes and points have been illustrated more thoroughly than others; however, within those themes, I have also tried to include minority views. I ascribe to the importance of listening for opinions that may differ from the majority and hold to the notion that my research should highlight views that could otherwise be lost in other forms of research. Space does not permit all the examples I wanted; the used represent the co-researchers' voices. Some candidate themes were rejected as, after cautious deliberation, they were either not fully represented across all data points or did not satisfy the research aims, no matter the level of fascination.

Introduction of Participants

All co-researchers in this study identified as male and ranged in age (27-64), sexuality, and ethnicity. All co-researchers disclosed past suicidal behaviour: a suicide attempt or an arrested suicide attempt, and, if not already in therapy when that occurred, were referred or sought psychotherapy because of their suicidality. Participants had at least a year of weekly sessions of psychotherapy with one specific therapist; some had significantly more time and worked with many more mental health professionals. The theoretical orientation of the therapy was diverse and spanned the humanistic, integrative, Jungian, psychodynamic, psychosexual, and cognitive behaviouralist modalities.

Table 0-1 Participant Information

Participant pseudonym	*Age range*	*Number of suicide attempts*	*Number of years of weekly therapy*	*Ethnicity*	*Sexuality*	*Number of Therapists*	*Main Therapist Gender*

Nathaniel	*60s*	*2*	*10+*	*White British*	*Homosexual*	*3*	*Male*
Ravi	*40s*	*7+*	*7*	*Asian British*	*Heterosexual*	*5+*	*Female*
Eric	*20s*	*3*	*2*	*Indian Asian*	*Heterosexual*	*3*	*Female*
John	*40s*	*1*	*1.5*	*White British*	*Heterosexual*	*2*	*Both Male*
Kyle	*30s*	*1*	*9*	*White British*	*Homosexual*	*3*	*Female*
Victor	*40s*	*3*	*2*	*White Irish*	*Heterosexual*	*4*	*Female*

Context of Participants

In this preamble, I thought it necessary to contextualise the six lives of my co-researchers. Each brought their unique experiences and, in a way, are as disparate as any other randomly selected men. The only thing they had in common was that, in the past, they wanted to kill themselves and, subsequently, engaged in long-term therapy. However, as I reflected on our shared research experience, I found another mutual demographic. All had an experience of significant relational and developmental trauma that linked in some way to their suicidality. There was a notion of creating a separate theme or sub-theme to encapsulate this shared history. On reflection, however, it was not strictly within the remit of my research question as it influenced therapy but was separate. I thought it misguided to ignore the context of their common emotional hinterland. A universal past that brought them all to consider ending their lives.

I did not specifically ask questions about their past, but our conversations naturally allowed them the opportunity to tell their story of how they ended up being suicidal and needing psychotherapeutic help. However, whilst analysing and reflecting on the six interviews, I became aware of co-researchers' histories and stories of relational trauma. Although the context of our meeting was one of researcher and co-researcher rather than therapist and client, consequently their stories were lightly held and not explored in their entirety, my analytic side was piqued. I was struck by the ubiquity of early formative and significant traumatic experiences but, moreover,

how they made sense of it from their male-gendered position seeking healing through psychotherapeutic means. Considering this, the following excerpts paint a fuller picture of these suicidal men in therapy. Honouring what had happened to them before, how that influenced their help-seeking and the therapeutic dyad's relational dynamics. It also offers an opportunity to see beyond, consider the full gestalt, and alert us to the less traversed shadowlands behind many male suicide attempts.

The Traumatic Backdrop

Some of the co-researchers were quite clear about traumatic events fuelling their psychological problems that resulted in suicidal behaviours. Often, their trauma was centred around historic sexual abuse. Ravi, who had at least eight suicide attempts, describes the impact of a single incident, the far-reaching and dramatic shock on his development as a young man, and his resultant dissension into addiction.

> *"I wasn't progressing up I didn't know what was wrong with me. And that was the, that was the core of my depression[...] And it weren't till I was 19 the memory came back, what I went through…only one instance of abuse. Only one, and if I was to tell someone about it, it may not sound too bad, but it was enough for me." (Ravi)*

Similarly, Eric confided that in therapeutic exploring, he had understood the roots of his suicidality. Here, he described how his therapy was now moving on to trying to understand the genesis of his depression, dissociation and suicidality. He contended that it was strongly linked to sexual abuse in childhood.

> *"So so, now we're trying to discover where it comes from and a lot of it has been because of childhood abuse and some of those things, mostly trauma." (Eric)*

Victor spoke of "*the thing that got me to my life attempt"* was being cohesively controlled at the hands of a female partner, which precipitated his third, and hopefully last, suicide attempt. Here in the interview, he was quite clear that the trauma of that abusive relationship had a significant role in his suicidality.

> *"I was in a controlling relationship down in Bournemouth where she was isolating me from people… I didn't have anywhere to turn and I genuinely felt that there's no point." (Victor)*

John spoke of his experience of marital infidelity and divorce being a traumatic experience that was for him caused deep depression:

> "S*he'd been having an affair for two years after we'd be married for a year". (John)*

Nathaniel spoke of what made him suicidal. There was not one specific incidence of abuse, sexual or otherwise, that he spoke of. However, he did, in the context of being a gay man, point to the trauma of rejection and the non-acceptance by his religious institution as a driver for his suicidality. His subsequent forays into the abusive practice of conversion therapy to make himself acceptable were its nadir. Here, he maps out the impact of the church's systemic abuse via their homophobic attitude and the role it took in his suicidality.

> *"Why I was feeling suicidal. It was… what should have been the biggest source of comfort and of solace, and a place where I should be able to speak out my suicidal thoughts and be accepted, was the last place where I could be." (Nathaniel)*

There was a feeling that other areas of co-researchers' lives added to their suicidality that were not attributed to direct acts of sexual abuse. However, one other commonality was the relational trauma of abandonment and bullying. Both Kyle and John had been survivors of significant bullying early on in their lives, but neither attributed this to **the** sole reason for their suicidality.

> *"It wasn't to do with childhood and bullying" (Kyle)*
>
> *"And actually, it wasn't just that it was there were kinds of traumatic experiences with my brother bullying me quite badly and stuff." (John)*

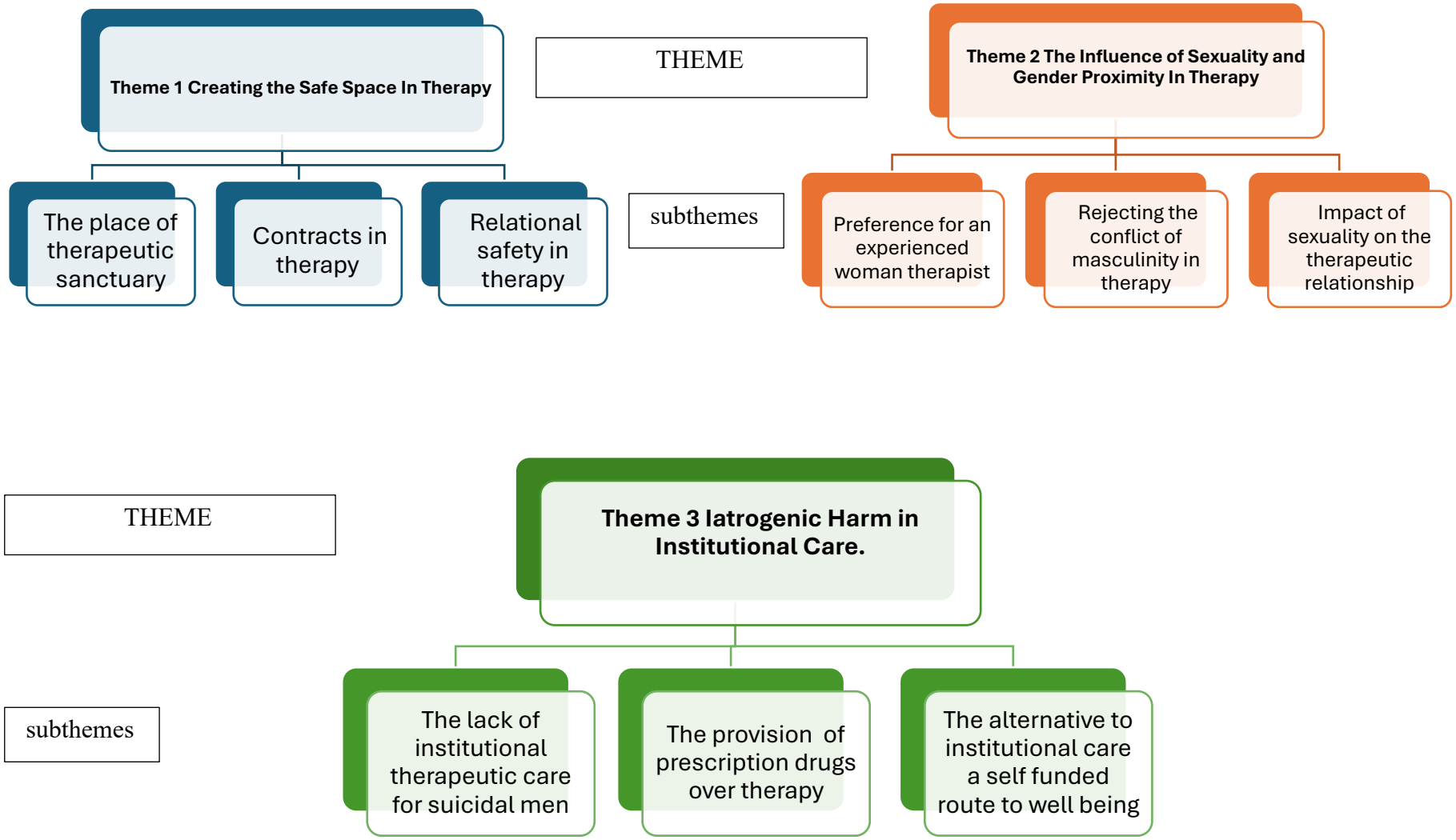
However, both also talked about significant acts of abandonment trauma being a catalyst to their depression and suicidality.

> *"I fell in love with someone and, it was nothing to do with me it was not my fault it was more them, it just got cut off completely and that's when I turned suicidal*." (Kyle)
>
> *"I feel one of the main things that sparked off … complex PTSD was having kids who were approaching an age (7) of when I went away to (boarding) school" (John)*

Overview of Themes and Sub-Themes

I generated three themes that address my research question by interacting with and interrogating the interview data and creating and combining codes to encapsulate and create meaning. These are summarised in Fig.1 below. Each theme and associated sub-themes will be briefly introduced with an extract from the interviews prior to proceeding to a fuller analysis with further illustrative material.

Figure 0-1 Map of Themes and Subthemes



Theme 1 Creating a Safe Space in Therapy.

The first theme considers the central role that safety played in co-researchers' therapeutic development. Participants spoke of a delicate balance between showing their psychological state and that act not being emotionally overwhelming because difficult emotions were safely navigated.

Subtheme – The Therapeutic Sanctuary

This sub-theme focuses on the impact of the therapy environment on safety. Interviews suggest that the therapy room is crucial in ensuring safety during therapy. Creating a pleasant but neutral environment enhanced containment and safety, whereas medicalised clinical spaces were not experienced as favourably. The physical distance between the therapy space and the co-researchers' geographical location also contributed to safety. The liminal space between home and therapy offered a reflective space, which enhanced the process. This was replicated when online therapy took place. Participants also found that a geographically distanced space offered anonymity and helped establish social boundaries, reducing potential unforeseen shame or stereotyping.

Subtheme – Contracts in Therapy

This subtheme examines how therapeutic contracts and confidentiality breaches affect men's safety in psychotherapy. By providing a framework and reference point, therapeutic contracts helped men navigate the unfamiliar territory of psychotherapy and contained the process of psychological healing/change. However, some found them to be more about protocols and a way to reduce the therapist's anxiety rather than in service of the client.

Additionally, co-researchers expressed that how contracts were delivered was important, and poorly thought-through delivery devalued them. Counterintuitively, contracts, in some cases, decreased therapeutic trust and negatively impacted the therapeutic relationship. Breaking confidentiality had a mixed effect on the progress

and efficacy of therapy. When executed collaboratively, it was therapeutically beneficial; however, if done without negotiation or proper care, it risked terminal rupture and lasting damage to clients.

Subtheme – Relational Safety in Therapy

In this sub-theme, I delve into the therapeutic relationship's profound impact on client safety. Participants consistently expressed that having a therapist they trusted had a tremendous effect on their overall sense of security and made exploring relational trauma possible. I also consider and emphasise other areas of a safe relationship, including the importance of the therapist being separate from the client's family or social circle. This separation allowed them to feel a sense of objectivity and helped create a safe space for exploration and healing. The co-researchers also highlighted the significance of feeling understood by their therapists. Where professional standards could have been better, the quality of therapy was severely impacted. However, when co-researchers' therapists displayed humanistic qualities such as non-judgment, non-shaming, compassion, and empathy, feelings of hopelessness were significantly reduced, and suicidality decreased.

Theme 2: The pull and push of sexuality and gender proximity in therapy

This theme was particularly evident in some interviews. Participants remarked on the impact the gender proximity of their therapists had on their ability to be more open to change, address mental health needs, and avert further suicide attempts.

Subtheme – Preference for an Experienced Woman Therapist.

In this subtheme, I contend that co-researchers chose older female therapists over either younger female therapists or men because it helped fill a gap in their relational development.

I posit that the therapeutic relationship was a developmentally needed one. This relationship had two aspects. First, it addressed issues related to early childhood

development or toddlerhood. Second, I propose that an older female therapist might be particularly adept at exploring the teenage parts of self, so that clients found it easier to be vulnerable and either let those parts be seen or that older female therapists found it easier to attune to them in those moments.

Subtheme – Rejecting the Conflict of Masculinity in Therapy.

One interesting view expressed was that co-researchers did not want male therapists as it ignited a belief that men were unable to navigate masculine competitivity within a therapeutic relationship. That was exemplified by poor past experiences with men in general and when engaged with a male therapist.

Participants pondered if one influence on their choice of a female therapist was that the concept of therapy was socially constructed and located in the female domain. That therapy was female pursuit. This not only influenced them in their individual choice but also due to the workforce demographics of there being more female therapists rather than male ones - the workforce does not have the numbers to meet the needs of men seeking therapeutic help from male therapists, thereby effectively giving men a ‘mono-gendered’ choice. It was thought by a minority that suicidality was a function of a male mid-life crisis and would need a more masculine response because there was a lived experience of that.

Subtheme - Influence of Sexuality and the Erotic in Therapy

Participants noted the influence of erotic feelings surrounding both their choice of therapist and therapeutic work. Some chose a therapist based on their erotic feelings and potentially used erotic transference to control the therapeutic progression and depth of the relationship. Other co-researchers rejected relationships that had the potential for erotic transference as they were seen as a potential cause for therapeutic rupture. They found that having a younger, attractive therapist added a level of complexity either erotically or when discussing matters around sex and

sexuality. Many favoured a safer erotic intimacy found with older women that reproduced a supportive maternal relationship.

Theme 3 Iatrogenic harm in Institutional Care

Participants described reacting to their experience with the NHS when seeking help whilst actively in a suicidal state. Often, they considered that the service dismissed men's mental health conditions and that the only option open to them was either taking antidepressants and/or seeking private therapeutic help.

Subtheme – The Lack of Institutional Therapeutic Care for Suicidal Men

Whilst co-researchers may have found institutions to be, on occasion, a force for good, they were often experienced as unhelpful and a source of distress. Participants occasionally described the extraordinary lengths they had to go for help.

Iatrogenic harm within the NHS was ascribed to a combination of long waiting lists, bureaucratic red tape, and an attitudinal disregard towards men's mental health. Male suicide was not seen as a priority. However, other institutions also offered a damaging service. In one instance, a co-researcher was a victim of the profoundly unethical practice of conversion therapy.

Subtheme – The provision of Prescription Drugs Over Therapy

Most co-researchers were offered psychiatric drugs as a treatment for their mental health issues. This was overwhelmingly the primary and often only institutional response to their need. Many co-researchers described experiences that detailed the range of different drugs and how quickly and easily their psychological problems were addressed by drugs.

Initially, co-researchers reported that prescriptions were helpful and kept them safe, and some saw it as the solution to their problems. However, this initial perspective shifted when prescriptions ceased to be effective. Participants spoke of a prescription lottery where ineffective drugs were replaced with seemingly random alternatives. Some co-researchers felt it folly to trust using psychiatric drugs that had unpredictable side effects whilst in a suicidal state. Many lamented the affect-blunting caused by long-term use and had stopped their use or were actively reducing their medication. Similarly, many felt that long-term talking therapy was a better way to address their psychological needs.

Sub-theme - Self-Funded Route to Well-being

Many co-researchers felt that the institutional services they received did not fully meet their needs. All of them sought help through private therapy and, in one case, alternative drug therapy. Participants found their needs were met more fully by seeing a private therapist.

Detailed Description of Themes

Theme 1 – Creating a Safe Space in Therapy.

This theme explores how therapeutic safety is created whilst addressing co-researchers' psychological needs. How they felt safe enough to risk being open, explore their emotional landscape, and face the potentially uncomfortable phenomena of their mortality/suicidality. For Nathaniel, below, the experience was good

> *"I experienced it and that I know, I had a safe space […] and a place where I could if I wanted to speak, bring me." (Nathaniel)*

Feeling that his therapeutic space was safe, he could consequently be emotionally open, more fully present, and able to express himself. Moving from denial to acceptance and reflecting on how that may have happened. I also consider co-researchers' bad experiences, wondering what may have happened or been missed for terminal ruptures to occur. For example, Ravi and Kyle both stopped therapy relatively early on in their therapeutic work because the structure of therapy was shaming.

> "*It was a psychologist, and he wants me to do these little tests […] it was just wasn't a good experience." - Ravi.*

There were also occasions where therapeutic standards were judged to be poor. Kyle, for example, described his rage at his therapist for falling asleep early on in treatment, causing a terminal rupture.

> *"I said, 'If you're going to hold me to high standards, you have to hold yourself to the same high standards. I'm so done with you." (Kyle)*

Three subthemes were developed within this overarching frame: the therapeutic sanctuary, contracts in therapy, and relational safety in therapy. In the first sub-theme (the therapeutic sanctuary), I contemplate the therapeutic environment, relating it to a place of refuge. I consider how the safety of the sanctuary is fostered by distance, the separation from co-researchers' day-to-day life and enhanced by travel to and from the therapy hour. In the second sub-theme (contracts in therapy), I scrutinise co-researchers' experience of procedural safety regarding contracts, non-suicide clauses, and breaking confidentiality. In the third subtheme (relational safety in therapy), I explore the relational phenomena that contributed to therapeutic safety and trust in the therapeutic dyad—exploring if and how emotional vulnerability seeded an understanding of the co-researcher's suicidality and its genesis.

Although each of the subthemes can be considered independently, they can also be considered interrelated. For example, the physical space of a therapy room impacts the ability to form a therapeutic relationship, and how therapists handle contracts and

procedures, such as breaking confidentiality, can profoundly affect the dynamics and trust within the therapeutic dyad.

Subtheme - The Therapeutic Sanctuary

Victor's first experience of therapy as an outpatient followed a suicide attempt and a ten-week inpatient stay in hospital. His comments highlight the impact which the physical environment can have on therapy. He did not feel at ease during his NHS hospital-based psychological treatment, equating it to physical medicine rather than mental wellbeing. Here, he describes his discomfort in addressing his psychological needs in a place that was associated with disease and illness.

> "*My head was saying – 'this is all about medicine; this isn't about my thought process' […] I found that awkward, still being attached to the hospital." (Victor)*

He noted that the treatment's clinical setting and directed nature created an austere atmosphere, leaving him unsatisfied. Although it was helpful, and he acquired some techniques to use independently, he did not get as much out of his therapy as he would have liked had he had more time to explore issues in greater psychological depth. Ultimately, he failed to get to the bottom of his low mood and suicidality.

> *"Yeah, very clinical, very 'this is your time slot'. Clinical psychologist. It was all sort of like project based so this week we're going to do this, this week we're going to do that […] you can use the exercises but again, it didn't get to the basis of why I felt absolute crap." (Victor)*

This contrasted with his longer-term therapy in a private consulting room, where the therapist had created an environment, that while personal, was still professional. He felt attending therapy in a therapist's home would be too intrusive and uncomfortable. On the other hand, experiencing a more neutral space that had some home comforts aided his therapy.

> *"Yeah, you don't feel like you're in someone's house, because that could be sort of, off putting but it's got enough neutrality… Yeah, it's got that perfect feel between office and home*." (Victor)

Ravi's experience was similar, though he had not minded being in the therapist's house. He noted the significance of the therapeutic space and its area and expressed its importance and impact on his therapy.

> *"I suppose the venue was quite important, it was quite nice venue. It was her place, it was her house, it was a big house. And she had this little room there. It was a nice area as well." Ravi*

He went on to explain how his geographical location also influenced the efficacy of his therapy. His therapeutic journey and the subsequent distancing from his area facilitated his expectation that therapy would be helpful; it helped him feel more relaxed and opened him up to gaining insight from the whole process.

> *AC*
> *"Why was that good?"*
> *Ravi*
> *"It was nice to get away from my area it was nice to drive half hour, 40 minutes to go and see her […] the journey there, kind of put some music on, put some tunes on to drive up there. It was nice to look forward to it and go and see her you know. To share my stuff and hoping to get some wisdom some feedback and some wisdom from her..."*

John echoed Ravi's comments about choosing a therapist away from his local area. His motivation to find someone further away was rooted in a concern about encountering his therapist outside the therapy room. John specifically chose someone outside of his area as he was keen to separate his therapy from his day-to-day life. He explained how he was "*not necessarily willing to be bumping into someone in the Co-op"*. Here, he hints at the ethical dilemma of meeting his therapist in his local area as this might intrude upon therapeutic work.

Victor also expressed his reluctance to access mental health support in his local area. He viewed this as counterproductive because of the potential for shame.

> *Victor*
> *"The negative side of it would be if you went to a "well man's shed" that was purely for manic depressives or for schizophrenics 'cause the outside world would know what that shed is."*
> *AC*
> *"There'd be some judgement?"*
> *Victor*
> *"Or you would **feel** that there is judgment."*

Here, he reflects on how he felt judged attending a "man's shed" in his hometown for support. He felt that he risked being overlooked by people in his social group, which could have resulted in being judged as a man with mental health issues. This was one reason why he found it difficult to engage more fully with the socially prescribed 'well man's shed' his local mental health team offered him.

Finally, geographical distance enabled a journey to and from therapy and was seen as part of the therapeutic process, the crescendo and diminuendo that bookended therapy. Victor remarked that the journey there aided "*getting into the mode of being open",* echoed by Ravi "*That's what it felt like* (driving to his sessions), *I want to deal with some stuff today…to share my stuff and hoping to get some wisdom." For Victor,* the journey back enhanced his therapy, giving him time to reflect on his progress and readjust to the outside world. It gave him a sense of accomplishment.

> "*Yeah, then on the journey back… it's genuinely the journey back is kind of like I've done it again." (Victor)*

John, who had experience of virtual working with his second long-term therapist, found that taking time to readjust after a session, perhaps reproducing the journey to and from therapy, helped him return to psychological equilibrium. Below, he

describes how his therapist encouraged him to transition back into his day-to-day life.

> *"And he (therapist) would always suggest, like if at all possible, make sure you like get up and go for a run straight afterwards not just sit here, and I think I did always do that…that was definitely kind of part of the whole kind of journey." (John)*

However, this distance and journey back to everyday life was not always considered containing. Nathaniel explained how challenging his mood was after therapy; his return to equilibrium was not confined to a simple ride on the bus home. He found the psychological impact of recognising his shame, his internal homophobia and how it had driven him to be suicidal fostered an unhappy mood that needed longer to process.

> *Nathaniel*
> *"The stirring up, the talking it out, which is ridiculous to say, but it's true this is my, this is my journey, actually, that was the difficult part of the therapy. That very often you will hear clients say 'oh it's such a relief to be able to talk about this; I feel that it feels lighter for it'."*
> *AC*
> *"But it actually made you feel heavier?"*
> *Nathaniel*
> *"It didn't make me feel more suicidal, but it made me feel bad about myself; it brought up all the shame. Bringing up the shame for me and the incongruity and the non-integrity was difficult to deal with in the aftermath…there is a lot of aftermath for me."*

Nathaniel's experience of the aftermath of therapy, as he explains later in his interview, the stirring up that therapy does, highlights the impact that it can have on clients and the potential difficulty of navigating therapy safely. Participants spoke of how the therapist acknowledged that safety more formally through therapeutic contracts, which is the next subtheme explored.

Subtheme - Contracts and Safety in Therapy

In this subtheme, I contemplate the impact of procedural safety measures applied by therapists and whether the pseudo-legal formality, represented by contracts and safety plans, had the intended effect on co-researchers. Across all six co-researchers, there was some variability in the application of contracts of service and safety plans. Some were formally presented, and co-researchers were required to sign them, indicating their agreement with the conditions of the therapeutic contract. Other co-researchers had a verbal agreement, and some were expected to sign explicit suicide safety conditions for working with their therapists.

Kyle vividly recalled his first-ever therapy session and how helpful his therapist's contract was. Here, he describes his feelings of containment arising from the precise agreed structure of how he and his therapist would work together. As a nineteen-year-old, having this explicitly explained to him helped him navigate a novel and complex situation.

> *"Knowing the ins and outs of what to expect and how it works, yeah, I had something to go by rather than it being a free for all." (Kyle)*

Not all co-researchers were aware or could remember what they had signed. When he had therapy after his first two suicide attempts, Victor hinted that he did not have the mental capacity to understand his contract fully. When talking about safety contracts and plans that he may have been given to sign, he admitted he was unable to take on board the information because he was psychologically overwhelmed. He signed them to comply with his therapist's wishes, but on reflection, he recognised it had had little or no impact on his mood or actions.

> *"To be honest, where my brain was the first couple of therapies that I did, I probably just signed it but didn't take much notice." (Victor)*

Victor, a man who had tried to take his own life, was unaware of how any safety mechanisms were to be enacted. This suggests a certain degree of passivity on his behalf, as if he was a passenger amid a process intended to keep him safe. He may thus have forgotten or been psychologically unable to focus on or comprehend a service contract. This contrasts with his present-day therapist, someone he has been seeing for eighteen months. With them, he does not have a written signed contract, though paradoxically, he has internalised the contractual responsibility for his well-being. Here, he describes how his 'contract' is different than before, as he had made a personal agreement with himself that he wants a better life through therapy; subsequently, he had not missed a single session,

> *"I've always gone, that's been 'cause, even though I haven't got a contract. I know I want to get better, so it's a contract for myself." (Victor)*

However, contracts and therapists describing how a therapy service works are a time-honoured and ethical way of working. However, from a practical point of view, it is also a way to demarcate roles and responsibilities and help clients develop confidence in both their therapist and the therapy—a starting point for a therapeutic alliance. Contracts are not just for the client's benefit but also to protect the therapist. It is essential to set out a framework of how therapy should work, how it should not, and what ideally will happen if a client's safety is in question. But, having the ritual of signing was sometimes seen as a procedural box-ticking exercise, a way to assuage the clinician's apprehension about working with a client with a suicidal history. Eric wondered if the non-suicide contract that his therapist asked him to sign was a way of lessening *her* anxiety rather than keeping him safe. He commented:

> *"I think my therapist is really scared of me killing myself… since we started, she made me sign a no-suicide contract*." (Eric)

He went on to explain how he felt it was a way for her to protect herself procedurally rather than a vehicle primarily intended to reduce his suicidality. Although it was not a terminal rupture, it could have diminished her professional standing.

Eric

"I asked what's the point of it if I kill myself? And I think she was really flustered."

AC

"Do you feel that's helped you keep safe?"

Eric

"I don't think so, I think it was a sweet mostly thought she did it, but I mostly laughed about it. I thought that had no effect on me doing anything even subconsciously… I mostly thought of it as a joke even though she was really serious about it."

Safety protocols in the therapeutic relationship are typically only acted upon once disclosure of danger to self or others is voiced. Again, there were several views expressed by co-researchers when they felt confident in the disclosure of any increase in suicidal ideation or behaviour. Nathaniel was clear that, at the start of therapy, he did not have sufficient trust in disclosing his acute suicidality to his therapist for fear of losing autonomy, which in turn made it less likely he would seek help.

"I wouldn't let anybody do anything for me, I do now, I have been on that journey and it's much more enriching and all of that and I get that, but so therefore to ask for help because I'm suicidal? Of course I am not going to ask." (Nathaniel)

Confidentiality within the therapeutic relationship was a subject co-researchers raised. Eric had experienced two instances where different therapists broke confidentiality. Both times, the therapist contacted his family. The first was without his knowledge, which led him to leave therapy. The second, which was condoned and done with his full knowledge, was a turning point in his therapy and served as a way to lessen his hopelessness.

"It was her idea to share with him (brother) because she felt like I needed more support beyond therapy that could only come from home, so that was

> *nice. I felt like after that session, that was a significant turning point; well, I felt significantly lighter…. not sad, at least in front of my brother." Eric*

This suggests acting multilaterally when confidentiality is broken can reduce adverse effects, enhance client safety, and improve the working alliance. If done without consent, it risks a terminal therapeutic rupture.

Nathaniel, now an experienced and qualified therapist, added his thoughts about contracts and safety plan protocols and how, ultimately, the client has the choice about his (or her) safety.

> *"It does not matter how good our risk assessment are, what our protocols are, we can do all we can to keep somebody safe. But if somebody wants to kill himself themselves, they will kill themselves"*. (Nathaniel)

Subtheme - Relational Safety in Therapy

Participants spoke about relational safety and the importance of developing a trusting therapeutic relationship. Starting from the initial therapeutic alliance, which was sometimes facilitated by contracting, as with Kyle, through developing a two-person psychological relationship that encapsulated the humanistic core conditions of therapy, co-researchers described the development of that relationship and what elements were particularly important or detrimental to it.

Many co-researchers felt relationally safe knowing or feeling an anonymous someone was seeing and holding their distress. Here, John described his first experience of therapy and the implicit sense of safety he felt with his therapist. Having someone external offering him permission and freedom to explore the challenging emotional landscape he was experiencing with his family.

> *AC*
> *"What was that first experience of therapy like?"*

John

"It was a feeling of protection and security that was outside of me, and that was hugely comforting."

Having someone else hold them in mind was a common sentiment expressed by all co-researchers. However, as hinted at by John's experience and in the context of co-researchers' suicidality, it was acknowledged that 'the other' had to be someone neutral, outside and separate from family and friends. To reflect on his state of mind and his suicidality, Victor articulated the need for someone detached from his family and social group. His concern was about the reaction of his loved ones exploring the topic and the impact their response would have on him if it engendered difficult emotions such as shame. In this extract, he talks of the anguish that he felt thinking about his family's reaction if he had been successful in his third suicide attempt and how he could be open about it with his therapist as someone outside of his community.

Victor

"Suicide is a part of me that I don't like to reflect about to everyone but I'm OK, I can't talk about it with my family that's a no no. And I think that's to do with guilt and shame."

AC

"Worrying about how they might react as well?"

Victor

"It makes me realise that if I had done it, how bad that they would feel, so I can't talk to them about it. I ***can*** *talk to my therapist about it."*

Kyle reiterated the effect of talking to and being heard by an empathic other. The impact of being able to voice his suicidality paradoxically gave him space to realise that he had other options than to kill himself. The emotional space created by his therapist by *just sitting there,* understanding him and his state of mind, was able to contain and reduce his suicidal intent.

AC

> *"How have your views about suicide changed since you started having therapy?"*
> *Kyle*
> *"I mean the main thing is that talking really dampens that urge and that voice, that tells you there's only one way out. It really dampens that by having somebody there just sitting there understanding you.".*

Nathaniel echoed this, how his therapist helped him live with his suicidality. Rather than trying to eradicate that part of him, his therapist helped him dampen the urge to kill himself.

> "*So have the suicidal and ideation fine, dialled down*." (Nathaniel)

He illustrated his experience of relational safety, emphasising the importance of his therapist's attitude and having the space to talk without worrying about how his therapist was receiving his material. He cited several other attributes that built upon his ability to speak about his suicidality and their empathy that Kyle described. Here, he describes his therapist's nonjudgment stance, adding that confidentiality, anonymity, and self-direction were also crucial to feeling secure and vital to his further therapeutic development.

> *Nathaniel*
> *"I could talk about my suicide and … that was positive because I didn't feel it was unsafe to talk about it or I was being judged*."

He continued…

> *AC*
> *"So, what do you think made that a safe place?"*
> *Nathaniel*
> *"Knowing that it was confidential, knowing that there was no reporting back, knowing that I was in control of it."*

This suggests that both the therapist's attitude increases safety by addressing his need for confidentiality and anonymity and letting him have *control* of his therapeutic journey. Therapy, for Nathaniel, was not a procedure he was on the end of; he was 'not done to' by his therapist but allowed to go at his own pace.

Relational safety can also offer access to repressed emotions and new ways of being. Victor cited this as an essential part of his successful therapy. In this passage, he recognises that his therapist had not done *his* therapeutic work; he had thought she had an important part to play. He appreciated that she did not sit in a deified space instructing him what he should do but instead refused to give him a solution to his issues or "*wave a magic wand*." He had to strive to find the resolution made possible by her permitting him to experience his previously prohibited emotions, which he had hitherto not allowed himself to acknowledge.

> *Victor*
> *"She hasn't waved the magic wand, because it's all my work, that's the intriguing thing about therapy. It's my work; I've got the answers; I've just got to acknowledge I've got the answers and sometimes work for them. It's fascinating, to be honest."*
> *AC*
> *"So, she hasn't told you…?"*
> *Victor*
> *"No, she hasn't told me she doesn't tell me how things should be. She will occasionally say to me, if I start talking about what's happened, she will occasionally say to me, 'Well, that's allowed. People are allowed to feel like that.'"*

Kyle commented on how a therapist can be perceived to hold power or sit in a deified space. Here, he explains his anxiety about how he felt her response would be when he returned to therapy following a suicide attempt. He describes his anxiety around therapist rejection, aware that his material could have a negative effect, had the potential for shame, and risked a dyadic rupture.

AC

"And how about that experience after you'd had a suicide attempt?"

Kyle

"Yes, it felt like…I was worried that, you know, she was going to be disappointed that I didn't turn up or anything. But she welcomed me with open arms and was just like…it felt really natural going back in there."

His return appeared to be a significant moment for his therapy. The potential rupture was a source of growth rather than a shaming event, described below as an "awakening" and the demarcation of a therapeutic shift. From one where his therapy was a means to finding endorsement or support from the world via his therapist to one where he understood himself more and could be more self-directed, self-supportive, and emotionally self-sufficient. Here, he goes on to describe that process.

"I think it was in that second experience I had the awakening, and it was more conscious and aware of who I was as a person. Whereas before I was quite confused about why I was acting the way I was acting when I saw her, the second time I was like 'I'm aware, I'm conscious'. Rather than looking for answers I was articulating my own answers. This is why I'm like that. I wasn't looking for answers I was looking to have a conversation with myself and have those answers already the first time I think I was seeking some sort of validation, whereas the second time I could validate myself." (Kyle)

Self-actualisation was not everyone's experience of making known their suicidality or history of suicidality. Eric described here how an early therapist reacted to him talking openly about his suicidal ideation. It seems she could not contain her reaction to this and, in effect, discharged him from her client roster. The impact of her response to his candour left him feeling less safe than before he started therapy with her.

"Two or three sessions, then she told me this (his suicidality) is something that is beyond her capacity… she said she would rather recommend I look for a

> *clinical psychologist … I felt more abandonment, even my therapist was leaving me so that was really, I felt really hopeless." (Eric)*

Conclusions to Theme 1

This theme has mapped out three aspects of safety that co-researchers experience in therapy. Firstly, the geographical place and the physical venue in which therapy occurs were significant in developing the therapeutic relationship. Participants who experienced harsh, medicalised, or uncomfortable environments found it deleterious to their therapeutic endeavours whilst, unsurprisingly, a more individual and private space was appreciated by co-researchers and fostered a sense of safety. The journey to geographically distanced therapy impacted how co-researchers internalised and made sense of their therapeutic development and return to their day-to-day lives, unexposed and in a place of psychological safety.

Secondly, the role and use of contracts, particularly safety contracts, were largely not experienced as helpful and did not, in the co-researchers' experience, help develop a safe and trusting relationship. There is a suggestion that these were experienced as an official 'box ticking' exercise or a method that therapists used to help them navigate the therapist's own anxiety. However, when confidentiality was broken with their consent and blessing, it supported safety and the therapeutic relationship.

Finally, co-researchers highlighted the vitality of relational safety and described the elements needed for that to develop. When therapists created an emotional environment that honoured anonymity, neutrality, and acceptance, it helped co-researchers express themselves freely. Participants noted that an empathic other, unphased by the content of their narrative, facilitated co-researchers' self-determinism. Time was needed for this level of safety to develop.

Reflexivity 8

Reflections on Theme one This theme has a few surprises for me and confirms some of my deeply held beliefs. The importance of building safety in a therapeutic relationship is key and

how it is no surprise to me that therapists who offer and practice the basic skills of humanistic therapy. This simply cannot be done in a short time scale. I recall how when finishing with 'training' therapist who I had spent 5 years of weekly therapy which added up to about 220 hours of therapy. 5 years seemed a lot but in actual fact when seen as 220 hours it represents less than two weeks.
However, I was keen to be open to short term work being useful. I also have to concede that sometimes therapist can fall into being a bit repetitive and so here I see a mirror of my struggle between the need to be active and doing things to make things better for clients and not to press so much and objectify clients. What I find interesting and am understanding is that these were not 'suicidal' men needing treatment for 'suicidality' but men who have suffered significant trauma and may well be suffering from or presenting with complex PTSD and seeing them through that lens of course reminds me that to help needs to go slowly and SAFELY. I also wonder how overlooked men are in this regard – the idea of PTSD being confined to the military and emergency services. Here there are men who have never been near a battlefield, a burning building or a crash site, which a lot of research is based on. Their trauma is hidden and unseen, they do not sit in the hero position that gives then license to be so impacted.

Theme 2 - The Push and Pull of Sexuality and Gender Proximity.

In this theme, I further explore therapeutic experiences and the role that sexuality and gender had on co-researchers' choices and experiences. Gender strongly influenced co-researchers' perception of therapeutic safety, as discussed in the previous theme; however, gender influence was more nuanced and also concerned containment, levels of relational engagement, and attunement, such that a distinct theme was warranted. The intersection of co-researchers' masculinity, sexuality and the therapist's gender was identified as a significant factor in selecting a therapist and establishing a successful therapeutic relationship. Participants reflected on how the therapeutic process was related to their own masculinity, with Victor succinctly expressing his choice of therapist and how he connected with her during his treatment.

> *"I **do** think gender plays a massive role." (Victor)*

In this exploration, we consider the client's perspective and how their gender identity shapes their experience. It's important to note that I am using the co-researchers' own terminology to discuss how gender affected their psychotherapy. I examine how

gender-based assumptions impact their experience and whether the roles and responsibilities assigned within the therapeutic relationship are beneficial or obstructive to their well-being.

The following reflections provide insight into how gender influences co-researchers' experience of psychotherapy, acknowledging that some define gender in binary terms. While acknowledging co-researchers' gender concepts, I maintain an open stance on gender as a socially constructed phenomenon and hold a more diverse understanding of gender beyond binary terms. I also address how issues of sexuality, both therapists' and clients', may influence their therapeutic experience. In some cases, this was explored in depth, and the data collected offers valuable insight.

Table 0-2 Overview of Participants' Age and Gender

Participant	*Gender of therapist*	*Age of therapist*	*Age gap*	*Proximity*
Nathaniel	*Male*	*Older*	*Small < 5 years*	*Gender near Age near*
Ravi	*Female*	*Older*	*Large > 20years*	*Gender far Age far*
Eric	*Female*	*Older*	*Small < 5 years*	*Gender far Age near*
John	*Male*	*Older*	*Large > 15- 20 years*	*Gender near Age far*
Kyle	*Female*	*Older*	*Large > 20 years*	*Gender far Age far*
Victor	*Female*	*Older*	*Large > 20 years*	*Gender far Age far*

As can be seen in Table 4-2, most co-researchers, four out of six, had older cisgender female therapists as their main therapists. It was observed that these co-researchers tended to seek and remain in therapy more often with older females than with younger females or male therapists of any age. This suggests that they

found therapy to be more effective and engaging when working with an older female therapist, specifically someone who was both older and of a different gender. Consequently, my second theme explores the origins of this phenomenon and the factors contributing to a lasting therapeutic relationship between male clients and older female therapists.

The next three subthemes explore the attraction towards seeking an older female therapist, the aversion to male therapists, and the impact of sex, sexuality, and sexual orientation on the therapeutic experience. These interconnected issues of therapist-client dynamics are categorised into three sub-themes: sub-theme 2.1, Preference for an experienced female therapist; sub-theme 2.2, Rejecting the conflict of masculinity in therapy; and sub-theme 2.3, How sexual attraction and sexuality influence therapy. These sub-themes delve into how co-researchers' experiences in therapy are intertwined with their individual sexual and gender histories, their emotional and developmental requirements as men, and how their psychotherapeutic progress was perceived within a gendered context.

Subtheme – Preference for an Experienced Woman Therapist.

Participants spoke of the significant role gender played in their selection of therapists, the longevity of therapy, and the perceived success of the intervention. For most co-researchers (4/6), the best and most extended therapy was with an older female therapist. A common position was that co-researchers' choice of therapist met the need for developmentally missed relational experiences; they had better-lived experiences with women and felt it easier to be vulnerable with a female therapist.

Kyle and Victor echoed this issue of the developmentally needed relationship or 'gap' that an older female therapist might fill. In this extract, Kyle alluded to his feelings of parental transference, describing his realisation of his wish for an older female therapist because, amongst other things, she could offer him the containment, emotional consistency, and maternal affect regulation that seemed to be missing from his childhood.

Kyle

"I realise I'm drawn to older women. Because I find them quite nurturing."

AC

"So, you think age was an issue as well… Of choosing her or staying with her because she had a nurturing motherly…?"

Kyle

"Yeah, very motherly yeah that's what it was."

AC

"So that kind of reparative relationship… was an important factor for you?"

Kyle

"Yeah, not that my mum's a bad person or anything, but there was something there. I saw that my mum was sort of emotionally unavailable to a certain extent, so I looked at older women for that comment to get what I didn't get from my mum."

Victor explained that his therapy addressed needs that came from both early and late childhood. Here, he talks about how he and his therapist worked together to identify and meet the needs of his younger parts, both consciously and unconsciously. This process emulated the affect regulation of the mother-child attachment from early years. Also, it provided appropriate guidance for his teenage part, ultimately helping to keep Victor safe from self-harm and suicide.

Victor

"So, I've got the toddler side that needs nurture, the attention, then I've got this teenage side that's sort of like, kind of definite Kevin and Perry, the teenager the pre-adult comes with, that's the dangerous one."

Victor went on to explain that he had reached a point where he felt safe enough to delve into aspects of his identity and the process that led him to feel suicidal. Through a longer therapeutically reparative relationship, he recognised his depression and suicidality were linked to his teenage self and explained how his therapist had guided him, like a teacher or parent, to be more in control.

Victor

(talking about in-therapy dynamics)

"I have been a petulant teenager, that's something I'm working on."

AC

"What was that like?"

Victor

"Funny, came out the week that I did it, she allowed me to do it. And the following week she said, 'you do realise you were just like the typical petulant teenage last week?' And it's 'what do you mean', 'oh, there it is again. There he is again.' So, she's helping me understand where I am and the different parts that are that control sometimes. When I'm in an uncomfortable situation and asked to do something uncomfortable, then my petulant teenager comes out. It's very much like a Kevin and Perry scenario it's very strange. She's teaching me."

Here continued to expand on how his teenage part related to his past suicidal behaviour and by the symbolic use by his therapist of parts of self, helped engender self-compassion.

Victor

"I don't want to get rid of the suicidal part of me; the suicidal part of me is a teenager who thinks it is an adult but hasn't got the skills to survive in the world. He hasn't got there... he doesn't know how to deal with the adult world but thinks he can. So, when it all falls apart, he gets very depressed and wants to end it all."

AC

"So, I'm interested in how that happened; when did that happen in therapy?"

Victor

"We always talked about the inner child and so started it off as everybody's got an inner child. It's just learning to recognise that child and when that child is present. So, it kind of developed after four or five months of me understanding my personality."

Eric expressed how he found it easier to communicate with women. Although it initially appeared to be an implicit choice, he later explained that he believed women have a universal ability to facilitate men's vulnerability, which is why he chose a female therapist.

> "*It becomes easier for me to talk to a woman, and I don't know why that is." (Eric)*

> *"There's a phenomenon that men feel more comfortable being vulnerable with more female members, so that's definitely a criteria I have consciously thought of." (Eric)*

Victor's choice of having a female therapist perhaps reflected his issues of needing emotional freedom, indicating his belief that the territory he was 'stepping into' was more feminine. This was linked to his history of having a better-lived experience when interacting with women - a dynamic that he hoped to reproduce in therapy - one he would be unable to create with a male therapist as readily.

> *"But I think I've always got on better with women. I can relate and open-up to females quite easily." (Victor)*

He speculated that this was partly due to his inability to feel vulnerable around men. Here, he talks of his innate desire, as a man, to navigate toward a female therapist because the intimate emotional relationship with them was more straightforward and that, although he may not understand why he felt this, he was conscious of the unease of communication with a man in comparison.

Subtheme - Rejecting the Conflict of Masculinity in Therapy.

In this subtheme, I examine why men tend to avoid engaging with male therapists and instead are more inclined towards female therapists, as discussed previously. This issue is explored from several angles. Firstly, I explore how men may find male therapists helpful only in specific ways. Secondly, I consider the social bias that

leads men to exclude male therapists from their options. Thirdly, I consider how personal histories and experiences with "masculine" relationships may lead men to avoid male therapists. I suggest that men may prefer female therapists because the dynamic between a male client and a male therapist is more likely to be competitive or combative.

There was a minority view, from John and Nathaniel, who chose male therapists, that the challenge facing them was rooted in a gender-specific phenomenon. John believed that another man would be more understanding of his psychological issues because of his ability to relate to, be better informed about, and understand a male in his 40s having depression and suicidal tendencies.

> *"Maybe it was the idea of of this being kind of midlife crisis and that being a kind of male territory." (John)*

Nathaniel also had male therapists, three in total. The first he chose because they were recommended by a Christian organisation that provided "counsellors," a trusted organisation within a church that shared his religious beliefs. He, like John, thought that a male Christian counsellor would understand his story more readily.

> *"It's a helpful question, why did I choose…? His name was J***** and I choose a Christian counsellor […] believing at last you'll get to me and at last I'll have got an answer […] He'll get my story."*

However, the reason why his therapy "*wasn't that helpful"* was because he was involved in conversion therapy, which perpetuated his internal homophobia, the main reason he was suicidal.

> *"I heard about conversion therapy, and I realised, oh my gosh, this is what's happening; this is what I am getting caught up in."*

Often, male therapists were considered, but co-researchers did not follow through with it. Here Kyle, whilst speaking about the pull towards a female therapist, talked

about how he actively contemplated a male therapist and his future desire to do so, as it would offer a different perspective.

> *AC*
> *"Would you consider having a man therapist?"*
> *Kyle*
> *"I thought about it. I wonder what that experience would be like. I'd love to have that experience at some point."*

He went on to discuss the impact of the gender imbalance of therapists and how that may have influenced his choice. He wondered if more men were needed as therapists or if the balance was right because men are happiest talking to women.

> *Kyle*
> *"Statistically, there are more female therapists than men, I think that does play into it. Maybe that's my assumption that maybe there should be more men to talk about this stuff, but maybe men don't want men to talk to… maybe they want women to talk to."*

Some co-researchers expressed how their adherence to traditional gender roles and narratives resulted in a reluctance to engage with male therapists. Ravi neatly sums this up in his views on competition between men. In his opinion, therapeutic work would be hampered by the competitive dynamic that relates to verbal put-downs and more base or fundamental drivers such as sexual prowess, physical strength and competitiveness.

> *"We mug each other off, we take the piss out of each other. Play it like the big man. I'm bigger than you; my dick's bigger than your dick. I can fight better."*
> (Ravi)

Eric also spoke of why he felt unable to have a male therapist, as he "*felt betrayed by the man"* (therapist) and undermined. But he also speculated about the influence

of traditional masculine traits related to his therapy. He reflected on not wanting a male therapist because he feared a loss of control. He, like Ravi, anticipated that there would be a struggle for power among men, leading to a lack of trust and an inability to be emotionally vulnerable, necessary for a more profound psychological connection and the therapeutic process.

> *"I think it's also the fact that men feel like they're so smart, we know what they're (the therapist) gonna say, and that's something I hear my friends say […] they want to feel so much in control, they can't feel vulnerable…*
>
> *… I think the gender bit is also important because I feel like if I'm talking to a man, men feel competitive in a conversation that they want to be the alpha. I think that might be a thing that needs addressing where if I'm talking to a man I wouldn't want to be as vulnerable." (Eric)*

Subtheme - Impact of Sexuality on the Therapeutic Relationship

Participants spoke of how their sexuality, sexual attraction and erotic transference affected their choice of therapist and the experience of therapy. This extract from Ravi's interview illustrates how his concerns about erotic thoughts and his previous "*really pretty woman"* therapist influenced his choice of professional. To avoid erotic thoughts and feelings towards his therapist, he opted for an older therapist he did not find sexually attractive, which would have been distressing and lead to self-recrimination and a possible rupture.

> *"I thought with a younger woman…I may end up getting thoughts for her…. that would have made me angry*." *(Ravi)*

Interestingly, this early experience of therapy opened up further thoughts about finding the proper levels of intimacy with an older female therapist. His interview highlighted the need for some intimacy but not too much, that his therapist became an overtly sexual object, illustrated by the termination of addiction counselling by his younger, attractive therapist. He was unable to develop a deep therapeutic

relationship because of his sexual attraction to her. Choosing a male therapist offered too *little* intimacy, and his therapy seemed dry and worthless. However, selecting an older woman he was not sexually attracted to permitted him to be intimate *and* develop a more profound therapeutic relationship, allowing him to explore his relationships with women and attend to his emotional development. Here, he contrasts his experience of seeing a male therapist, who seemed to offer him very little, with the reparative or corrective emotional experience that his older female therapist offered him, recognising that therapy with her helped him experience female intimacy in a safe and contained way.

> *"I did see a man, it was a free counsellor, and he didn't really tell me a lot. He just kinda listened, he was quite elderly, in his 50s or 60s. And he he actually, he didn't say a lot to be honest […] with a female therapist it was like, because I hadn't had any female attention or any female relationships with anyone or female type of relationship, I was kind of filling that gap with her as well to some extent." (Ravi)*

Navigating erotic transference was also an issue for Eric, who did have a therapist in her thirties, older but relatively closer in age. He spoke of his awkwardness in talking to her about his lack of sexual performance and his concern that she would find the topic embarrassing. He expressed his unease at putting her in a potentially awkward situation.

> *"I'm concerned about talking to a female therapist about it because I don't want to make them feel … I don't want to make her uncomfortable." (Eric)*

When considering his choice of an older female therapist, Kyle made the connection to his sexuality as a young gay man. He foresaw the potential pitfalls around erotic transference, rejection and abandonment if he employed a male therapist. Choosing a female therapist was safer as it negated any prospect of romantic rejection by an object of his desire. Having a rejection from his therapist, due to the untenability of such a relationship and his understanding of the ethical ramifications of a client-therapist relationship, would, for Kyle, have been analogous to the rejection he

suffered when his romantic relationship ended, which led to him becoming suicidal. To avoid this possibility and avoid a feared increase in suicidality, he opted for a therapist he would not have found sexually attractive and, in doing so, kept himself safe.

> *AC*
> *"Is there any other aspects about you that dictates your choice of therapist?"*
> *Kyle*
> *"I'm wondering about my sexuality and if that plays a part in it. I may trust women more than men, I guess there's a fear…what if I fancy a male therapist. How do I detach myself from that?"*
> *AC*
> *"So, in a way, having a female therapist is safer? You're not going to fancy your female therapist?"*
> *Kyle*
> *"And a lot of my working is to, is to do with abandonment, so if I was to see a male therapist and fancy them, fall in love with them, whatever, have feelings for them and then get rejected, even though it's not a rejection, it's an ethical issue. I would internalise that and take that as a a thing. And one of the reasons why I got sectioned was because I fell in love with someone, and it was nothing to do with me. It was not my fault. It was more them, it just got cut off completely, and that's when I turned suicidal."*

Later, he also considered if his choice of an older woman therapist mirrored the 'safe erotic' relationship he enjoyed with a BDSM mistress from his past. His therapist, he asserted, replaced the role of his mistress and offered containment through her knowledge and the dynamics of being older and more dominant in a safe, motherly way. Like with his mistress, where he could play out sexually, in therapy, he could perhaps play out psychologically and express desired and vital unconscious thoughts and feelings in a safe and contained way.

> *Kyle*

> *"There's also another part that I feel plays into this it and it is going deep into it, but I used to have a mistress, I'm part of the BDSM scene and I used to have a mistress, it was non-sexual. I used to play out and she was an older woman, a motherly figure, so that dominating older figure worked for me. So, in a therapy sense, you've got that older dominating, more knowing woman that plays into it as well, so I'm getting what I need out of that."*
> *AC*
> *"So, what do you think that is?"*
> *Kyle*
> *"Yeah, it's a motherly containing that I spoke about at the start. Where I don't have a mistress now that is kind of in place."*
> *AC*
> *"That deeper psychological need, that containment, that motive in the past being from mistress, you'll find it from a therapist."*
> *Kyle*
> *"I just put two and two together for every moment is a moment of realisation. That makes sense to me, so I was looking for that mother figure, be it a mistress or a therapist."*

This stance somewhat contradicted Nathaniel's choice of opting for a male therapist. He described how gender had influenced both his choice and direction of therapy. He always chose a male therapist, and he achieved two different mandates. Firstly, he acknowledged that as well as an interest in his philosophical stance, erotic feelings gained from his therapist listing photographs were a major determinate in choosing him. Secondly, he harnessed the power of erotic transference to enable him to be more in control of the therapy and not have to fully address the cognitive dissonance around his sexuality and his religious beliefs. To have "*another easy ride"*, as he put it, which hints at the erotic. Potentially, he used the erotic transferential phenomena within the therapeutic encounter to protect himself from a more profound therapeutic relationship, disavowing deeper significance. He speculated that the reason he avoided a female therapist was to evade the inevitable

deeper level of therapeutic challenge that would pose and address the friction of his cognitive dissonance.

> *"And I have always chosen a male therapist. I thought and and I will be completely open and honest with you – oh, he looks nice …Go on then, it turned out to be right, but it was another easy ride… He was great and he allowed me to me to dictate the pace he was very good therapist in that regard but far too passive than I needed. I need to be challenged and be able to sit through, …have help, gain help and understanding through a female's therapy. And I won't go there, I know I won't." (Nathaniel)*

Conclusions to Theme 2

In this theme, I postulate that the gender and age of therapists impact co-researchers' therapy experience. Generally, suicidal men in this study chose an older female therapist rather than a male therapist. Participants illustrated this phenomenon in several interconnected causes. Firstly, there was a pull towards having a female therapist. Participants described the ease of communication, the ability to feel safe with vulnerability, and the emotional regulation women offer as major factors in successful psychotherapy. This use of a reparative or developmentally needed relationship was particularly useful in exploring where suicidal tendencies came from and addressing that through maternal nurturance of younger parts of self. There was a feeling, amongst some, that a male therapist might better understand and empathise with the position of a suicidal man. However, most co-researchers actively rejected an all-male therapeutic dyad; some feared that it would be sullied by traditional masculine traits such as competition and not be conducive to emotional vulnerability. Sexual attraction and sexuality were a noted topic. An older woman therapist gave a different erotic transferential experience of maternal holding rather than the more sexually charged associated with younger women.

In contrast, co-researchers hinted that male therapists may find it difficult to offer such maternal holding. The older female therapist provided just the right level of erotic transference. Some gay co-researchers rejected a male therapist because of the fear that they may develop an erotic transferential relationship that was difficult to navigate, whilst others hinted at using that to keep their control in therapy.

Reflexivity 9

Developing this theme gave me a lot of surprises. I started my journey with this research with a burning sense of injustice around the gender disparity in psychology and psychotherapy. I was ready to take my findings as a way to campaign for more men to take the steps I have in becoming a therapeutic mental health professional. I step away from the soap box – this is not so simple. A far more complex system is in place and perhaps it is too easy to blame the feminisation of therapy as a reason why men don't talk – in fact feminised therapy seems to be quite helpful and many of these men have positively chosen that feminisation. A quick view of listed therapist in my area gives a ratio of 1:3.5 ratio of male to female therapist – an interesting ratio that mirrors the death by suicide ratio in the UK. What is evident for me is that perhaps there is a reason why that disparity exists and for this group of men that may be a good thing. I am really intrigued about the similarities of acting out psychologically as a needed developmental stage and sexuality, how Kyle experienced his older female therapist in comparison to his BDSM mistress – neither were sexual but both were essential to enable him to develop be that a therapy room or a dungeon.

Theme 3 Iatrogenic Harm in Institutional Care

My third theme considers co-researchers' experience of institutional therapeutic care. All co-researchers had experience seeking help from institutions, primarily the National Health Service (NHS), often in the guise of mental health wellbeing services, their general practitioner (GP), and accident and emergency departments (A&E). Experiences of institutional therapeutic assistance from other quarters were also considered. Although all co-researchers' most extended engagement with the therapeutic world was through private psychotherapy, the impact of engagement with institutional bodies was significant. I felt it necessary to voice and reflect on their experience, be that connected to counselling and psychotherapy, psychological or psychiatric assistance. In this theme, I also scrutinise interviewees' experience of prescribed psychotherapeutic medication, their experience of being prescribed them,

how effective they were in impacting co-researchers' mood and suicidality, and the broader impact on their mental health. The theme is split into three subthemes: The lack of institutional therapeutic care for suicidal men, The provision of prescription drugs over therapy, and The Self-Funded Route to Well-Being.

Subtheme - The Lack of Institutional Therapeutic Care for Suicidal Men

In this subtheme, I consider co-researchers' experience of psychotherapeutic care through engagement with service providers and organisations. This concerns the National Health Service (NHS) and access through general practice (GP) and institutions such as the Church and Narcotics Anonymous (NA). Institutions were sometimes a force for good, either as therapy providers or as catalysts to explore more help working in tandem with private practice. However, often, institutions were experienced as unhelpful and a source of distress. Within the NHS, this was ascribed to a combination of long waiting lists, bureaucratic red tape, attitudinal disregard towards men's mental health and reprioritisation away from male suicide. In other areas, such as the church, harm was caused by deeply unethical practices. Often, the only consistent offering to co-researchers was psychiatric drug therapy, which is considered in the next subtheme.

Victor detailed his good experience of having 12-week autogenic training (AT) on the NHS with a clinical psychologist. He attended this after his first suicide attempt, and although he found it clinical and delivered inflexibly, he was keen to register that it had helped him retrain his thinking patterns.

> *That was on a one-to-one basis, very clinical, typical NHS to be honest […] very clinical very 'this is your time slot'. Clinical psychologists. It was all sort of like project based, so 'this week we're going to do this this week we're going to do that' […] it worked. It* ***did*** *work."* (Victor)

John described how the NHS helped him while he was actively suicidal. In extending his seven-minute appointment to fifty, his GP indicated how seriously he took John's situation. He felt seen, and because his distress was recognised by the authority of his GP, his state of mind and the need for help ascribed validity. This, in turn, allowed his wife, who was very scientifically minded, to understand and acknowledge the seriousness of his suicidality and where his recovery began.

> *"It was very helpful for me to be able to describe my conversation with the GP. Cos it lent my experience credibility*." (*John)*

He continued to explain the impact of that appointment, how they took him seriously, and how he felt heard by his GP, which then started his recovery.

> *"…he said, 'I'll have multiple conversations today with people who are depressed and suicidal, but what you've described to me was an imminent moment and so I'm taking this particular seriously'. That was quite helpful. It was kind of okay like 'let's listen to this'. Then this is, was, this is where the recovery actually starts." (John)*

Ravi explained how being supported by NA had helped him explore a more vulnerable side of himself, aiding his private psychotherapy. He experienced encouragement and responded to the organisation's openness; this gave him the impetus to seek further therapeutic help.

> *"After going to NA Narcotics Anonymous, where everyone shares their stuff […] after sharing my stuff, getting a sponsor, talking to people, them sharing their stuff. Asking for help is what I done […] I went straight to see a psychosexual counsellor." (Ravi)*

Ravi's experience of NA was positive, both as an institution and the people he encountered. Nathaniel's experience of his employer (a church organisation) following his last suicide was equally supportive. His suicidality was related to his

difficulty of being a gay, HIV-positive man and the moralistic stance that his religious organisation had on homosexuality. Here, he recollected his feelings and worries about the meeting and his catastrophic thoughts about his future.

> *"I went to my leaders […] to tell everything, the whole story to who you need to tell. Knowing that you're likely to get sacked in the process." (Nathaniel)*

Instead of the rejection he anticipated, he found acceptance, care, support, and the freedom to get the help he needed in a way that he chose, that the institution funded.

> "*I then spoke to my leaders, told them my story. And they were very supportive and gave me six months leave of absence without any loss of money or home... (they said) 'You obviously know what help you need… go get whatever help you need, and we will provide'*." (Nathaniel)

These experiences, I contend, illustrate that institutions have an essential role to play and were a force for good in helping the co-researchers recover. Unfortunately, many interactions with institutions were, at best, ignorant of the needs of suicidal men and, at worse, were actively harmful and exacerbated their suicidality. I contend that an institutional blind spot exists regarding suicidal men.

Many co-researchers cited a lack of access to suitably qualified, free point-of-contact psychotherapeutic professionals, as a barrier to their well-being and recovery from suicidality. A combination of factors created this difficulty; however, waiting time for NHS therapy and petty bureaucracy was often cited. Many co-researchers saw this as a signifier that men's mental health services were of low priority. Kyle exemplified the issue in the time it took for his referral to be (un)realised either through supply and demand issues or referral red tape. This was, for him, a source of harm and he gave a disturbing and frank experience of being on an NHS waiting list. Here he expressed his frustration, detailing the extremely long amount of time he had waited for face-to-face therapy and calculated the length of time he was on a talking therapy waiting list. Reflecting on his feelings of oppression that accompanied it.

> *"I was on the waiting list for eight years! I kept on being pushed back down…"(Kyle)*

Kyle's experience of the NHS was one of insensitive and impersonal service. He offers insight into the impact of the bureaucratic hurdles that service users face. He recalled what happened while he was under the care of two different NHS services and his experience of trying to meet the requirement for free therapy.

> *"I went a year later, and they told me I was at the top of the waiting list but I was anorexic, so I wasn't able to start talking therapy until I started sorting out the anorexia….the second time around when I was top of the list I was sleeping too much so I had to go to a sleep clinic and an eating disorder clinic. I had to attend all these clinics before they would even allow me talking therapy." Kyle*

Here, he reflects on the Kafkaesque nature of his struggles to get therapy, how others who are unable to afford private therapy may fare and concludes that he was fobbed off by the NHS with medication as his only option. The experience, intended to alleviate his psychological distress, ultimately caused him psychological (iatrogenic) harm.

> *AC*
> *"That's quite punitive; I don't know if that's my reaction or yours."*
> *Kyle*
> *"It was … I just gave up; it was lucky that I managed to pay for the therapy I was having; it angered me so much there are people out there who can't afford the therapy who don't get to the top of the list […] the anorexia clinic discharged me and said "there's nothing we can do". And then they (IAPT service) said "you need to put on weight". And I said "I can't put on weight". But then they said "you need to in order to be referred to therapy".*

> *And I'm like, "What are you actually doing for me apart from just giving me pills?"I had so many arguments with them, so many, it was exhausting, my anger was huge back then, the frustration of not being listened to."*

His frustration at his attempt to be heard peaked with his attendance at the accident and emergency department at his local hospital. In a mental health crisis and desperate for help, he was sectioned under the Mental Health Act, but only after a considerable battle with staff.

> *"I went into hospital, and I said I was going to kill myself there and then and it took four attempts of them saying "no you're fine, don't worry", so I basically said to them "if I leave this hospital I going to walk out in front of a bus". And that was the point where they sectioned me. After like hours of being there saying I'm really down, I'm really depressed." (Kyle).*

Kyle was not alone in his unhappy experience of NHS waiting lists; Victor describes having to wait for almost a year after his first suicide attempt at 20 before he could see a psychologist.

> *"Yeah, stayed in hospital for About ten weeks as an inpatient. And they got me onto the psychology, but it took that took about a year to come through." (Victor)*

Over twenty years later, Victor had his last suicide attempt and was faced again with a long and potentially dangerous wait to see an NHS therapist. He was advised by a friend not to delay, being fortunate to have therapy funded by the same friend.

> *"I told Mic (pseudonym) and told him everything was going wrong…then he said "I'll get you a therapist don't wait for an NHS one because you might have to wait too long, so I'll get you a therapist". (Victor)*

Once waiting lists were navigated, some co-researchers faced indifferent professionals. Ravi recalled his GP referral to a psychiatrist following his third suicide

attempt and a spell in drug rehabilitation. He indicated that there was a lack of thought and a level of institutional indifference towards suicidal men.

> *"I saw my doctor after that. And he sent me to see a psychiatrist, So I saw a psychiatrist and with him, he was a bit blasé really. He seemed a bit blasé. It was a few different psychiatrists again it was through the NHS." (Ravi)*

That indifference was echoed by Victor, who reflected on the apathy towards male suicide in the NHS. Here, he compared the provision for other medical needs and men's mental health provision. He purports that male suicide is still a hidden topic, and the prioritisation of services is either along gendered lines, favouring females, or medical issues. He also contemplates male suicide data as symbolic of the hidden nature of male suicide in society.

> *"I don't think there's enough emphasis on mens' mental health to be honest, there's not enough. You go into my, if you go into my doctor's surgery, you've got leaflets everywhere, like the main ones that you see are like women's abuse and then cancer and stuff like that. You don't see one about, so, like, how many men commit suicide? Over 25, it's the biggest biggest killer." (Victor)*

The NHS was not the only organisation that seemed to cause harm to suicidal men. Nathaniel, a minister in a Christian organisation, described an experience of institutional psychological (mis)care. When he faced his suicidality and the reasons behind it, he sought help from a Christian organisation affiliated with a local evangelical church. There, he attended two twelve-month therapeutic programmes and underwent a course in what he later found to be conversion therapy.

> *"I went there and it was great, and I I really believed it. And then six weeks later, I thought, 'Oh', and I got caught up in, and then I heard about conversion therapy, and I I realised, 'Oh my gosh, this is what's happening, this is what I am getting caught up in.'" (Nathanial)*

In his interview, he described his experience of the cognitive dissonance of being a closeted gay man and a member of a faith organisation that forbade homosexuality. Here, he explains how his sexuality and his internal homophobia precipitated his suicidality. The answer presented to him was to make himself acceptable and 'cure' his homosexuality, and conform to the church's canons. Here, he describes how he tried to achieve that conformity by "*killing off his homosexuality*" through conversion therapy. He thought then that if he could be converted by treatment into being straight, he would be acceptable to the church, and his suicidality would be abated.

> *"I was, right there, was a part of me that wanted to kill myself. And it was my homosexuality of course that was. If that could have been killed off. That's why the conversion therapy, so that, that could have been killed off."*
> *(Nathaniel)*

He, in retrospect, reflected on the experience of conversion therapy, which helped him contemplate the contradiction of the practice and the harm this brand of therapy perpetuates. It was unable to hear, see and accept him for who he was because his counsellor was entrenched in a dogmatic and inflexible paradigm driven by the institution of the evangelical church. This stance was (and is) at odds with both his LGBTQAI+ identity; it confirmed and magnified his suicidality by preserving his internal homophobia. It is a deeply inegalitarian practice and, by its nature, iatrogenic. He was seeking internal and institutional acceptance. Conversion therapy proved that desire was impossible. The fundamental inflexibility of its doctrine – that being gay was a mortal sin - made him unacceptable to God, and the church, who, in his eyes, should have been able to offer him the succour needed when suicidal, could not. His sanctuary became his tormentor, and that fuelled his suicidality.

> *AC*
>
> *"What caused you to be suicidal was…?"*
>
> *Nathaniel*

> *"Why I was feeling suicidal, it was… what should have been the biggest source of comfort and of solace, and of a place where I should be able to speak about my suicidal thoughts and be accepted, was the last place where I could be."*

Returning to John, who sought help from his GP when in a suicidal crisis, where he received medical validation and support. However, he found that the help available was limited to medication. He had hoped for more comprehensive care, such as access to other forms of mental health service provision, such as talking therapy. Still, unfortunately, the only available treatment was drug therapy.

> *"I said the GP, 'like is there a recovery plan to get me better or are you just giving me some antidepressants?' He said 'we are just giving them to you, there isn't a plan around this'." (John)*

This form of intervention that was offered to John, prescription drugs with minimal contact or access to psychological therapies, was a common phenomenon and often cited as a particular difficulty or barrier to well-being by co-researchers and is a topic considered more fully in the next subtheme.

Subtheme The Provision of Prescription Drugs Over Therapy

The experience of psychiatric drug therapy was almost a ubiquitous topic for co-researchers (5/6). Most co-researchers accessing NHS services were offered psychiatric drugs as their main treatment. Initially, they reported that prescription drugs, such as antidepressants, were helpful and taking them kept them safe and was a solution to their suicidality and mental well-being. There was a feeling from some that they helped access psychotherapy. However, often usefulness was limited and could be counterproductive. Participants found that they lost their efficacy or interfered with getting in touch with their feelings and so were an impediment to both living a full life and therapeutic work. Some remarked that the experience was damaging because care seemed random, and they felt objectified - once one drug

stopped working or a new diagnosis was arrived at, another pill was prescribed that had random levels of effect. Some co-researchers rejected this route to well-being, either because they felt the impact of psychiatric drugs was unpredictable or because the side effects were too impactful. Many co-researchers were on medication for a very long time (over 20 years). They had changed their minds about taking drugs, pointedly lamenting what they had lost because of prescription-induced, emotional blunting. I argue that co-researchers indicated that, when appropriate talking therapy or psychological self-help seeking is employed, they internalised their locus of control, and well-being increased proportionally with a reduction in medication. Similarly, long-term talking therapy was a better way to address their psychological needs.

Returning to John when seeing his GP whilst he was actively suicidal illustrates a shared experience of how the NHS tackles men's mental health primarily with, and often only with, psychiatric drugs. The following extract encapsulates not only how John sees the medicalisation of the 'psychological' but also laments the absence of any appreciable alternative to drug therapy and illustrates his opinion that the NHS displays an overtly dismissive attitude towards suicidal men.

> *"The NHS, here is a pack of antidepressants there, now fuck off and see how you're doing in six months' time." (John)*

John continued to affirm his scepticism of antidepressant treatment. He described not wanting, whilst in a suicidal state, to take a psychotropic drug that he had no prior experience of. He was personally reluctant to embark upon a course of antidepressants, citing the lack of clarity around the impact of SSRIs working to elevate his hopelessness and perceiving that taking them may risk an increase in his suicidality.

> *John*
> *"My main concern was that I was having periods where I was actively suicidal, suicidal so to take something that I've never taken before that may shift…"*

AC
"May shift that one way or the other?"
John
"Didn't seem like a safe thing to do."

Kyle and Victor, like John, both felt the only option offered to them for dealing with distress was through medication. Here, they display a very similar experience at a young age, at the start of their long battle with depression.

"So, I started with citalopram when I was 19/20, that's because of depression, through my GP". (Kyle)

"I probably started taking antidepressants when I was like 19. And then carried on. So I've done like the prozacs, the cerocsacs, then the citralapram" (Victor)

Both also found the experience patronising, either by being belittled by the lionisation of medication, Kyle being told that "*you'll be fine"* just with just the drugs, and his request for more help being appeased with a leaflet on depression and counselling. *'Well, they said "if it gets too bad here's some leaflets on depression and counselling"'.* Victor described how he felt the drugs themselves had infantilised him, commenting that he had been "*medicated for so long I almost feel very childlike"*.

Eric was also automatically advised by his Indian clinical psychologist to start medication when he first sought help for his depression. Here he explains his conflicted view on medication and his reluctance at first to comply with an early request to have a prescription. He thought it unnatural, was clear that they didn't cure him and questioned their efficacy; however, he benefitted from his titration and found them helpful.

AC
"So, throughout this time, you've had a prescription with some medicines?"

Eric

"It was recommended at the beginning since we started, but I've been on the fence about medicine effectiveness […] I didn't take medicines for a long time until way later and then I thought, I have to get this as an aid and then see if I still feel. I don't want to rely upon medicines. I don't want to alter my brain, is what I used to think I think… I'm in a much better place."

The experiences of John, Kyle, and Victor indicate the response by institutions to the suicidal man is to focus on pharmaceutically driven care. However, like Eric, some co-researchers have found drug therapy helpful. Ravi detailed his experience of NHS psychiatry and the impact of being given a prescription for depression. He found it more supportive than the psychological services he had previously received (NHS clinical psychology-led psychotherapy). He described the impact of his fluoxetine prescription as dramatic and helped him engage more fully with the world around him.

"The antidepressants, initially, they gave me my life back". (Ravi)

He also reflected that they may have helped him with his therapeutic endeavours, making his therapy more effective. However, at the same time, he considered the continued effect of the prescription may well be placebic rather than the medication having an impact.

AC

"If you weren't taking antidepressants, your prescription, do you think your therapy would have been as effective?"

Ravi

"I don't think so, no. I don't know if, if it's, I've done it for so long now, I don't know if it's a psychological thing or if they are actually doing anything. No, I don't think it would have been as effective if I hadn't if I wasn't taking them."

Interestingly, often, co-researchers' initial optimism around psychiatric medication changed and gave way to frustration at both the way they were treated by the psychological institutions and the impact the medication had on their ability to identify and regulate affect. This led to infantilisation and exacerbated their hopelessness. Kyle detailed how he felt when first prescribed medication by his GP. He expected to be free from depression and, like Ravi, see a positive change in his life. Although also a possible anticipatory effect, he believed he would be 'cured'.

> *AC*
> *"Was it a relief to get the medication?"*
> *Kyle*
> *"It was, I thought it was coz it would solve all the problems, yeah you could take a pill and it'll be all better."*

However, his medication did not have the long-term desired effect and marked the beginning of a long and challenging relationship with the NHS, medication and diagnoses. Here, he talks about its impact on his daily life and charts his apostasy in drug-led therapy. Moving from hopeful expectations that citalopram would improve things to frustration and anger after being referred to the mental health team, receiving multiple diagnoses, and a merry-go-round of medication. This not only failed to ease his psychological distress but made his life worse. He contended that treating him solely with medication meant that his ability to function as a member of society was deeply impacted, which in turn added to his hopelessness and exacerbated his underlying psychological issues.

> *"Citalopram wasn't working so we tried Sertraline that made me anxious as hell so two weeks of that and I was like no I'm not doing this […] around that time I got diagnosed with bipolar type 2 and borderline personality disorder, so they were like 'right let's try on some new medication.' Then I was on, I haven't got the list – mirtazapine, quetiapine, lamotrigine, everything you could try, but all of those were sedatives, and I spent about a year trying the different ones, about eight different ones, and I said: 'these aren't working, all I want to do is sleep, I can't function as a human.'" (Kyle)*

Victor, like Kyle, had over 20 years of taking psychiatric medication and charted his experience, almost the only form of NHS intervention he had. Here, he questions the overreliance on drug therapy, its ineffectiveness, and the resultant lack of personal agency. He felt that this method of psychiatric drugs both obfuscated the source of his mental illness and extended its impact.

> *"... I might have had a negative experience with psychiatry. So, like in Norfolk especially, it feels too much about putting the cosh on people. Rather than sort of like actually getting to the reason why someone actually might be feeling like they are." (Victor)*

Here, he described the disorienting effect of medication on his cognition and daily functioning. He expressed his fear of losing control of his life during recovery from his first suicidal episode at the age of 20.

> *"I was on so much temazepam to calm the anxiety and sleeping pills to get me to sleep and then the antidepressants, it was like, 'I don't know what the hell I was doing!'" (Victor)*

Reflecting on his long history of psychiatric drugs, he detailed his systematic reduction and how, through that process, he has regained his mental clarity, autonomy and replace medication with psychotherapy. Talking to a qualified psychotherapist, he found a much better way to address his psychological needs.

> *"… I think I stopped taking medication for ages. I stopped taking it, started paying for the private counselling, so rather than having to take the pills, I was actually able to talk about it." (Kyle)*

Victor similarly expressed how, under the supervision of his therapist, he was able to reduce his medication and become aware of his once blunted emotions. He also expressed his sadness and remorse at the personal impact of being medicated for so long.

> *"Whereas now I'm starting to have the experience of feeling certain things, it's learning how to use your emotions I suppose really… Which is something that I have difficulty with because I was so well medicated before… 'cause I cried when I got married 'cause I was happy, but I was medicated at the same time so, I never fully had the experience." (Victor)*

Subtheme - The Alternative to Institutional Care, a Self-Funded Route to Well-Being

For many co-researchers, institutional services could not meet the needs of the six men interviewed fully. All found help via private therapy and, in one instance, alternative drug therapy. At first, some lacked the knowledge of private psychotherapy or the idea it was something they could access. Kyle here explains how he had never considered private therapy before his friend introduced him, not knowing it was available or that he was allowed to access it.

> *"I don't know why but I didn't even know…that private therapist existed … it never even crossed my mind I could have private therapy" (Kyle)*

Of the co-researchers, John was the only one paying the 'market price' for therapy. The Church fully paid for Nathaniel's therapy; Ravi was charged at a negotiated lower rate; Eric's therapy was a service based in India and cost significantly less. Kyle had some therapy paid for and then was also charged at a lower rate, and a friend met the whole cost of Victor's therapy. Kyle and Victor noted that their friends' funding of private therapy circumnavigated the NHS waiting list.

> *"He said I'll get you a therapist don't wait for an NHS one because you might have to wait too long." (Victor)*

> *"I was on the NHS waiting list. Obviously, the waiting lists are way too long, so everything fell through… so he recommended his therapist, and he paid my first ten sessions." (Kyle)*

Ravi and Eric were both able to access help from their therapists by either negotiating a lower fee, as with Ravi, or choosing an online, non-UK-based professional who charged significantly less. Here, Ravi explained that his therapist's listed cost was too high for him, but he was able to get her to charge at a lower level.

> *"I couldn't afford her, but she had a sliding scale, so I told what I could afford, and she agreed."* (Ravi)

Eric described the process he went through in choosing a therapist, explaining that one of the main determinates in his choice was affordability. In choosing a therapist in India, he was able to find someone whose tariff was low enough for him to participate.

> *"I wasn't earning a lot so I found a therapist who I used to pay £8 pay an hour for the session, that's when I started talking." (Eric)*

Nathaniel was the beneficiary of his church's sponsorship of him, initially for six months of therapy and then funding a further six years as he trained in psychotherapy.

> *AC*
> *"Okay, did they (the church) help pay?"*
> *Nathaniel*
> *"Financially, yes"*

Without the means to pay for private therapeutic care, many of the co-researchers in this study would have been facing their suicidal tendencies without professional help, bar sporadic trips to their GP for their prescription renewal for psychiatric medication.

John took a very different approach to his well-being. Although he did attend therapy and concluded it was helpful up to a point, he felt that his own exploration and private therapeutic use of psilocybin had been the decisive element in his living a fuller, more hopeful life.

> *"Yeah I mean the psychedelics are… without doubt the thing that has resolved this". John*

When quizzed about how that had interacted with his therapy, he was clear about his difficulty with psychotherapy working within a capitalist marketplace as opposed to a more communal approach to well-being.

> *John*
> *"I did wonder about, with the therapeutic relationship, if if we are in a kind of corporatized, commercialised world, you know, the fact that we have to pay for this hour to have that conversation…*
> *AC*
> *"What do you think the difference between talking to friends and talking to a therapist might be?"*
> *John*
> *"The thing that immediately springs to mind is is the community aspect of it. That it hasn't been kind of bastardised by the commercial relationship.*

Conclusions to Theme 3

Participants often described many of their interactions with institutions as problematic. Evidence from the interviews with this group suggests that a form of iatrogenic harm has been experienced by many in the group. Although there have been times of hope and help from institutions, these men are undoubtedly alive

today due to the assistance they received from organisations such as the NHS, the Church and the NA. However, good, timely, and free therapeutic help was hard to come by. Waiting lists were impactful on their recovery. Where therapy was free or cheap, it was often short-term, delivered poorly or unethical. The case of Nathanial and his experience of conversion therapy illustrates the enormous danger of unethical practice.

In the NHS, being prescribed medication was experienced as the first and, often, the only option for combatting suicidality and mental health difficulties. Medical staff offered little or no consideration of any other alternatives to drug therapy. There was an acknowledgement that medication could be an essential tool in reducing suicidal risk. As with Ravi, Eric, Kyle and Victor, it had a role in their mental well-being. But only in the short term. Often, co-researchers had been taking prescribed medication well past the recommended timescale, some for over two decades. In the long term, the impact of being solely reliant on this narrow, medicalised approach to improving mental health was detrimental to co-researchers' ability to access emotions and understand and learn self-affect modulation. It was detrimental to fully understand the roots of their psychological issues, which had led them to become suicidal in the first place and points to its lack of efficacy.

Both lack of provision and the championing of medication within institutions, over talking therapy, for suicidal men represent a form of iatrogenic harm. For this disparate group of men, one of the common factors was that they had the resources, either financially, intellectually or socially, to source help from outside of institutions. Possibly, their lives depended upon that luck either through attending private therapy sessions or seeking help through other alternate means.

Reflexivity 10

This theme has made me very sad and angry. Sad that so many men in a mental health crisis are ignored and fobbed off with such poor and derisory services. I feel a deep sorrow for the men who *did* ask for help but were denied and could not afford or find the right help. The insult that more than half had of being given a leaflet to counter the threat to life – imagine if that had happened to someone with a medical rather than a psychological 'illness'.

Discussion

In this study, my goal has been to contribute to research on male suicide and amplify the overlooked voice of post-suicidal men, Illuminate the challenges of therapy and gain insight into the processes of change as seen from their perspective. My research questions were to explore the lived experience of psychotherapy for post-suicide men, how seeking help had influenced their recovery, and in what way therapists can be aware of the needs of men who display suicidality. Three themes and nine subthemes were identified by analysing data from co-researcher interviews.

The first theme highlighted the challenge of creating safety in the therapy room. Specifically, I focused on the impact of the therapy room's physical and geographical aspects, the use of contracts in therapy, and the influence of the therapeutic relationship on client safety. The second theme focused on the impact of gender on the choice and direction of the therapeutic process. Participants found that therapy was best navigated with an older female therapist. They expressed difficulties around competition within all-male therapeutic dyads and noted that erotic transference affected both their choice of therapist and the direction and efficacy of therapy. Sexual attraction added a level of complexity when present in the therapeutic relationship. The third theme focused on the impact of institutional iatrogenic harm, highlighting inadequate and sometimes harmful service provision received by co-researchers, primarily from the NHS. It also addressed the effects of prescription medication on co-researchers' mental health and interactions with psychotherapy. Participants were clear that they had to take their mental well-being journey out of the sphere of institutions to meet their mental health needs. This required seeking specialist private psychotherapeutic help and/or alternative medication.

Within this chapter, I examine the research findings and position them both theoretically, within a broader social context. The discussion is structured around the three themes identified in the findings. I investigate how these findings contribute to the current literature on supporting men in recovery and scrutinize any divergence from existing research. Additionally, I evaluate the strengths and limitations of the

research and offer clinical recommendations. Finally, I consider potential future research directions and conclude by sharing my final reflections on the research.

Theme 1 - Safety in Psychotherapy

Consistent with existing literature proposing its fundamental importance in psychotherapy (Mair, 2021), co-researchers uniformly noted how safety was vital to therapeutic engagement and success. Safety in therapy is a complex and multifaceted issue (Liotti & Gilbert, 2011; McWilliams, 2004) shaped by various environmental (Podolan & Gelo, 2023), interpersonal (Shapiro et al., 1999) and intrapersonal (Frankel & Levitt, 2009) factors. Hanlon et al., specifically note the importance of safety when working with suicidal men (2022). However, in this study, three subthemes were expressed throughout the interviews and marked as noteworthy: the place of therapy, contracts in therapy and the therapeutic relationship.

In my first subtheme, 1.1, I highlighted the safety co-researchers found in the geography and physicality of the therapy room. Researchers have noted the importance of the physical space (Podolan & Gelo, 2023; Sinclair, 2021) and how geographical location and journey to the therapy room can help the therapeutic process (Galasiński et al., 2022). This study upheld many of these findings. In line with Trzpuc et al.'s (2016) findings, therapeutic spaces that were overly clinical, such as hospital rooms, were thought of as unhelpful as they carried connotations with physical medicine, which thwarted relational depth and so were experienced as less safe. In contrast, a neutral, pleasant, aesthetic physical environment aided a feeling of safety and enhanced therapy. My finding chimed with Jackson's (2018) work, which suggested client security is enhanced when a space balances the office and home. The privacy and anonymity afforded by geographical distance and the journey to and from therapy were important elements of the therapeutic process. Having the anonymity of conducting therapy in a geographically distinct place from their home community was containing. The significance of the buffering space of going to and from therapy was noted, as it provided, for most, a crucial space for reflection,

emotional processing, and the gradual reintegration of the client's therapeutic experience into their daily life. Also, where therapy was conducted online, the idea of having a proxy journey, such as a walk or run after therapy, aided the therapeutic process. The effect of being overlooked by their community was detrimental to co-researchers and, for many, triggered a shame response; this was a theme not evident in current literature.

In subtheme 1.2, I considered how the use of contracts impacted safety. It has been recognised as key to creating safe therapeutic spaces (Epstein, 1994; Sills, 1997; Zur, 2007), and my findings support the idea that, for some co-researchers, relational safety was increased, and suicidal intent decreased through the use of good therapeutic contracts. Baourda and Lakioti (2020) note how contracts aid therapy as they clarify roles and responsibilities, a sentiment voiced by co-researchers. Participants contended that when confidentiality was broken in collaboration with the client, it enhanced both safety and the working relationship; when confidentiality was broken without consent, it risked terminal rupture, a theme identified by other academics (Davidson et al., 2010; Li et al., 2024; Martindale et al., 2009).

One area noted by a minority of co-researchers was their experience of no suicide contracts (NSC). Research over the past twenty-five years has questioned the clinical validity of NSC (Mcmyler & Pryjmachuk, 2008; Range., 2001; Range et al., 2002). Jobes (2023, p. 62), when collating evidence for what reduces suicidal risk, noted that no-suicide or no-harm contracts "*do not work."* This was supported by the co-researchers' views in this study. The insistence on an NSC being used undermined the therapist's professionalism and was seen as unenforceable. Poorly thought-through and badly enacted safety protocols increased risk and underscored the limitations of relying solely on formal agreements. While contracts may provide a framework for the therapeutic relationship, they do not guarantee the emotional connectedness and trust required for individuals who have been suicidal, nor do they create security in the therapeutic setting. It is posited, in line with MacNeil et al. (2009), that the role of the contract is as much to reduce therapist anxiety about working with the suicidal client as it is, service to the client.

When writing this, I call to mind René Magritte's well-known painting *Ceci n'est pas une pipe* (van der Stare, 1995), in that we could equally say *Ceci n'est pas un contrat.* A seemingly absurd statement. But a contract that is written on paper and signed in ink is not a contract; it is a representation of a contract; the real contract exists inter-psychically between the therapist and client and, more importantly, intra-psychically within the client, and no end of written psychotherapeutic contractual obligations can become a facsimile for that commitment.

In subtheme 1.3, findings suggested that co-researchers found therapy most effective in a relationally supportive environment. The importance of anonymity, neutrality, and acceptance of an empathetic other was stressed. Participants were calmed when therapists were unshocked by the content of stories, which developed trust through a co-regulating therapeutic relationship. As a necessary ingredient for this level of trust and safety to evolve, everyone recognised time as essential. The therapeutic relationship has been recognised as one of the most critical constituents of various psychotherapeutic approaches (Clarkson, 1990; Erskine, 2015; Gelso & Carter, 1994; Horvath & Luborsky, 1993). Compelling evidence demonstrates that the quality of the therapeutic relationship is a significant predictor of clinical outcomes, even in serious disorders (Priebe et al., 2011). Research by Leach (2005) is specifically relevant to this study. It contended that a vital factor in successful therapy was a therapist's ability to be able to hear men's stories, their trauma, and self-loathing and be unfazed by it whilst offering the core conditions of therapy. He contends that this trust and safety took time to develop and was, unsurprisingly, only apparent when men engaged in long-term (20 weeks plus) therapy. My study supports this notion.

Thoughts on Theme 1

As ever, with exploratory research such as this, each subtheme offers up further issues to expand upon; however, my focus is drawn to further analysis around the therapeutic relationship, forfeiting further introspection on other ideas. Consistent with existing literature, co-researchers uniformly noted a strong correlation between relational depth, therapeutic success and psychological safety. These are

interdependent; relational depth without safety is untenable, and therapeutic healing is stymied. One imperative evident from testimonies was the time needed for relational depth to develop safely. It seemed that months rather than weeks were needed for sufficient safety for more profound therapeutic work. This seems plausible as many of these men if not all, were survivors of significant relational or sexual trauma and expressed as much in interviews. It would be unethical to confirm any diagnosis on co-researchers, but many offered up a variety of mental disorders. An often-voiced opinion was that interpersonal/relational “small t” trauma, “big T” trauma and/or sexual abuse, often dating back to adverse childhood or early adulthood experiences, was the main driver of suicide behaviour and that they suffered from post-traumatic stress disorder or PTSD/CPTSD. This is evident in research, and a clinically significant link between PTSD, suicide and the efficacy of adapting treatment to integrate different theoretical psychotherapies has been put forward (Rozek et al., 2022; Stanley et al., 2021). Rozek et al., (2022) also suggest a statistically proportional relationship between the severity of PTSD and the severity of suicide attempts. As such, viewing their suicide as an isolated event rather than a continuum of that trauma would be imprudent, and I believe that when working with this group, it must be taken into account. So, suppose suicidal men are statistically far more likely to fit into the diagnostic criteria for PTSD. In that case, it follows that they should be at least considered for a treatment that honours that.

The therapeutic literature and guidelines on the best method to treat PTSD are unclear, suggesting no superiority of any specific therapy method or treatment model (Levi, 2013). However, there is a suggestion that a more personalised and longer treatment is needed for CPTSD (Cloitre, 2021; Cloitre et al., 2011; Levi, 2013) . Current National Institute for Health and Care Excellence guidelines (Leichsenring et al., 2023), which steer the NHS workforce, recommend some talking treatments, principally cognitive behavioural therapy (CBT), Eye movement desensitisation and reprocessing (EMDR), peer support, and drug therapy, typically selective serotonin reuptake inhibitors (SSRIs). Both talking therapies, CBT and EMDR are short-term interventions (8-12 weeks). This is a point that I expand upon more fully in my third theme when considering if effective, impactful therapeutic work with suicidal men can be accomplished in such a short time. All co-researchers in this study accessed

long-term therapy; some did so after taking part in short-term therapy with mixed results, but most were unable to access it.

Most research and literature on male suicide and therapy investigates suicide prevention, what stops men from killing themselves or how they can be helped in crisis. Although prevention is vital, it is far from the full story of suicidal men's well-being. There is evidence of the effectiveness of community-based, evidence-informed, short-course therapeutic intervention in suicide prevention for men, as provided by the likes of James Place. However, the longevity of its efficiency is yet to be established. Efforts and research in this arena must be concerned with prevention. Still, if prevention is the only focus mental health professionals consider, then I fear the opportunity for more sustained psychological change that a suicide crisis may offer could be missed. Seen through this lens, it is perhaps easy to see the potential for longer-term therapy to be both preventative in the short term and in the long run healing. This idea is developed further in theme three

Theme 2 – Gender Proximity

My second theme explored how gender influenced the choice of therapist and the course of therapy. I contend that suicidal men often prefer to work with older female therapists rather than younger females or male therapists. I identified several interconnected push and pull factors that I merged into three subthemes. Participants reported a pull towards a therapist offering a reparative developmentally needed relationship. This was characterised by ease of communication, feelings of safety whilst vulnerable, and emotional regulation. Participants found that older women offered these key factors, which I considered as a reflection of the reparative or developmentally needed relationship. Participants found this dynamic particularly useful in exploring the origins of suicidal tendencies and addressing them through a matrix of maternal nurturance.

In the second subtheme, I postulated that most co-researchers actively rejected an all-male therapeutic dyad, fearing that traditional masculine traits, particularly competitiveness, would interfere with the tasks of psychotherapy. Working with a male therapist would intrude on the building of a therapeutic relationship that relied

upon emotional vulnerability. However, this was not uniform as two co-researchers had exclusively chosen men, one because he felt that a male therapist might better empathise and understand the experience of another man in crisis, the other because he was uncomfortable with the prospect of deep therapeutic work with a female.

The final subtheme examined sexuality and erotic transference; co-researchers described the older female therapist as offering a more maternal "holding" experience, in contrast to the potentially more sexually charged dynamic with a younger female therapist. Some gay co-researchers rejected male therapists out of concern about navigating any erotic transference, while others hinted at using that dynamic to maintain control in therapy.

Ultimately, the gender and age of the therapist appear to play a significant role in the therapeutic experience of suicidal male clients, with older female therapists often being the preferred choice due to factors like emotional attunement, safety, and the ability to navigate sensitive topics around sexuality and gender.

Recent research into therapeutic gender mix is inconclusive. Some studies argue that men generally have no gender preference for the therapist (Liddon et al., 2019; Seidler et al., 2022) or, if they do express a preference, favour women. Blow et al., (2008), contend, in an extensive review of gender and therapy, that therapist gender has a minimal effect on therapeutic outcomes. Importantly, Pikus and Heavey (1996), posit that gender is too crude a measure in defining a therapist, as male and female therapists share many qualities that cannot be measured by gender alone, but, as my data strongly indicated, gender was a frequent phenomenon in transcripts, I would argue that there is merit in understanding the co-researchers' choice. I endeavour here to examine the motivation behind their choices in a more nuanced way.

Some research corroborates my findings. Cooper et al. (2023) noted some expression for a female therapist and a preference for an older, experienced psychotherapist. This was based on a study that had a minority of males (23%) and

so somewhat inconclusive. However, Seidler et al., (2022) noted that severely depressed men prefer a female therapist.

It is important to note that there was a tacit acknowledgement by co-researchers of the workforce gender imbalance, with the implication that the lack of choice of trained male therapists would have interfered with choice. Nonetheless, choice was attributed to wanting the specifics of therapy with an older female therapist rather than not having the choice of a man. This supports previous findings that increasing the number of male therapists is not necessarily the most important factor in making therapy more male-friendly (Alston, 2012; Seager et al., 2014) but that there is a need for better training in how to meet the therapeutic needs of men (Seidler et al., 2021). These points were partly evident in my findings and support the conclusions of a bias towards severely depressed men seeking female therapists (assuming that suicidal men are severely depressed, it seems absurd to think otherwise). The research gives little insight into what motivated co-researchers' choice of older female therapists.

Thoughts on the Gender-Age Matrix

Although the sample size was small, there was a consistent choice of an older female therapist. Most co-researchers chose a female therapist (4/6) or thought they should have (1/6), leaving one with a definitive selection of a male therapist. This suggests a depth of feeling in working with an older female therapist; co-researchers were far from ambivalent, contrary to some research. For this population, I propose a more nuanced understanding and view of how and why this seems such an important phenomenon.

Table 5-1 below illustrates the possible interaction between age and gendered factors expressed in interviews and offers possible underlying motivations for that interaction. It demonstrates that co-researchers chose an older female therapist because they were perceived as a positive maternal figure, non-competitive, and safely sexual.

Table 0-1 Motive in choice of therapist

	Male	Female
Younger	Non-parental figure Competitive Potential sexual object	Non-maternal figure Non-competitive Potential sexual/erotic figure
Older	Parental figure? Competitive Not potential sexual object	Maternal figure Non-competitive potential maternal erotic figure but not sexual figure

The Reparative Relationship is Gendered and Aged

Both Clarkson (1990) and Gilbert and Orlans (2011) attest to the potential of any therapy to have a reparative aspect through a different relational experience. They state that researchers and therapists across diverse disciplines have recognised that a good therapeutic relationship provides the client with a similar sense of security found in a good maternal relationship (Alexander & French, 1980; Schore, 2011; Stern, 2018; Winnicott & Rodman, 2010). A different relational experience was potentially easier for these men to accept with an older woman therapist. This, I think, can be in part attributed to the lack of any perceived threat of competition co-researchers projected might exist in an all-male dyad; significantly, their choice was mediated by historic negative therapeutic experiences with men or life in general. And partly because it reduced the risk for erotic feelings or transference to develop with a desired younger therapist. Both scenarios could engender either a fight or flight or a shame response. In this context, I wonder if it was preferable for an older female therapist as it made it easier or safer to accept therapeutic phenomena and happenings, such as the rupture repair process. Consequently, co-researchers sought out a maternal figure to experience a reparative or developmentally needed

relationship as expressed and illustrated by many theorists in psychotherapy, be it Winnicottian holding (2010); Bion's container- contained (1985); or Bowlby's safe base (2008).

I also consider the possibility that an older woman could, as well as being a maternal object, recreate a needed, safe, erotic relational object. Recreating the psychological environment in which a psychological relational phantasy can be experienced. Potentially, the dyad replicates the unconscious developmentally missed need to act out sexual phantasy present in the (young) maternal-child dyad safely. I wonder if it also replicated the need to act out the rebellion and anger found in the maternal-teenage dyad, where containment is so important. I suggest that these therapeutic phenomena would not be so easily manifest if the therapist represented either an object of sexual desire or a judgemental paternal transference, hence co-researchers' rejection of both male and younger therapists.

Thoughts About More Man-Friendly vs Feminised Spaces

There has been speculation that the physical and socially constructed space of therapy is over-feminised and consequently off-putting to men. To promote greater engagement of men in psychotherapy, some researchers have proposed the need for a more gender-sensitive approach to assessment and treatment (Cochran, 2005; Deering & Gannon, 2005). Lindon et al. (2019) argue for adopting male-friendly therapeutic styles that emphasise problem-solving, action-orientated, physical assertion or all-male groups. Although there was some evidence that some co-researchers saw having a male therapist as engendering an easier understanding of things in the specific male domain, in this study, co-researchers did not seem to want a masculine therapeutic style and actively rejected it. The men in this group were not searching for therapy as a problem-solving exercise nor as a process to fix their suicidality but as an opportunity to understand the roots of their hopelessness. There was a view that, although helpful, socially prescribed interventions, such as attendance of men's sheds, were not a replacement for long-term therapy. This was perhaps a rejection of action-orientated, all-male groups and a reaction to the perception of their competitive nature. Many found that the ongoing psychological

healing process could only be achieved in the delicate, relational framework of long-term therapy with someone with the interpersonal acumen to provide such a space.

Taking a historical viewpoint and perhaps reflecting on where we are situated socially in popular culture can highlight the importance of this consideration. Old age, in Western post-industrial society, is generally viewed negatively. Older citizens are often depicted as being past their usefulness, as being a burden and vulnerable (Makita et al., 2021). Sontag (2018) posits that because older women are not able to produce children, are not seen as sexually desirable, and are economically burdensome, they are pushed to the social and cultural sidelines. In history, the older woman healer was often doubly at peril, as she could be accused of witchcraft: “Over vast spans of Western history, women healers were branded as witches and punished for practising witchcraft as well as denied influential healing roles” (Yakushko, 2018, p. 18). However, this research highlights a more positive recognition of the ability of the older, wise woman to help suicidal men.
What is more, the rejection of youth and of the sexually appealing female and the wise older man runs contrary to Western postmodern cultural norms. The erotic was problematic and dissuaded men from engaging in therapy with an object of desire, either younger women for straight men or attractive men with gay men. In one notable exception, where there was an explicit recognition of choosing a sexually desirable therapist, the context and manner in which this was done, in a way, further strengthens my point. His choice, I argue, allowed a psychic defence of the developing emotional depth that others were seeking. His explicit control of the direction of therapy via the erotic transferential relationship allowed him to ignore the cognitive dissonance of his internal homophobia. Perhaps an engagement at a deeper psychological level, through a female therapist, would have challenged this more fully.

Theme 3 Iatrogenic Harm

In my final theme, I argue that institutions responsible for safeguarding the mental well-being of the most vulnerable have largely failed this population and constitute a source of harm. My first subtheme detailed the inadequate and inaccessible

psychotherapeutic resources experienced by co-researchers. I contend that this dereliction of duty was more than a simple neutral absence of care but detrimental to their mental well-being and added to their suffering. Outside of the NHS, one co-researcher found himself in deeply damaging conversion therapy; others were victims to long waiting lists and bureaucratic hurdles for a perceived poor quality short-term service. My second subtheme detailed that the lack of credible free at the point of delivery therapeutic services resulted in a heavy reliance on psychiatric drugs, with many co-researchers undergoing difficult and prolonged medication adjustments. While medication was beneficial in the short term, there was a sense that long-term usage was harmful. I consider both issues as institutional iatrogenic harm. My final subtheme proposed that suicidal men could only find appropriate therapeutic help through engagement with private practice therapists or connecting to new communities offering alternative drug therapy. This was personally expensive but ultimately helpful.

The assertion I make that harm has been done to these men and potentially to a far wider population is not taken lightly. It is not intended to undermine colleagues working in the NHS. However, it is fair to ascribe institutions as sickening agents as many of the co-researchers have experienced lasting harm, intentional or not. This is a blunt statement, and it is right to remember that studying iatrogenesis in psychotherapy is complex (Parry et al., 2016) and that researchers have commented on the profession's difficulty in acknowledging the issue, noting despite its ubiquity in psychological services, it is under-examined (Berk & Parker, 2009). This could partly be due to the difficulty that individuals sometimes experience on their therapeutic journey. What might seem harmful may be a necessary difficult juncture in treatment. This echoes Curren et al. (2019), who counsel the importance of distinguishing therapeutic harm from more transient negative experiences that typically occur during therapy. It would be remiss of me to ascribe missteps in treatment as long-term iatrogenic harm. However, many of the adverse experiences documented were not as a result of difficult interpersonal psychotherapeutic moments or boundary violations. I argue that what I uncovered is not solely due to a bad fit of therapeutic modality, as Hook & Devereux's (2018) research attests or other interpersonal factors detailed by other researchers (Vybíral et al., 2024). Although, rightly, there

are criticisms of methods employed by institutions, the main iatrogenic harm expressed by my co-researchers was structural, caused chiefly by systemic failures within the NHS, either by the restriction of access to psychotherapy or the misuse of psychiatric drugs. There was also a minority experience of the unethical practice of conversion therapy by the Church. I believe the experiences of many in the group were commensurate with recent literature detailing service users' experiences of systemic issues with NHS mental health services (Aves, 2024; Sweeney & Taggart, 2018).

Lack of Therapeutic Provision for Suicidal Men

There was a specific acknowledgement that the under-provision and long waiting lists were at the heart of iatrogenesis for many of the co-researchers. Where co-researchers had therapy provided by the NHS, only two out of the six co-researchers, it was experienced or perceived as manualised and inflexible. This experience is reflected in the research by Lawson (2023), who speculated that institutional harm can be done by DBT provision in the NHS. They noted that clients' therapeutic difficulties were due to the adherence to a mono-theoretical manualised style of therapy despite needs. This was not a majority experience in my study, not because they found NHS therapy poor, but because psychological services never saw them, despite repeated attempts. Participants were either ineligible for NHS services, as they were not UK citizens (1/6), or, more commonly, the barriers to entry were too hard to navigate and were never seen (4/6) despite requesting psychotherapy or had to wait over a year to be seen. One co-researcher (1/6) refused to engage with NHS therapeutic services as he predicted long waiting times. Consequently, in this study, the factor cited as particularly harmful was not the orientation of therapy, the gender mix, or other demographics but the lack of provision. Participants often expressed frustration with bureaucratic red tape from the NHS institution. Aves (2024), writing as a lived experience expert, comments on the long-term impact and considerable harm that bureaucracy within NHS mental health services has on service users. All my co-researchers wanted therapeutic help after their suicide actions, and most sought it from the NHS. Help was parsimonious. Some were rebuffed and denied therapy, being offered leaflets or crisis telephone numbers in its place and languished on a waiting list. This experience increased

anxiety and was psychologically harmful. Only one succeeded after an over twelve months wait. Many lost their faith in the system, and all resorted to paying for their own help. Commentators have reasoned that men do not seek help because they adhere to stoic masculine norms. Although there is more than a grain of truth in this notion, in my study, it was clear that these men requested help from many areas and were largely ignored. There was an overwhelming sense that services were blind to men's suffering and ignored what has been identified as one of the most vulnerable sectors in society. Studies in epidemiology have suggested that the high rate of 'successful' male suicide events is due to the use of more lethal methods, greater aggression and a greater intention to complete a suicidal action (Nock et al., 2008). However, one could also reason that the statistics reflect the myopia that therapeutic services have towards men's suffering.

Pharmaceuticals the Only Option.

Commentators have noted the troubling therapeutic and ethical landscape posed by the wholesale strategy of prescribing psychotropics, in particular anti-depressant drugs, too willingly (Fava, 2020; Fava & Rafanelli, 2019; Maris, 2015). They note the potential harm and exacerbation of psychological difficulties that drug use and withdrawal effects may have on an individual. Maris notes that:

> *"One of the great ironies of modern psychiatric treatment is that for some people the medicines designed to reduce emotional pain and suffering can paradoxically contribute to or even cause the very outcomes they were intended to mitigate or prevent. For example, antidepressants can iatrogenically exacerbate or worsen depression and even contribute to suicide risk (including ideation and behaviour)."(2015, p. 7)*

However, the issue pertaining to this research was the impact that psychiatric drug therapy had on the wider psychological lives of these men. If the right prescription was applied, it reduced suicidality in the short term, which was a positive outcome. Participants experienced a haphazard approach from professionals, and some refused the prescription from their doctor, not wanting to take something whilst suicidal that may increase their suicidality. Other co-researchers endured long-term consumption of ADs which came at the cost of a fuller emotional life. Of the men who were known to be on long-term medication, all were actively reducing their titration

with a view to being drug-free. In my opinion, the real iatrogenic harm was, firstly, drug therapy was the only option from the NHS, contrary to NICE guidelines [NICE, 2022], which recommend options other than or as well as pharmaceuticals. Participants were never offered an alternative to drug therapy. These guidelines have come under considerable academic scrutiny. Leichsenring et al., (2023) note a missing link "*between evidence and recommendations"* (2023, p. 45)*;* over half of these men had no offer of assessment for manualised CBT, the first step towards receiving therapeutic input. Secondly, there is a growing body of evidence that, for a minority, SSRI and SNRI consumption (which constituted the majority of co-researchers' prescriptions) induces or increases suicidality when compared to other anti-depressants (Möller et al., 2008) and for the suicidal, there is known potential harm of increasing suicidality from taking ADs (Brent, 2016) and worryingly, ADs have been linked to a significant increase in suicidality at the start of titration (Valuck et al., 2009) which potentially is the most vulnerable time frame—many experienced pharmacology as a lottery regarding what they were prescribed and the psychological and social outcomes. Third, there was evidence from co-researchers of long-term adverse effects of being on medication. This included emotional blunting, sleep disorders and sexual dysfunction. This made co-researchers' lives worse, not better. Finally, the impact of withdrawal has been linked to a myriad of 'symptoms' and is often misdiagnosed as a depressional relapse (Horowitz et al., 2012; Horowitz & Taylor, 2022). Perhaps guidelines should take this more into account and offer psychotherapy or socially prescribed help first and pharmaceuticals second.

Further Reflections.

One of the main inspirations behind my conceiving of this study was my engagement with the Male Psychology section of the British Psychological Society, with whom I share their desire for the gendered needs of men to be better understood. Reflecting on their work of illuminating men's psychological and therapeutic needs, I am curious about how my findings map onto the ideas espoused by Liddon et al. (2019). There is support for their argument for the visibility of men in psychology and their desire for psychological services to fully account for men's needs, just as in any other

section of society. They asserted that male-friendly psychological approaches and relationally attuned therapists were vital to this. In this study, therapy was more successful when co-researchers experienced acceptance within a humanistic framework. However, the wish for a group setting or a solutions-focused approach was not as present in the co-researcher's scripts. Although not explored fully, there was a notion that it is easy to hide within a group, which hinted at a less successful outcome. More evident in transcripts was a want to get to the root of issues rather than finding solutions to being suicidal. Suicidality was often thought by some co-researchers to be the effect of underlying trauma, and a long-term psychological exploration was needed to aid insight into their psychological process that interacted with suicidality. Much of that processing was initially unconscious and took time to be acknowledged. Therapeutic relationships had to develop robustness and trust for that to occur. Short-term manualised therapy was thought not to offer the time nor flexibility for that to manifest.

Furthermore, therapy did not need to be reframed as 'strategies for living'; co-researchers committed to treatment and were invested in a more involved therapeutic experience. They did not need to have therapeutic work presented as something different. Therapy was undertaken as a purposeful and deliberate act of self-discovery. Perhaps they better understood what therapy entailed; two worked as therapists, and all had undergone significant therapeutic work, mostly experienced as positive. However, the group was not one that I would class as an *in-group;* as well as working in academia, two worked as manual labourers, one was a mature student*,* and one worked in a call centre. Despite this heterogeneity of profession and perceived 'class', none of the men presented with the idea that therapy emasculated them. A large part of that was, I believe, engaging with a well-trained, relationally attuned therapist who could take the time for a healing relationship to develop. Surprisingly, the shoulder-to-shoulder 'men's shed' style of well-being help was rejected as not particularly useful. It was a minority experience, and although signposted by mental health professionals, it was not considered a professional intervention, and its limitations were recognised. The shortcomings of informal help, such as the men's shed movement, are well documented by Kelly et al., (2021, p. 8) who stated that "*Sheds could only provide a complementary, rather than an alternative, route for male health improvement that exists alongside formal public*

healthcare services.". I intend not to cast dispersions on that movement, but my worry is that in a society that is becoming more aware of men's mental health needs, the emphasis on creating quasi-mental health support could be seen as a replacement and alternative to professional mental health. Perhaps this is a too cynical view but in a political and cultural atmosphere where different groups compete for seemingly ever-diminishing health resources, suicidal men are easy to overlook. They are hidden, and if a cheap alternative is seen to be addressing their needs, this could further reduce their access to good quality, relationally attuned psychotherapy.

The Randomness of Life

These stories of how men have experienced psychotherapeutic interventions have several common threads, and thankfully, they have all navigated their way to a healthier mental space. However, underlying each case, and perhaps at the heart of this study, was the failure of their suicidal intent. With all their accounts, which at the time of data gathering seemed peripheral to my study, there was a randomness as to why they survived. Each of their experiences had, for want of a better word, luck. They were fated to live where, perhaps on another day, a capricious god may have had darker intent. Nathaniel sent a text at the top of a cliff rather than, as planned, on the way down. The recipient was on a 15-minute work break, had their phone on and responded to his distress immediately. What if they had been busy or skipped their break? What if the phone battery was flat? Ravi, who had by far the largest number of attempts (at least eight), confessed, in mawkish, gallows humour, that he was essentially not very good at killing himself and so gave up at the age of 40. Victor took one hundred-plus paracetamol tablets in a hidden, isolated spot where he could not be pinpointed except by sharing his location using the phone application *what three words.* This gave the police the ten-minute window in which to get him to the hospital and save his life, any longer, or if he had not previously installed the application on his phone the year before, he believed he would be dead.

More in keeping with this study was the randomness of finding the right combination of help. The right therapist, prescription or community. Knowing that professional

help was available and that they could access it was perhaps the saving grace. It is well documented that health inequalities are proportional to income (Scambler, 2012) and in the gendered health inequality of suicide, this is all the more apparent. As it stands, for suicidal men to have the needed long-term resource of talking therapy, they must be able to afford private therapy or the right friends or employers to fund that. Psychotherapy is seen as a luxury by the government and is taxed as such; however, if taken at face value, a six-month course of weekly therapy would cost in the region of £1,000-2,000 and could be lifesaving. Putting this into the context of other health issues, the average treatment cost for prostate cancer in the period of 2016-2018, was £7,437 (Wills et al., 2024). Prostate cancer killed around 2700 men a year under 75 years of age in 2020, and suicide of men aged 20-75 accounted for around 3500 in England alone in 2022 (Office for National Statistics (ONS), 2023).

In terms of my practice, I concede that I have a much richer body of experiential knowledge than I did before. Sitting with six men who, for whatever reason, are still alive has deeply impacted me. Professionally, I am more confident and competent in working around suicide. Perhaps I have drawn the sting out of it by my familiarity with their stories, which has given me the alacrity and dexterity around Camus's (2005) primarily philosophical question that introduces The Myth of Sisyphus. I am eternally grateful to them for allowing me into their world.

In the act of honouring their stories and creating meaning from what these men shared with me, I can offer up the absurd notion of life itself. This process has given me a deeply paradoxical understanding of the nature of truth. Of fortune, of fate, and of choice. I am perhaps more at ease, maybe even blasé when talking about suicide. What it has left me with is that although Larkin (2012, p. 191) , in his poem Aubade, mused, "*Most things may never happen, this one will*", knowing the inevitability of death I would like to squeeze out as much of it as possible and help others do the same without hastening that day.

Reflections on the Strengths, Challenges and Limitations of my Research

A major strength of this research is that it was undertaken using an idiopathic qualitative methodology. This enabled me to explore the subjective experiences of my co-researchers more thoroughly, whereas a quantitative methodology would miss the complexities and nuances of those experiences, and I would have risked misunderstanding my co-researchers. Using a qualitative methodology, I got closer to the co-researchers' lived experiences and my findings more gravitas. Furthermore, choosing the philosophically agnostic reflexive thematic analysis as my method gave me the epistemological space to apply my critical realist stance as a methodology and, in so doing, allowed me the flexibility to consider transcripts from different perspectives.

My methodology also sanctioned utilising a double hermeneutic position, which represents another significant strength as it allowed me to account for intersubjectivity. As a major part of my integrative therapeutic model as a researcher, my intersubjective methodology was a good fit with my professional stance, further adding to the strength of this study. Consequently, I have been thorough throughout the research process and keenly recognised my part and what I bring to its production. I recognise how I have shaped its narrative structure from the inception and initial questions to my reaction to interview co-researchers and my decisions on how to code and what to focus on in my findings. I have not been a passive observer but have played an active role in producing the new knowledge in this study. This acknowledgement adds weight to my findings and the overall efficacy of my research rather than detracting from it.

Another strength of my research is my use of traditional and novel reflexive methods. I have kept a research journal throughout. However, although helpful, it did not fully meet my reflexivity needs, so I created a novel experimental method using the creative arts in the form of a stage monologue and the production of a short film. This enabled me to both clarify and disseminate my findings.

A further strength of this research, the most important in my eyes, is that the raw material comes from the main protagonists in the study of male suicide, men who have been suicidal and have been provided with the reflective space to contemplate their experiences. As in my therapeutic practice, I was adamant that my research

would honour real lived experiences rather than the views of the therapeutic community or the student population. These views were, for me, vital as I believe the psychological phenomena of male suicide were deeply rooted in the subjective experiences of my co-researchers rather than a second-hand account of it. It could have been far easier for me to base my research on the experience of therapists working with suicidal men. I rejected this avenue as I was not convinced it would fully answer my desire to add as much to the literature on how suicidal men can be helped therapeutically. Although a therapist's opinion is insightful, I wanted to consider the client's point of view or, as I say, gain a view from *the other chair*. The repercussions of this choice were numerous; many ethical and logistical hurdles had to be overcome. I am thankful for the rigorous ethical process I needed to undertake before recruitment, as it gave me confidence that I was taking all necessary precautions to ensure co-researchers' safety. My ethical processes represent a further strength of this study and may act as a blueprint for other studies, adding to academic guidelines and policies in the future.

Although I acted as a researcher rather than a therapist in this endeavour, there is a tradition of the research practitioner that I aimed to embody. This allowed me to take a relational approach with my co-researchers and, in so doing, co-create knowledge within a safe and attuned environment. This significantly increased the quality and depth of interviews and illuminated new phenomena that would have been hidden from other researchers taking a less relational approach.

A major challenge for this research is that it used a small sample, just six men, all of whom had disparate and diverse narratives. This makes it difficult to claim the ubiquity of my findings and apply them outside of that group. However, the study highlighted shared characteristics within the complexities of the phenomena of male suicide, which adds weight to the finding's validity. The group was very diverse, and this may weaken my conclusions. One co-researcher was not a UK citizen but from India and had an experience of therapy from his home country. Although his primary therapist was qualified to master's degree standards, there is a concern, voiced by Bedi et al., (2020) of inconsistency in training and quality control in India. However, evidence from his interview suggested that his therapist displayed skill and worked ethically. In almost all demographics, the group was heterogeneous. I would argue

that the homogeneity can be claimed through other means. Although they had a very different history in the number of times they had tried to kill themselves, they all shared the same characteristic of crossing the boundary of an attempted suicide. The nature of recruitment may be problematic as it was self-selecting, so the research was subject to the vagaries of who replied to advertisements. However, this was beyond my capacity to influence, limiting the reach of who would be attracted to my study.

Guidelines and Policies.

My research findings, presented in various sections, have useful implications for individuals working in men's mental health, whether counsellors, psychotherapists, psychologists, medical professionals, or mental health first aiders. It also has implications for training institutes and policy and commissioning authorities offering support to men. The following section will help guide those involved in working therapeutically with men with a suicidal history. The list is not exhaustive and is in addition to good therapeutic care.

Individuals working in a therapeutic capacity:

- Developing a good therapeutic relationship with male clients that stretches beyond theory is paramount and should be championed above other tasks.
- Suicidal men may prefer to work with an older female therapist and should be given the opportunity to express that choice.
- It may require some time to develop enough therapeutic safety for men to explore the roots of their suicidality and should not be rushed.
- The use of no-suicide contracts should be avoided.
- The course of therapy with this group may uncover significant past trauma, and therapists must be confident that they have the training and supervision support for such occurrences.
- Breaking confidentiality can be a therapeutically important maneuver but, wherever possible, must be done collaboratively.

- Often, men may have been ignored by other health services and, as a result, minimise their issues. Take them and their issues seriously.
- The immediate time post-therapy may be emotionally difficult, and men may need support in how they navigate this period.
- Practice in a non-oppressive, egalitarian manner
- Understand the impact that psychotropic medication, deprescribing and withdrawal may have on clients and that collaborating with their medical professionals is paramount.

Training institutions

- Trainees must be aware of the therapeutic needs of men as with any other distinct group and understand that non-oppressive practice relates to men just as it does to any other section of society.
- Staff and trainees must take questioning and critical stance to stereotypical narratives around traditional masculinity.
- Trainees must be aware that men may have significant adverse childhood experiences and be survivors of childhood sexual trauma, trainees must be proficient in skills to combat the impact of them.
- Staff and trainees must be taught the impact that psychiatric medication can have on men and the limits of their involvement in recommending their use or termination.
- Staff and trainees must be aware of the limitations of contracts.
- Staff must highlight the ethical dilemma that is associated with suicide and help trainees become adept in navigating client issues and supervision needs.

Policy and commissioning authorities

- Give parity of care when considering the needs of suicidal men in line with others in need of psychological or medical help.
- Have alternatives to psychiatric medication.

- Offer men longer-term therapeutic help in line with other medical services.
- Consider that although social prescriptions, such as men's sheds, are important, they should not be used in place of proper psychological and therapeutic support.
- Services need to be streamlined with less emphasis on assessment and more on service delivery.

Dissemination

Embedded in my proposal is the idea of creating an original contribution to the field of counselling psychology when working with men who have experienced significant suicidality (either an arrested attempt or a failed attempt). Although just one researcher (myself) has undertaken this study without the backing of a large employer or funding organisation, I do believe that I have shed light on the issues in the domain and have emphasised and discoursed difficulties in an innovative way that are widespread, as such this study will provide insight across many domains be that therapeutic, medical or social.

This research fills a gap in the literature that the expert dominates. Consequently, it amplifies the voice and perspective of the male client who presents with present or past suicidality. This perspective can and will help inform professionals working with this client base. To achieve this, I aim to communicate the study's findings to the broader therapeutic community in multiple forms.

I intend to extend my dissemination via professional conferences. The British Psychological Society (BPS), Division of Counselling Psychology (DCoP), chose me to deliver a keynote talk at their last conference (June 5th, 2024) about my research methods and how using film to disseminate my research findings can be an effective method of communicating findings and methodology. Once ethical clearance has been granted, this will become part of a new initiative and website that they have set up.

I aim to present my research to wider therapeutic communities and am applying to present at several conferences across the UK and internationally. These include the UKCP conference: Psychotherapy in November 2024, the International Conference on Clinical and Counseling (sic) Psychology in May 2025 in Florence, and the Male

Psychology Section Conference in November 2024, as well as presenting at future Metanoia Research Academy conferences.

My thesis will also be publicly available via the Middlesex University and British Library repositories. As for longer-term projects, I am interested in publishing the research in journals such as *Psychotherapy Research* Journal and *European Journal for Qualitative Research in Psychotherapy,* as well as psychotherapy and counselling publications such as *Journal of Counseling Psychology,* and suicide research *Archives of Suicide Research* as well as seeking publication in the second edition of *The Palgrave Handbook of Male Psychology and Mental Health*. I would also welcome the opportunity to deliver workshops and training on using creativity in research and supporting suicidal men in therapy. I have been in dialogue with York St John's University to that effect. I will also be looking to present

Future Research

The challenge of working with suicidality and such a potentially fragile group invites nervousness and trepidation, and as such, little research in this area exists, but this should not stop further investigation. This study was an initial exploration of the client's experiences, and consequently, it had a wide remit and did not have a specific focus. However, through this study, I have drawn attention to various aspects of the therapeutic field that need further investigation. Firstly, the area around the impact of SRRI-type drugs and the resultant emotional blunting in mid-aged men is important to look further into. I am also very interested in the impact of conversion therapy and how that interacts with internal homophobia and suicidality how non-heteronormative individuals experience formal spirituality and religious organisations offering mental health support.

This study raised the question of the impact of therapist gender on the relational experience of suicidality in men. The current study was limited to the experiences of clients. Future research would benefit from focusing on the masculine therapist experience. Such research could help understand any potential gender differences in men supporting other men. The client's experience of maternal erotic transference as a reenactment of possible childhood sexual development was briefly touched upon in one co-researcher interview, but this was not consistent across other interviews nor elaborated on the one case. This would be a significant avenue for

further research as the literature notes how vital the reparative relationship is in allowing, understanding and representing developmentally missed stages. Finally, I would like to develop my creative research methods and methodology that facilitate a different language in research and wider research dissemination—helping therapists and clients to create new ways to communicate non-verbally and bring psychological issues to a wider audience.

Reflexivity 10

These stories of how men have experienced psychotherapeutic interventions have several common threads and thankfully they have all navigated their way to a healthier mental space. However, underlying each case, and perhaps at the heart of this study, was their failure of their suicidal intent. With all their accounts, which at the time of data gathering, seemed peripheral to my study, there was a randomness as to why they survived. Each of their experiences had, for want of a better word, luck. They were fated to live, where perhaps on another day a capricious god may have had a darker intent. The text that was sent to three friends at the top of a cliff rather than, as planned, on the way down. Of the three people that received them, one thought it a joke, one did not reply, and one was on a 15-minute work break, had their phone on and responded to his distress immediately. What if they had been busy? skipped their break? or the phone battery dead? Ravi, who had by far the largest number of attempts (at least eight) confessed, in morkish, gallows humour, that he was essentially not very good at killing himself and so gave up at the age of 40. Victor took his one hundred plus paracetamol tablets in a hidden, isolated spot where he could not be pinpointed except for by sharing his location using the phone application *what three words.* This gave the police the ten-minute window needed to save his life, in which to ‘blue light’ him to hospital. Had he not installed that on his phone the year previously he believed he would be dead. What about the randomness of finding the right help. The right therapist, prescription or community. Knowing that there is professional help available, that they are allowed to access. Having the resources to afford private therapy or the right friends or employers to fund that. But perhaps to consider this phenomenon in its singularity is mistaken.

References

Automatic citation updates are disabled. To see the bibliography, click Refresh in the Zotero tab.

Appendices

Ethical Approval

METANOIA INSTITUTE

Programme Research Ethics Committee (PREC) Ethics review form - Resubmission

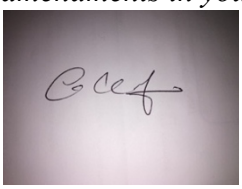
Name of Candidate: Alistair Coomes

Project Title: A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Adult Men with a History of Suicidality

Reviewer 1 name: Joel Vos Comments and conditions:

Recommendation to approve.
The student has met all the conditions to a satisfactory standard.

Reviewer 2 name: Comments and conditions:
When both reviews are complete please send this form to the Chair of the Programme Research Ethics Committee, who will forward the feedback for the candidate to the Academic Coordinator.
Decision of Committee:
a. ⎪ The Programme Research Ethics Committee has approved the application.
Ethics review form 21.04.22
b. ☐The application will need to be resubmitted with amendments to address the feedback above to the programme Academic Coordinator. *Please note that you need to highlight all amendments in your revised submission.*



Chair of PREC committee:
Date: 05/07/2022
Dr Ariana Jordan, pp Dr Joel Vos
Ethics review form 21.04.22

METANOIA INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Alastair Coomes
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

22 July 2022
Ref: [Alastair Commes/1/20220722]

Dear Alastair,

Re: A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Adult Men with a History of Suicidality

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, you are required to submit an Amendment to Ethics form from the Moodle 'My Registry' page for approval before continuing with your project.

Yours sincerely,

Dr Ariana Jordan, CPsychol
Director of Studies (DCPsych)
Faculty of Research and Doctoral Programmes

On behalf of Metanoia Research Ethics Committee

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

Research Supervisor Confirmation of Consent

METANOIA INSTITUTE

Research Supervisor Confirmation of Consent

Name of student: Alastair Coomes

Name of research project: A reflexive thematic analysis of the experiences of psychotherapy of adult men with a history of suicidality

This is to verify that as Research Supervisor for the above research project I have seen proof that appropriate consent has been obtained from the participants used in the project.

Supervisor's name: Dr Joel Vos PhD Msc MA CPsychol FHEA

Signature: 

Date: 28 Aug 2024

Letter of Venue Confirmation

Phoenix
Counselling & Psychotherapy Service

Date 27/6/22

Dear Alastair

I am happy for you to use the facilities at Phoenix counselling for your interviews for your doctoral research. I understand that you are looking at men's experiences of therapy that have had suicidal behaviours in the past and have subsequently has therapy to help their recovery. That your focus will be on the experience of therapy rather than the events that lead them to display suicidal behaviours.

I am aware that this may be a subject that may be uncomfortable for some participants and understand that you will have robust protocols in place to safeguard all parties prior, during and post interview.

I also understand that you will be conducting interviews only when other therapist will be present in the building. Other therapist will be aware of your presence and briefed as to the nature of your presence.

Warmest Regards

Fran Halford

Director

Pheonix Counselling Services
1-3 Hanworth Road, Feltham, Middlesex TW13 5AF
0208 890 3133
Phoenixcounselling@hotmail.co.uk
Phoenixcounselling.org

Recruitment Advert / Flyer

Men, Suicide and Therapy study

I am looking to recruit and interview men over the age of 25 for my study on the experience of therapy after a suicide attempt. It will help us understand what it is like for male clients and inform best practice.

The interview will take up to one hour in person ~~or via zoom~~. You will only be encouraged to talk about experiences you are happy to share and will not be forced to reveal anything you do not wish to. To qualify for the study, you will need to have experienced a suicide attempt and engaged in therapy as a result. If you are interested in participating, and meet one or more of the above criteria, then an initial screening call will be arranged to determine if your experience meets the criteria for the current study. As part of the call, and to determine eligibility, you will be asked to very briefly describe your experience/event, what impact it had on you, and how you feel about discussing it as part of a formal research interview.

This research forms part of my doctoral research in Counselling Psychology and Psychotherapy at Metanoia. If you are interested in taking part or have any questions, please email me a

Please note: emailing does not commit you to participate in the study.

PLEASE NOTE THAT PARTICIPANTS MUST HAVE HAD THERAPY OR BE IN THERAPY FOLLOWING SUICIDE ATTEMPT AND NOT HAD A FURTHER ATTEMPT IN PAST 12 MONTHS.

Suicide Screening Interview Protocols

Screening interview protocol and script ID

(Screening questions in red, discontinuation script in *italics*)

Q1 As this research deals with male suicide, it's important that we make sure that I ask you about how you are doing now as I don't want to put you in any danger of upsetting you. Is that, ok?

YES – CONTINUE TO QUESTION 2

NO – EXPLAIN THAT THEY WILL NOT BE. SUITABLE FOR THIS STUDY

Ok, thanks for being honest, however due to what we will be talking about, it might not be in your best interest to continue with using you in my study and use your contributions for my research. I hope that you understand. Do you have any questions for me at all?

Q2 In the past few weeks, have you wished you were dead?

YES NO

If YES use script explaining that they will not be suitable for the study and direct them to organisations and named therapist for help.

Ok, thanks for being honest, however due to what we will be talking about, it might not be in your best interest to continue with using you in my study and use your contributions for my research. I hope that you understand. Do you have any questions for me at all?

If NO continue to Q3

Q3. In the past few weeks, have you felt that you or your family would be better off if you were dead?

YES No

If YES use script explaining that they will not be suitable for the study and direct them to organisations and named therapist for help.

Ok, thanks for being honest, however due to what we will be talking about, it might not be in your best interest to continue with using you in my study and use your contributions for my research. I hope that you understand. Do you have any questions for me at all?

YES No

If NO continue to Q4

Q4. When did you have your last attempt on your life?

_____

If answer is within the past 12 months use script explaining that they will not be suitable for the study and direct them to organisations and named therapist for help.

Ok, thanks for being honest, however because I am only looking at men who have had a life attempt over a year ago I won't be able to use your contributions in my study and research. I hope that you understand. Do you have any questions for me at all?

If not within the past 12 months proceed to Q5.

Q5 Have you attended any medical facilities in the past year due to self-harm?

IF YES run through the script:

Ok, thanks for being honest, however because I am only looking at men who have had not self-harmed in the past year I won't be able to use your contributions in my study and research. I hope that you understand. Do you have any questions for me at all?

If NO go to Q6

Q6 As we are dealing with a sensitive topic, and we may talk about triggering material, if you felt like you did when you were suicidal are you happy to seek professional help for that?

If YES

What help would that be?

IF NO run through the script:

Ok, thanks for being honest, however because of safety reasons and what we will be talking about, it might not be in our best interest to use you in my study. I hope that you understand. Do you have any questions for me at all?

Initial open-ended questions; intermediate questions and ending questions.

Initial questions (possible)

Can you tell me about how you found your therapist?

What was the first experience of therapy?

What influenced the length of time you spent in therapy?

Intermediate questions

Can you tell me something about how you may have changed during therapy, how has it helped you?

Can you tell me about your experience with your therapist?

What affected your work together?

Ending Questions

Can you tell me how your views ~~about suicide~~ have changed since having therapy?

Are there any thoughts that you have had during our time together that you may not have thought about previously?

Is there anything that you would like me to know to help me understand what it was like having therapy?

Is there anything you would like to ask me? How has this interview been?

Participant Information Sheet (PIS)

Participant ID Code:……

SECTION 1

1. Title of Project:

A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Adult Men with a History of Suicidality.

2. **Invitation**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

3. ***Study Summary and Purpose***

This study is concerned with how men, who have made an attempt on their own life, experience therapy. What it is like for these men to attend therapy. The aim is to find out if there are particularly helpful also if there are things that are unhelpful. This is important because little is known about it and, surprisingly little research has been done on this important issue. I am seeking participants who should be men over 25, had significant recovery time, either in or have had therapy for a significant time. Participation in the research would require you to attend an interview and take approximately 1 -1½ hours of your time. The prime purpose of the study is to inform therapists' practice and offer advice to them and other organisations involved in mental health and helping men recover from suicide.

4. **Why have I been invited?**

It is important that we assess as many participants as possible, and you have indicated that you are interested in taking part in this study. As the study is based on interviews rather than questionnaires or measuring something, I will only be looking

for 6-8 participants. As a man who has this experience it would be highly beneficial to hear first-hand what you have experienced. Our job, as therapists is based on having a deep understanding of our clients' lives but it's hard sometimes to know the effect of our work, our clients have left and can't tell us. Potentially the work we have done together is not fully understood until some-time after it stops. This study will give an opportunity to reflect upon something therapist don't often see.

5. Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. If you do decide to withdraw from the study then please inform the researcher as soon as possible, and they will facilitate your withdrawal. If, for any reason, you wish to withdraw your data please contact the researcher within a month of your participation. After this date it may not be possible to withdraw your individual data as the results may have already been published. However, as all data are anonymised, your individual data will not be identifiable in any way.

6. What will I have to do?

If you decide to take part in the study, it will involve a face-to-face semi-structured interview lasting approximately 60-90 minutes. This will involve answering some generic questions and talking freely on your experience of therapy. The study will involve audiotaping and I intend to publish my findings in academic journals which may well include verbatim comments extracted from our interview. All information will be anonymized, and participants' identity will not be identified from those scripts. I will be using a grounded theory methodology which seeks to find theories about peoples' lives from their own experience rather than have theories tested on them. Please note that to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. **What are the possible benefits of taking part?**

Although there is no intended benefit of taking part in the study, we hope that participating in the study will help you gain a perspective on events in your life. However, this cannot be guaranteed. The information we get from this study may help us to understand what it is like to participate in therapy after a suicide attempt and suggest guidelines to therapists. Risk of re-traumatisation will be minimised as much as possible, but if you display self -harm behavior or feel that your suicide risk has been raised by taking part in the study, you must be happy to take help seeking behavior action.

8. **Will my taking part in this study be kept confidential?**

The research team has put several procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password protected computer. All information you provide will be treated in accordance with the UK Data Protection Act.

9. **What will happen to the results of the research study?**

The results of this study will be presented at conferences or in journal articles potentially a guideline publication. However, the data will only be used by members of the research team and at no point will your personal information or data be revealed

10. **Who has reviewed the study?**

The study has received full ethical clearance from the Metanoia Institute Research Ethics committee (MREC) who reviewed the study.

11. **Contact for further information**

If you require further information, have any questions or would like to withdraw your data then please contact:
Contact Details of Researcher: Alastair Coomes alastair.coomes@metanoia.ac.uk

Contact Details of Supervisor: ~~Alistair McBeath alistair.mcbeath@metanoia.ac.uk~~
Metanoia Institute - 0208-579-2505

Thank you for taking part in this study. You should keep this participant information sheet as it contains your participant code, important information and the research teams contact details

12. **What are the possible disadvantages, burdens and risks of taking part?**

Participation in this research carries the risk of emotional distress, and accidental disclosure of personal or sensitive information. As I am a trained psychotherapist and have experience of working with individuals who struggle with a range of mental health issues, I hope to minimise these risks using my clinical judgement about how to conduct the interview. I will also have information about statutory and voluntary agencies which might be accessed for further help, and the interviews will be held at the Phoenix therapy Centre with other therapists available for consultation. You will not receive any direct personal benefits from participating but it will help mold future training and development of therapists and counsellors.

13. **Will my data be kept confidential?**

Data will be fully anonymized, and this anonymity will ensure that the participant cannot be identified by any means. All names will be changed and identifying information redacted. Recordings and transcripts will be kept secure by 256-bit encryption, files and documents passwords protected

14. 11. What will happen if I don't want to carry on with the study?

As a volunteer you can stop any participation (add detail here – test / experiment / interview etc.) at any time or withdraw from the study at any time before a month after the interview, without giving a reason if you do not wish to. If you do withdraw from a study after some data have been collected, you will be asked if you are content for the data collected thus far to be retained and included in the study. If you prefer, the data collected can be destroyed and not included in the study. Once the research has been completed, and the data analysed, it will not be possible for you to withdraw your data from the study.

15. What if there is a problem?

If you have a query, concern or complaint about any aspect of this study, in the first instance you should contact the researcher(s) if appropriate. If the researcher is a student, there will also be an academic member of staff listed as the supervisor whom you can contact. If there is a complaint and there is a supervisor listed, please contact the Supervisor with details of the complaint. The contact details for both the researcher and any supervisor are detailed on page 1.

16. Who has reviewed the study?

Research involving human participants is reviewed by an ethics committee to ensure that the dignity and well-being of participants is respected. This study has been reviewed by the Metanoia Faculty Ethics Committee and been given favorable ethical opinion.

Thank you

Thank you for taking time to read this information sheet and for considering volunteering for this research. If you do agree to participate your consent will be sought; please see the accompanying consent form. You will then be given a copy of this information sheet and your signed consent form, to keep.

Consent Form

Participant Identification Number:

CONSENT FORM

Title of Project:

A Reflexive Thematic Analysis of the Experiences of Psychotherapy of Suicide Recoveree Men over the Age of 25.

Name of Researcher: Alastair Coomes

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……..…for the above study and have had the opportunity to ask questions. [1]
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without penalty. [2]
3. I agree that this form that bears my name and signature may be seen by a designated auditor. [3]
4. I understand that my interview may be recorded and subsequently transcribed. [6]
5. I agree to take part in the above study. [7]

Name of participant
Date Signature

Name of person taking consent
Date Signature

1 copy for participant; 1 copy for researcher

EMAIL: alastair.coomes@metanoia.ac.uk
This study is part of Metanoia counselling psychology program supervised by Dr. Arian Jordan Ariana.jordan@metanoia.ac.uk

PLEASE NOTE THAT PARTICIPANTS MUST HAVE HAD THERAPY OR BE IN THERAPY FOLLOWING SUICIDE ATTEMPT AND NOT HAD A FURTHER ATTEMPT IN PAST 12 MONTHS.

Debrief Form

Thank you for participating as a research participant in the present study concerning your experience of therapy. The present study examines if and how therapy helps with men understanding and moving away from suicidal actions. Again, we thank you for your participation in this study.
In the event that you feel psychologically distressed by participation in this study, we encourage you to call your therapist or GP. If you are feeling distressed and are unable to contact a person known to you, please contact Phoenix Counseling center in Feltham on xxxxxx alternatively please reach out to one of the organisations listed below. Thanks again for your participation.

- **Samaritans – for everyone**

Call 116 123
Email jo@samaritans.org

- **Campaign Against Living Miserably (CALM) – for men**

Call 0800 58 58 58 – 5pm to midnight every day
Visit the webchat page - thecalmzone.net

- **Papyrus – for people under 35**

Call 0800 068 41 41 – Monday to Friday 10am to 10pm, weekends 2pm to 10pm, bank holidays 2pm to 5pm
Text 07786 209697
Email pat@papyrus-uk.org

- **Mind – for everyone**

MindInfoline: 0300 123 3393
mind.org.uk

- **Maytree**

Tel: 020 7263 7070
maytree.org.uk

- **Talk to someone you trust**

Let family or friends know what's going on for you. They may be able to offer support and help keep you safe.

If you find it difficult to talk to someone you know, you could:

call your GP – ask for an emergency appointment
call 111 out of hours – they will help you find the support and help you need
contact your mental health crisis team.

Interview Protocols

Recruitment procedures are taken from ethics application.

1. I will recruit from specific sources and organisations that I have only professional links with, avoiding personal relationships I have with other therapists or any clients that are known to me. I will not recruit from my personal social media.
2. I will not recruit participants from the NHS as I do not have ethical clearance form that body. Participants currently under the care of NHS psychological services will be excluded from the study.
3. I will recruit from several sources:

   - Phoenix Counselling service, a community counselling centre in Feltham, West London (I was an honorary therapist there until 2020, but now have no personal connection with therapists or clients there. I have included (appendix 7.3) a notification of their willingness to support me).

   - I will place my research flyer on professional web-based noticeboards of the UKCP, BACP and the British Psychological Society's Male Psychology Section, of which I am an active member.

   - I will also use my professional LinkedIn account, where I am a member of several mental health professional communities. I will not use any personal social media in recruitment or contact with sources.

Inclusion criteria

4. Using a thorough screening protocol (see section XX above) I will ensure that participants are only accepted into the study if they meet

the inclusion and do not meet the exclusion criteria. As well as explaining the nature of the study and potential risk with being included, I will specifically check their willingness to seek psychological help if they are negatively affected by our interview process. An unwillingness to do so will exclude participants.

5. I will utilise the ASQ questionnaire developed by the National Institute of Mental Health (L. M. Horowitz et al., 2012) to judge current suicidality. A positive answer to questions 1-3 would exclude participants and an answer to question 4 (covering past attempts) being within the last 12 months would also exclude participants. This will ensure that potential participants are no longer reporting suicidal behaviour, have sufficiently recovered from any attempt, are not self-harming. Excluded participants will be dealt with sensitively and I will calmly explain to them that they are not being included in the study because they don't meet the criteria rather than due to any personal failings on their behalf.
6. I will email all potential participants thanking them for considering taking part in the study and fully brief them. I will check the arrangements for the place and time for the interview.
7. Interviews will be conducted at a neutral space, a room in the Phoenix counselling centre in Feltham. This will be during a period where other counsellors are present in the building and can offer additional assistance if participants are in distress or I need help.
8. At the start of each interview a preamble will include an assessment of current mental health state using the short form Patients Health

Questionnaire (PHQ-9) (Kroenke & Spitzer, 2002) and Beck's Hopelessness Scale (BHS) (Beck et al., 1974). A score above low or mild distress in either assessment (10 or above for PHQ-9, 8 and above for BHS) will exclude participants and interviews will not take place. This will be sensitively handled.

9. Although I am aware of the different roles that researcher and therapist play, during interviews I will use my experience as a psychotherapist to contain subjects' emotional and possibly trauma-based processes. I will offer empathy to help participants manage any upsetting material. I will focus on their experience of therapy rather than what led them to be suicidal and, in that manner, guide them away from difficult personal territory. I will explicitly ask how they will let me know they are distressed and how I might know, if they can't say, that they are distressed and use that to guide me to the utilisation of my distress protocols detailed in section 3.3.
10. During the interviews, I will regularly check in with my participants about how they are so as be aware of their state of mind. If participants feel re-traumatised or emotionally unstable as a result of talking through their experiences, I will run through the distress protocol laid out by Haigh & Witham (2013) detailed earlier in section 3.3.
11. At the end of the interview, I will fully debrief participants and ensure that they have a copy of the debrief form, both electronically and physically. This signposts participants to organisations that can offer ongoing support.

I will also attend to my own self-care as the subject matter may traumatise me. I intend to schedule interviews on days on which I have contact with family and friends, ensure I attend to my hobbies and will set aside time for extra supervision and therapy if needed. I will also draw upon the support of both my peers and my own therapist.

Distress Protocol

Distress Protocol adapted from Haigh & Witham (2013).

The protocol for managing distress in the context my interview schedule:

Stage 1

- A participant indicates they are experiencing a high level of stress or emotional distress OR exhibit behaviours suggestive that the discussion/interview is too stressful such as uncontrolled crying, shaking etc.
- Stop the discussion/interview.
- Offer immediate support
- Assess mental status: Tell me what thoughts you are having?
  Tell me what you are feeling right now? Do you feel you are able to go on about your day? Do you feel safe?

If participant feels able to carry on I will, sensitively, resume the interview/discussion.

If participant is unable to carry on go I will move to **stage 2.**

Stage 2

- Discontinue interview
- Encourage the participant to contact their GP or mental health provider

OR

- With participant consent contact his health care professional/ therapist for further advice/support.
- Follow participant up with courtesy call (if participant consents)

OR

- Encourage the participant to call if he experiences increased distress in the hours/days following the interview.

- I will consider the potential physical and psychological impact on the myself of the participants description of life experiences.

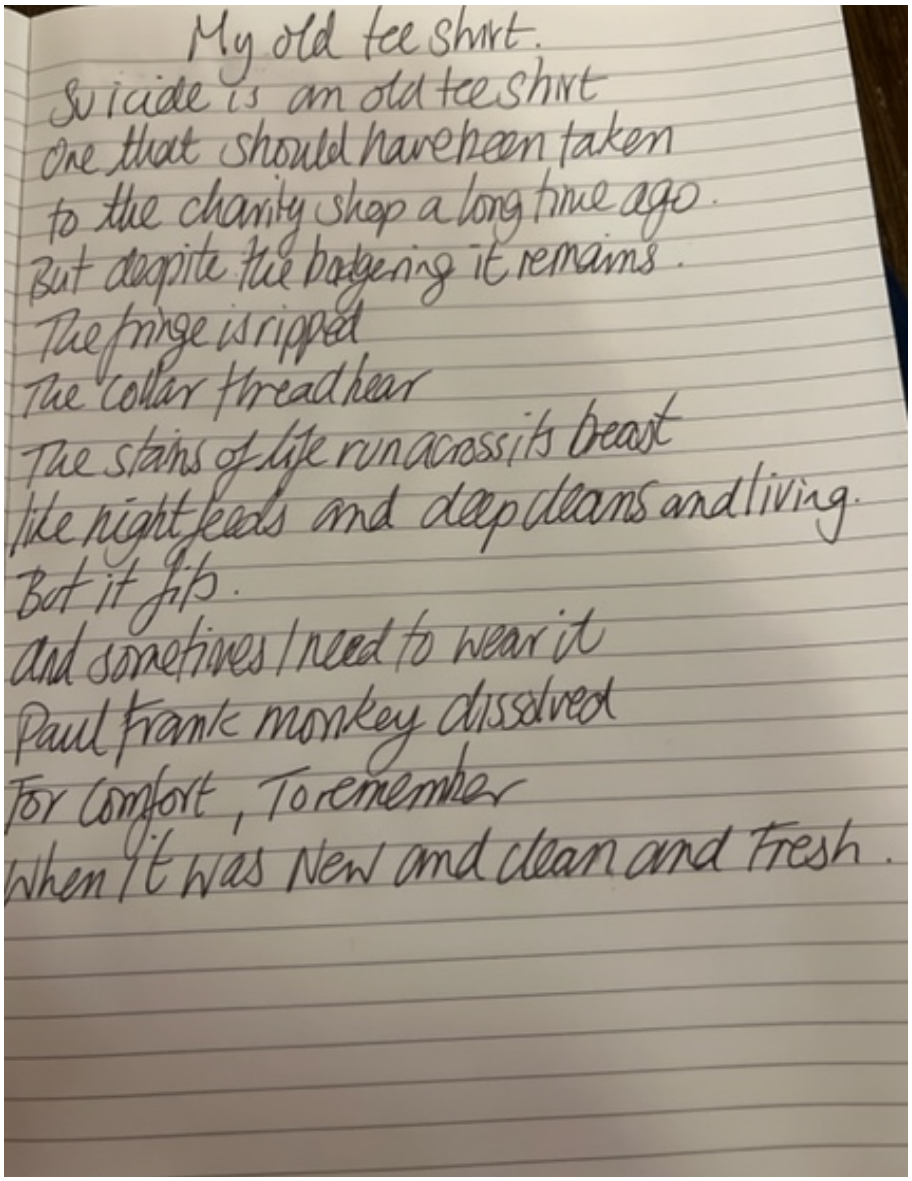
Stage 3

- I will consider how many interviews could be undertaken in a week.
- I will be aware of the potential for emotional exhaustion.
- I will schedule regular debriefing sessions with colleague and/or therapist.
- I will journal my thoughts and feelings which may then become part of fieldwork notes.
- I will be alerted prior to transcription review of potentially "challenging" or "difficult" interviews.
- I will access my research mentor if I experience increased distress in the hours/days following transcription.
- I will consider of how I will provide a "safe" working environment while also maintaining the "quality" of the research and ensure the ethical clearance process is robust.

- I will have regular scheduled debriefing sessions with a named member of my support network.
- I will have access to has an appropriate person for crisis counselling that includes resolution of personal issues which arose as a consequence of the work.

- I will continue to journal my thoughts and feelings, in the transcription phase which may then become part of fieldwork notes.

Example of Post Interview Poetry:



My old tee shirt.

Suicide is an old tee shirt
One that should have been taken
to the charity shop a long time ago.
But despite the badgering it remains.
The fringe is ripped
The collar threadbear
The stains of life run across its breast
like night feeds and deep cleans and living.
But it fits.
And sometimes I need to wear it
Paul Frank monkey dissolved
For comfort, To remember
When it was New and clean and Fresh.

Examples of Data Familiarisation.

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Voice	Data	Initial familiarisation	Refined familarisation
AC	So what do you think for you made that a safe place and a safe place?		
N	So, knowing that it was confidential, knowing that there was no reporting back, knowing that I was in control of it actually. so those three things definite. And knowing that actually, of all, each of the three therapist I've ever had through my life, they were equally understanding. If I can say and non-judgemental and not shocked. It was the non-shocking, which is really important. It was the believing, believing and the not trying to persuade me of talking out of it of it dark but there are lots of people that can't stay with it.	Confidentiality Understanding Non-judgemental – not-shocked important, not talking out of suicide of desire to end life	-Safety in therapy Transference relationship -Core conditions -Unconscious feeling of safety in connection -Therapist skill -Lack of anxiety to stay with difficult feelings

AC	What's the it in that?		
N	The fact that I actually want to kill myself and stay with the suicide, the desire to want to end my life. Rather than 'oh but look at all the…rather than turning into trying to persuade me otherwise. Now it was they… in other words, they were with me in the corner and allowed me to see for myself that in turning around that there are other option rather than just suicide. It was my, the biggest question for me has been through my supervisor again and it's, it's, it's, as I've shared my what its like for me to sit with suicidal clients and for the most part, people don't. It was the same for me they don't want to kill themselves. If you asked the question, what is what part they want to kill off? And actually I thought, is true for me did I actually want to end my life? No, I was right there was a part of my that wanted to kill myself. And it was my homosexuality of course that was. If that could have been killed off. That's why the conversion therapy so that that could have been killed off. That's the answer, I think, and so that's for me is	Distraction is not always right see options Not told sit with suicide parts of self not knowing if I wanted to end life kill part of me sexuality disavowed killed off key question of part of self Conversion therapy	-Therapist able to contain feelings – - Unconscious containment and safe space -Idea of parts of self - have time to let them be present – younger parts of self Cognitive dissonance between

	that is the ultimate question when dealing with suicide.		sexuality and faith.

Initial Code Generation

Possible Themes -

- **Sitting in a difficult position**

He took my shame but did not add to it.
Nathaniel

This theme explores how, in therapy, suicidal men sit with the discomfort of overwhelming emotions, traumatic personal histories with the knowledge and memory of thoughts and acts of self-destruction. It delves into what the experience of the client is like particularly the guided uncovering and 'sitting with' the emotions that led to suicidal thought and acts. How this is made safe, meaningful and navigated with the therapist. Within this theme encapsulates how these participants made sense of their suicide attempts and how they faced those part of them that no longer wanted to live.

Sub themes

Safely sitting in an emotionally dangerous space
Opening the can of worms
Facing the suicidal parts

- **Inside out, outside in and in between.**

Therapy is part of the process, but by all means not all.
Victor

This theme explores and develops the experience of therapy and its interaction in participants wider world. The concept of a flow of process out of the therapeutic relationship into their relational environment and also how that also flows back into the room. Part of this exploration considers what is kept in the room (boundaried / contained or perhaps dammed) in order to protect themselves and loved ones from the intimate and difficult emotional landscape. It also considers the impact of medication (self and prescribed) on the process; the impact of, and impact on masculine gender norms and how this ebb and flow has been experienced as therapy has progressed.

Sub themes:

Therapy as part of the experience – containment
Impact of and on Masculinity
Good drugs bad drugs
Developing authentic well being

- **The Cycle of Therapy**

I want to feel like I've dealt with that…but then it's slowly starting to open up again.

Kyle

This theme has been developed through looking at the therapeutic life cycle. How men engage with the process and how it develops over time. How and why participants choose their therapist, particularly interesting was their experience of *choice* and how they navigated the ideologically congested therapeutic terrain. How the event of their first session developed into a 2-person psychological dyad or ended in unmet need. The evolution of their way of 'doing therapy' and how issues remerged to facilitate a deeper understanding of self. This theme informs a better understanding of therapeutic ruptures and disagreements and how ending were navigated and negotiated.

Sub Themes:

The critical mass of choosing therapy/a therapist
The first (mis)step
The meandering long slog
Ruptures and endings

- **Power and Choice**

You need to comply to get therapy.
Kyle

This theme has been developed to question and investigate the influence of power over the experience of suicidal men finding help and the legitimisation of help seeking behaviours. Many of the participants spoke of the systemic disempowerment that governmental and societal structures exserted on their road to recovery (social services, NHS, feminisation of help seeking, masculinity in the 3rd sector). What is an underlying theme to be developed is the ironic experience of gaining agency in trying to take their own life and the choice that at any time that path is open to them. How that power is delt with in the relationship and how participants are aware of the anxiety it can create in the therapist.

Sub Themes:

Men mug themselves off.
Systemic disempowerment
Looking after the therapist

Developing Codes and Code Clusters Using Excel to Start Theme Generation.

Quote	Initial familiarisation	Refined familiarisation	Initial code	VOICE
	12 steps fellowship support	addition support needed	Interaction outside/in	R
	18 months seeing him till talk	Needing longer to build safety	Therapeutic Safety/process	J
	3 months of therapy admit to neighbour	Therapy can facilitate social support – not in a vacuum	Interaction outside/in	V
	5 months until address underlying process of suicide	Time needed to develop relational robust container	Suicide Safety	V
	a no no for some men toget in touch with feminine side	Masculinity interferes with process	Gender sexuality	V
	abandoment showed I was beyond fixing	Therapy attachment mirrors child attachment	Therapeutic Safety/process	E
	acceptable to god but not family and community	Cognitive dissonance of introjected homophobia	Interaction outside/in	N
	acceptance of childhood trauma	Making links of suicide and past trauma	Therapeutic Safety/process	R

Possible Refined code clusters

- Interaction outside/in
- Therapeutic Safety/process
- Suicide Safety
- Gender sexuality
- NHS or Medication

Possible subclusters

family and childhood journey
Other ideas
LUCK
Friends

	aceptance from church	Safety to be honest with self in therapy	Interaction outside/in	N	Choosing Safety Diagnosis confidentiality Affect
	acknowledging faults before therapy	Safety to be honest with self in therapy	Therapeutic Safety/process	K	
	acknowleging sexuality to therapist	Safety to be honest with therapist	Therapeutic Safety/process	N	
	active mental health crisis due to family crisis	Suicide and unprocess trauma	Interaction of outside/in	J	
	Actively seeking help	Non-masculine norms	Gender sexuality	R	
	acts of recognising own need important	Non-masculine norms	Gender sexuality	R	
	addiction therapy stopped by counsellor	Difficulty of erotic transference	Gender sexuality	R	
	addiction to anything	Adiction as trauma response	Interaction of outside/in	K	
	admitting suicidality in therapy alows frank conversations with loved ones	Safety of therapy room transfers to wider world	Suicide Safety	K	
	advice from friend not to wait for NHS referal	Impact os Systemic issues	Interaction of outside/in	V	

	age of therapist important	Maternal transference	Therapeutic Safety/process	E
	aims for therapy was to be in relationship	safe Erotic transference	Gender sexuality	R
	all have masculine and feminine side	similarities in genders	Gender sexuality	R
	all the other things were of benefit to me	not just therapy	Interaction of outside/in	J
	alowing parts of self to be viewed	Safety to be honest with therapist	Therapeutic Safety/process	V
	always felt empathy and compassion	Relational safety	Therapeutic Safety/process	J
	understood always offering help affected home life	developedrefletive ability	Interaction of outside/in	V
	always putting people first	understanding internal process	Therapeutic Safety/process	V
	always talk in one to one session	Safe psychological space	Therapeutic Safety/process	K
	anger in therapy motivation for change	Safe psychological space	Therapeutic Safety/process	J
	Anger at family	Safe psychological space	Therapeutic Safety/process	V
	Anger at unprofessional therapist breaking confidentiality	Safety of therapy room	Therapeutic Safety/process	E

	Anger shame and guilt of being suicidal	Containment of affect	Therapeutic Safety/process	K
	angry to fancy therapist	Erotic safety	Gender sexuality	R
	angry towards old therapist	Safety in contracts	Therapeutic Safety/process	E
	annoyed at idea of therapy for breaking confidentiality	Safety in contract process	Therapeutic Safety/process	E
	annoyed that acceptance found in secular therapy	Aceptance of sexuality and cog diss	Gender sexuality	N
	Antidepressants gave him his life back	Trust in medical world	NHS or Medication	R
	Antidepressants taking the edge of depression	Depression can be stopped	NHS or Medication	V

Developing Themes

Safety with Suicide in Therapy

Safety development	Therapist safety/paperwork/contracts	Recovery/developing agency
admitting suicidality alows frank conversations with loved ones	5 months until address underlying process of suicide	being able to catch myself
coming clean about attempts on life	at first being caught from suicide by therapist	being suicidal since I can remember
contemplated suicide	be able to engage at suicide level	chose to live rather than default of suicide
Isolation in suicide	before seeing therapist considered hanging himself	coming to terms with it not reliving it
it can take 5 mins to get into a suicidal mindset	before therapy did not know suicidal thinking would not go	control suicidality by noticing signs and coping
knowing that you can kill yourself keeps you alive	being able to call therapist in crisis	don't ever loose the suidality part
leaving a note	can now work out why more suicidal	elongating life through finding purpose
many differnt symptoms of suicide	continue with therapy need to survive	elongating the time till death
mentioning suicide to therapist	didn't need therapy to work out why suicidal	family event kept him from suicide

option of suicide keeps you alive	does not matter how good safety measures are people will kill themselves	hoplessness being suicidal
personal connection with suicide death	during crisis every day looking at therapists	moving from self perceiving as suicidal to having suicidal thoughts
really hard talking about his suicide	felt safe to talk about suicide	non- acceptability and suicide
reliving suicide attempt taking tablets	First therapy not suicide related	not ready to die
samaritans good in crisis	identifying roots of suicideality in childhood	Observing suicidal tendencies
suicide attempt due to sexual inadequecies	identifying the dangerous suicidal part	once you have tried suicide it is easier to try again
suicide is not something a weak person does	if someone want to kill themselves they will	realisation I nearly killed my self
suicide note	knowing suicidality will lift is enough to get through	realising how bad family would feel about suicide
suicide prevention helpline not effective	long term therapy following suicide atttemp	reason I kept alive because know how to live
talking about suicide made me feel shameful	little support after suicide attempt	Having relationship with suicide
talking about suicide with family a no no	made me sign a no suicide contract	relief of resisting suicide

Gender and Sexuality

Showing Femininity being a man/vulnerability	Choice of therapist	Sexuality/coming out	Issues with gender/misc	Challenge	ease of talking	other
a no no for some men to get in touch with feminine side	Chose woman to change attitude to women	acknowledging sexuality to therapist		Chose woman to change attitude to women	being open with female therapist helped with romantic relationships	Caste class gender age these are major factors that I would choose in choosing a therapist
all have masculine and feminine side	being open with female therapist helped with romantic relationships	childhood trauma taking away sexuality	Coercive relationship major topic of therapy	changing perspective on women	Being totally accepted by female part of recovery	choosing a man
Asking for help all my life - not masculine norm	Being totally accepted by female part of recovery	closeted gay man led to suicide		choosing a man against normal behaviour	betrayed by men	Male psychologist
Being brought up male you don't talk	betrayed by men	conversations promted by therapy	commerciation of therapy problematic	Chose woman to be challanged	choosing older man	men generally think they are too smart
being vulnerable to cohersion	Caste class gender age these are major factors that I would choose in	conversion therapy gave an answer	controlled men have nowhere to turn to	female therapist challanged perspective	easier to talk to women	specifically choosing a female therapist

	choosing a therapist					
changing attitudes to gender roles	changing perspective on women	fantasy of therapist desire	controlling female partner	female therapist would challange	fear of female therapist	Vulnerability
difficulty talking to female therapist about sex	choosing a man	far more than being a man	not seen did not understand control	male would not male therapist are easy ride	feel more comfortable talking to a woman	all have masculine and feminine side
fear of stigma stops men talking	choosing a man against normal behaviour	Female attention from female therapist	men and women have societal expectations	male therapist did not challange his thinking	female therapist helped be more open	being vulnerable to cohersion
felt judgement of going to mens shed	choosing older man	filling the gap of intimacy with therapist	Men don't talk about sexual problems	male therapist far too passive	I relate better to females	fear of stigma stops men talking
growing up a male won't let any one do things for me	choosing older woman to stop erotic transference	gender difference with talking about bodies	men don't talk about problems with bodies	need challange of female therapist	men feel more comfortable being vulnerable with women	felt judgement of going to mens shed
How men show emotion	Chose woman to be challanged	girlfriend representatinal figure	men have shame and guilt about their bodies	should see a female therapist	men fight each other don't help	How men show emotion

Medication, Self-Medication and NHS

Medication	NHS	Diagnosis	Self-medication
Antidepressants gave him his life back	NHS no therapy just drugs	Diagnosis helpful for family to understand	siting with childhood trauma without going to therapy
Antidepressants taking the edge off his depression	NHS system confusion	different perspective in sitting with discomfort of anxiety is change	taking psychodelics with intention of being well
being able to feel again off meds	NHS therapy ended too abruptly	difficult anxiety as metaphor not the essence of the feeling	therapy like psychodelics
emotions are normal but blocked by antidepressants	NHS therapy is underfunded	multiple diagnosis over years	timlessness of psychodelics
friend on antidepressant and therapy	credibility from medical profession	depression comes and goes	clarity of psychodelics
going through the motions on medication	crisis teams good but just keeping me alive	depression made me forget community	Narcotics anonymous
in a better place with medication	crisis teams just keeping alive	diagnosis and judgement delicate	protocols of psychodelics
less medication gives clarity of thinking	NHS therapy makes you feel medicalised	not recognising mental illness	use of psychedelics

Further Refinement of Medical Themes

Bad med	Medication neutral	Good meds	Bad NHS	NHS - neutral	Good NHS
being able to feel again off meds	All friend on antidepressant	caring psychiatrist	NHS therapy makes you feel medicalised	crisis teams good but just keeping me alive	credibility from medical profession
emotions are normal but blocked by antidepressants	medication and therapy relationship	Antidepressants led to better life	NHS therapy too clinical	crisis teams just keeping alive	GP said imminent danger of suicide
going through the motions on medication	medicine not fixing anything but useful	Antidepressants taking the edge off depression	different types of therapy confusing	Therapist asked him to see GP	recovery started when listened to by GP
less medication gives clarity of thinking	reducing medication is safer with therapy	in a better place with medication	NHS no therapy just drugs	Diagnosis	ridgid planned therapy did work
long term psychiatric medication stops full living	reducing medication with therapist	prescibing psychedelics	NHS system confusion	depression comes and goes	Telling GP about suicidality taken very seriously

Developing Agency

Client Agency through safety	Therapeutic environment and safety	Choosing starting ending
acceptance of childhood trauma	age of therapist important in understanding young generation	18 months seeing him
acknowledging faults before therapy	always talk in one to one session	abandoment showed I was beyond fixing
acts of recognising own need important	anxious before therapy	addiction therapy stopped by counsellor
Actively seeking help	appreciate when therapist connects things	
alowing parts of self to be viewed	asking the right question at the right time is skill	aims for therapy was to be in relationship
always felt empathy and compassion	believing me	Anger at unprofessional therapist breaking confidentiality
	breaking confidentiality must be done properly	Avoided ringing therapist
anger an important motivation for change	building raport	avoiding therapy because knew what they would say
Being allowed to be Angry at family	client feels more comfortable in person	become acceptable to me

Showing anger shame and guilt of being suicidal	comfortable environment helps	being sent to therapy not helpful
angry with therapist	comfortable room helps	being in the right frame of mind to do therapy
	confidentiality made therapy safe	Being stuck in therapy
anxiety as a metaphor	confidentiality vital	build up to therapy
anxiety is life helps	cultural understanding in therapist vital	changes due to therapy sessions
anxiety is not a weakness its just how you feel	difference between talking to therapist and friends	choosing existential for faith reasons
	directory to find help	choosing faith therapist
battling with own ego difficult	don't want young therapist	choosing no challange
being able to sit with anxiety	Effective therapy not manualised	choosing someone further away
being able to talk because of therapy	facetime not as good as in person	choosing the most experienced therapist
being critical but not rejecting ideas	feeling on the edge humour helps you stay open	choosing therapist near
being frightened what you might find out in therapy	feeling safe with therapist	choosing therapist on looks
being more boundried	Finding a counsellor online	choosing therapist you won't bump into locally
being open risks being hurt	finding therapist through friend recommendation	choosing to stop

Therapeutic Safety

Therapeutic Safety

looping back in therapy helpful

lots of impactful life experiences at once

love the anxiety

loving recognotion in the present

making sense of dissociation in therapy session

making sense of link mental health and abuse

making sense of trauma with therapist

making sense of traumatic experiences

more complex than what we hear

more therapy harmful process

therapist does not ignore elephant in the room

most people can't sit with suicidal

moving from surviving to being proactive in change

need to matter of fact with therapist

needed therapist to believe I won't kill myself

not being a perfectionist anymore

not enduring uncomfortable but needed therapy

not acceptability

not being in anxiety but observing it

not being truely met

Not changing the past

not exploring self love with therapist problematic

relief getting things out

reliving family bullying

resolution not found but useful to stir the pot

reticence of therapy

revelation in therapy was feeling in the present moment

riding wave of anxiety

run mouth off in sessions

rupture and defence

sanity is sitting with discomfort

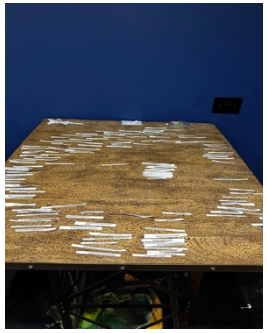
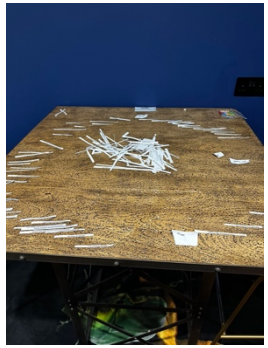
seeing change over long term

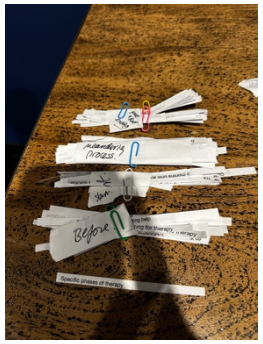
not every session

therapist draw out truth	not knowing how to love themselves	seeking therapy because of hopelessness
therapist has not told me how things should be	not looking at self	self Love is observing myself
therapist helped being open	not needing to go back into therapy	shame gradually reduced
Therapist helped identify emotions	not ready for therapy	shame in therapy
therapist helping me discover meaning	not resolving conflict but observing them is catharsis	shifting relationship to anxiety the journey
therapist listening means I can show myself	not talking me out of it	snowball effect of bad mental health
therapist modeling boundaries important	only you can fix things	so depressed was not able to perform for therapist
Therapist not robust enough to challange	opening up after being closed is scary	started in bleak place
therapist opinions closed me down	past admitting anxiety a weakness	started on edge then physically opened up
therapist purposeful slowing process	past defensive	staying with the darkness
therapist sense of humour relaxes me	permission to feel in a particular way	sticking to therapy
therapist understanding and accepting parts of self	personal vulnerability in therapy helped	Stirring it up
therapist will explore ruptures	petulant teenager get annoyed by therapist	stirring out the difficult part of therapy

Evolution of Theme and Subtheme Development from - October 2023

1 2 3 4 5



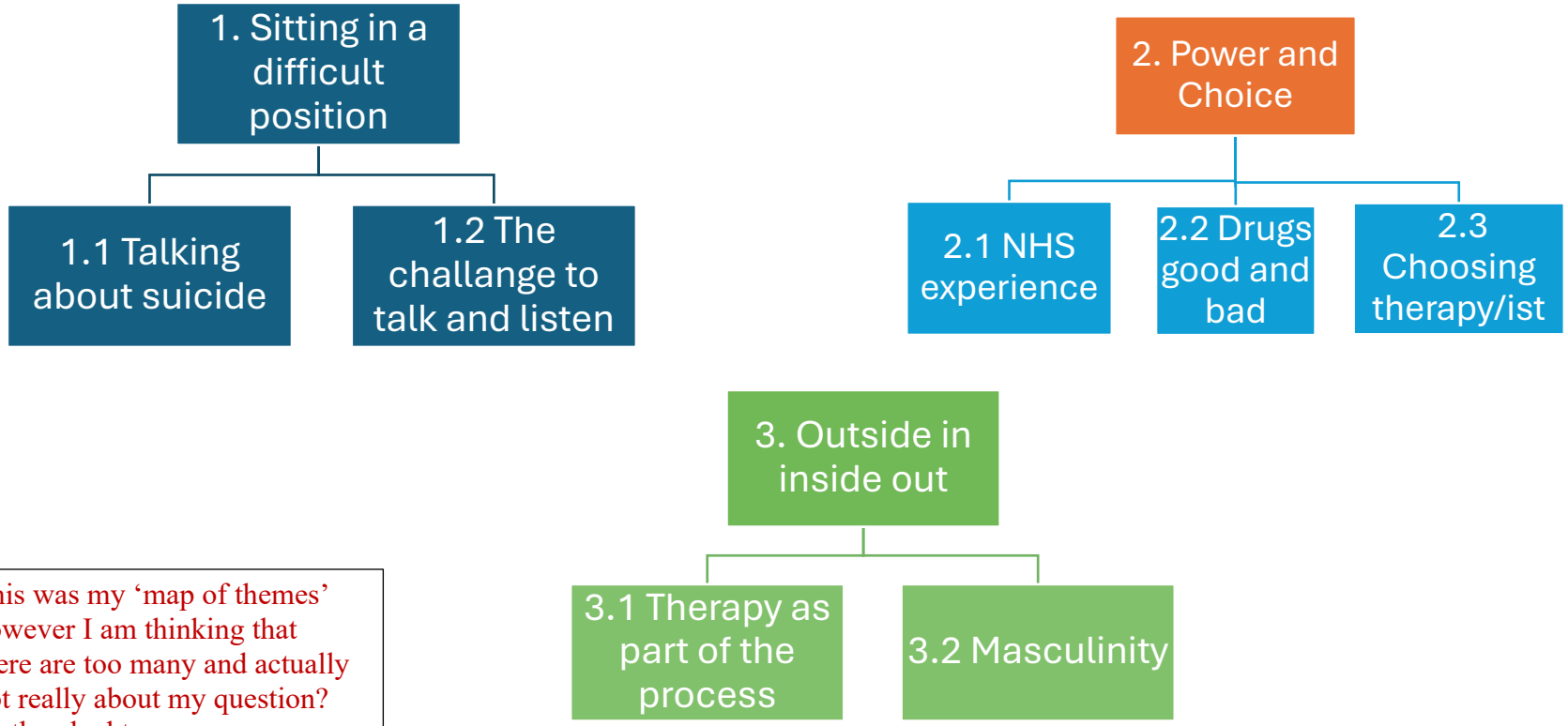
1 View of all printed codes from clusters
2 Organizing into initial groups
3 Refining of groups
4 Notetaking of groups and checking with
5 Consolidation of possible/candidate theme

Candidate Themes and Subtheme Ideas

Theme	Sitting in a difficult position	Inside out, outside in and in between	The Cycle of Therapy	Good drugs bad drugs	Power and Choice
Subthemes	It's Hard to Talk.	Therapy as part of the experience –	Choosing	Drugs helping	NHS experience
	The ability to listen/hear and be with.	Developing authentic well being	Starting	Drugs not helping	What and who is a therapist
	The ability to listen/hear and be with.	Impact of and on Masculinity	Opening up	Drugs the only option	The power of diagnosis
	Randomness and the paradox of recovery is to be unsuccessful		closing		

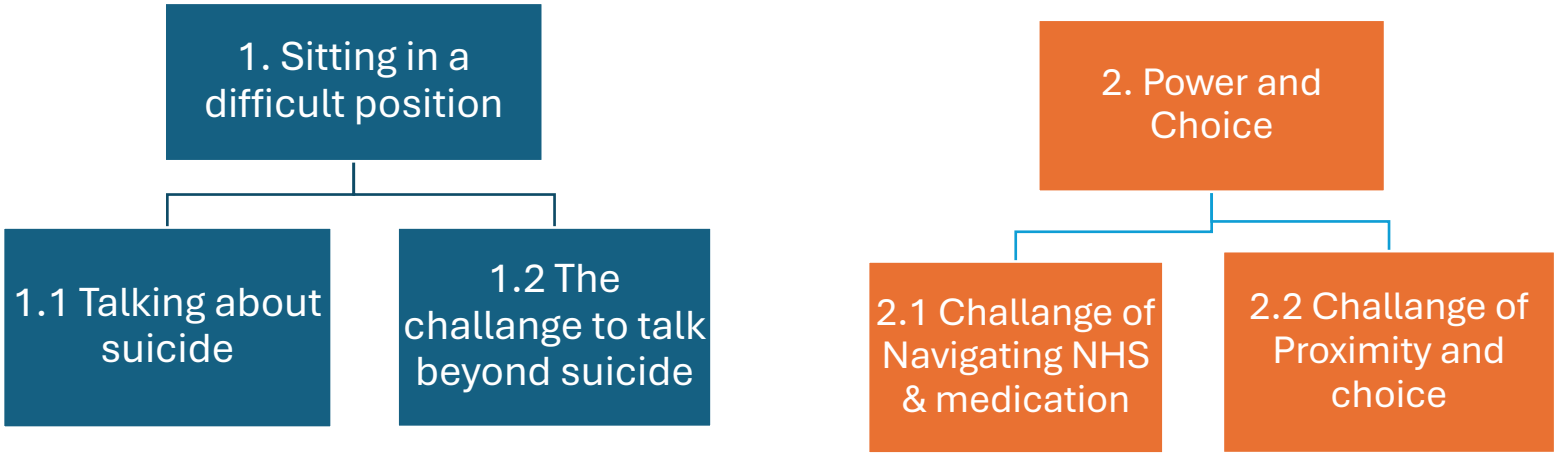
These are very general themes and are more descriptive rather than having any deeper meaning. The idea of the cycle of therapy is a little obvious and does not really say anything new about the subject. Good and bad drugs does not really give the context or develop the idea that this is a systemic issue that men face – no therapy just a bunch of SSRIs – why has this happened? what is the impact on these men ?

Second Theme Development



This was my 'map of themes' however I am thinking that there are too many and actually not really about my question? So they had to go

Third Theme Development



This is my thinking that the old 3rd theme is actually not really answering my question – it has some really nice stuff but its outside of the room and even though it is relevant to their therapy it is not relevant to my study so had to go
The bits that are – masculinity for example I am including in a subtheme of proximity – that can cover gender and age proximity, theoretical and also geographic proximity as well as working online.

Creative Writing to Build Story of Participants

Single session monologue

Note to our Therapists.

Setting: therapy room with standard 'therapy chair', clock behind his right shoulder and side table to left with water, box of tissues and potted plant. A 30-40 year old man is sitting in the chair and speaks directly to camera as if the camera is his therapist.

Man-

I thought that before we started talking properly and get that contract signed, that you might want to know a few things – you know, a few pointers on how we should or could work together. We are a difficult group to reach and apparently don't often ask for help – (*almost to himself*) although we do but quite often our requests for help are interpreted as something else...

Firstly, we would like to outline what we must do to make this all work, just in case you thought you were doing all the heavy lifting.

As clients, or should that be patients? We need to be committed to emotional hard work. That will mean risk, vulnerability; facing our fears of what we might find out together. Some of this 'material' has been so well buried and defended against that we don't even have a clue what it is. We will need to reflect and sometimes argue with you; even when every muscle, bone, sinew, corpuscle, and ounce of our existence is screaming to be quiet. Just nod and accept whatever it is you are

saying. It's safer that way – you are the expert in this right? We may also struggle to resist the urge to keep everything within our control so apologies for talking over you or being silent or rude or not coming back because it can be a bit frightening.
You see we are required or asked to be seen. Allowing you to look directly at us and into our somewhat tortured souls. Painful and very exposing – so please don't stare.
Please dear god, do not tell us that we need to love ourselves – what the fuck does that mean? You can do better than that. I'm paying north of £100 for not even an hour - the least that deserves is some originality not the pat answer you give all your clients – or do you call us patients.
Remember sometimes we have been strongarmed by our, girlfriend, wife, husband, boyfriend, employer, college, friend, BDSM mistress – MOTHER, into that cheap Ikea Poang chair opposite you. In hope that it might help us feel less depressed, anxious, controlling… It might save our marriage, magic up our libido, make us a better person, more in touch with our emotions. They are probably hoping mostly that we will be less angry or get some anger management tips. Ultimately everyone is hoping that it will help us understand our own act of suicide. And, before you mention it, I know our language can be a little indelicate. I know I shouldn't use the c word but sometimes… we say **commit** suicide because that is what we have learned so don't be offended if we do, we get it it's not a criminal act anymore.

Often, we are the brave ones as our partners won't do therapy. They stick to more objective and scientifically proven medical, evidence-based interventions, complete half-marathons or continue drinking the cheap Tesco merlot coolade. Sometimes we are the ones who want change, often after we put the empty bottles in the

neighbours recycling or wave our kids off after the bi-monthly clusterfuck of visitation. Sometimes there just isn't the space for our emotions at home, they are drowned out by the tsunami their tears. Yes, we may learn to be more aware and mindfully manage our temper and the ugly angry outbursts, but don't treat us like a fool. Slowly we may get to the bottom of things, uncover the boarding school double bind, the bullying, and the childlike shame at the theft of our sexuality – it might, eventually, help us to act less…suicidally. However, be gentle, we may not be ready to dive right in, or be ready for the depths we will plumet to - letting you know and see the truly unacceptability of our being, will be humiliating.

Please don't be positive. We will question why we are here. We can get a real hand job for half the price and feel happier and more satisfied in a fraction of the time. Remember, we will question *why the fuck we are here,* almost every time we sit in reception waiting for you to bound round the corner 2 minutes late with your lanyard askew. The over enthusiastic receptionist, who is obviously anxious at having a nut job on the premises, feeds our paranoia. We can see the fear in her eyes, taste her judgement no matter how well she covers it up with her bubble gum salutation. Sometimes that's when the rage and destruction flow through us. We remember what the dads would say to condition us into not to making a fuss, being chivalrous. OR how we'd recoil in timid embarrassment as mum would kick off at the slightest thing wrong and not noticing the red-faced, clammy little boy begging for the earth to open up beneath him. And what happened to us, **is** often a hill worth dying on, so please stir that pot.

After, we sit with the discomfort, take it home on the bus to rattle around for seven long days and nights. The knowing; the seeing of ourselves; sitting with the reality of discovery. Its hard to love that process sometimes so allow the depression to highlight the cause. We are not preforming robots for you to retrofit your developmental schemas around or voice your tired platitudes to like the drab counselling leaflet at the GPs. And please let us finish our sentences. Let us sit with the darkness and be with us. Left alone but not alone. That is resilience.

Know that we are not done yet, but might have been. That **in** our crisis; our mental health crisis; THE cost of our living mental health crisis, it is difficult to respond automatically. Our distress has inflated and reduced out emotional self-help spending capabilities. Sometimes we have nothing left after bailing out our small boat of self-esteem – a refugee on a sea of despair. Thank you for your awareness. Of not ignoring the pachyderm in the room. Remember we are like the operant conditioned elephant, that has learnt the pain of the heavy iron chain, fought it day and night till its skin is torn red raw into compliance. So much so that all that is needed is the threat of, the merest hint of that memory for cohesive control. Every so often it escapes the captivity of its own mental prison only to be gunned down, Orwellian style with the ignominy and shame of an audience. What is freedom if you don't have anywhere to put it …watching on as your life crumbles at the choice of truth and apostacy over lies and a roof over our head. So don't be afraid if we find this process hard and we don't fully comply.

What are the prerequisites for us to take this journey us Sisyphus's mountain?

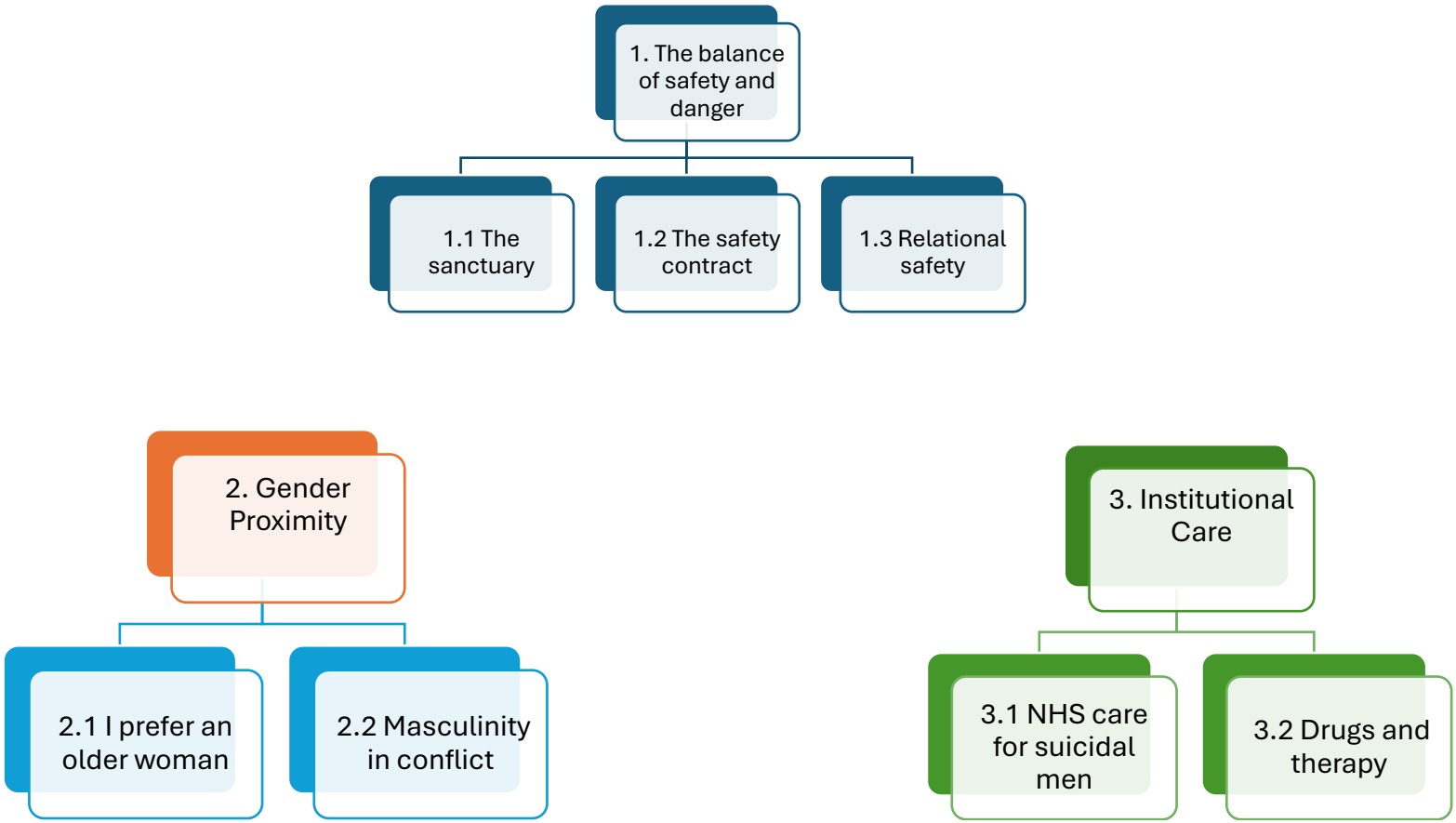
What are the core conditions that will keep us safe from, that irreparable harm that we flirt with daily. What will keep us afloat as we splash upon the icy waters of abysmal despair? – drowning not waving.

Well first you need to swear that you won't tell – that this is confidential. That what we say or how we are is safe with you. If you have to talk to someone – talk to us first, don't go behind our backs. If you do, I will give you a good slap. Our relationship can be destructive. Just because you have a few letters after your name doesn't mean you are immune to getting it wrong, so admit it, own it, and apologise. For us to commit, you need this place to be safe and you need to be safe. Have some mood lighting, a professional but homely space, make sure it smells nice. We also don't like it when we are being overheard or if we feel like it's an interrogation. We will worry about you, about all the shit we are shovelling into you. The hate and anger, the sadness, the pain, our hopelessness. We worry about 'boundarying' you and yet we crave to be free of the isolation. You can help us by looping back round, being curious and listening past the bright shiny life we project and explore the crumbling shame and guilt wracked edifice we truly think we are and think we need to project into the world – don't mug us off.

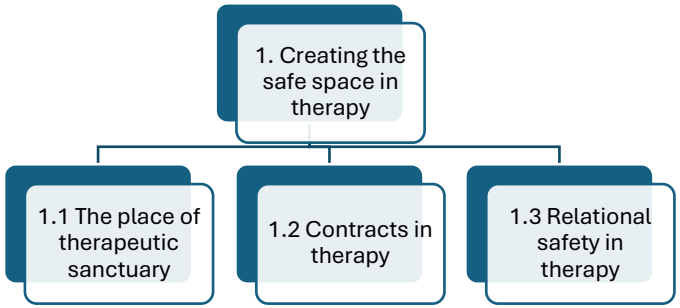
You act as a conduit; to build confidence, create calm. To be open and help us own our own vulnerability. You can change our thinking, drop our defences and help find our voice. You will witness us newly recognise that we feel. That we feel something beyond the self-destructive incandescent rage and icy fury. Touching our compassion. You can help us be brave and courageous, emote, vocalise and recognise ourselves. Help us develop our own narrative, not the one our fathers

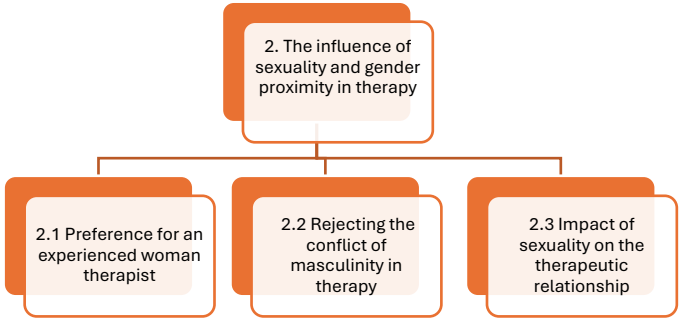
penned for us but the one we author. Take it slow, it is scary and teach us to learn from our own ruptures. Teach us the power and positivity of saying no. Help the petulant teenager to relax. Read the goodbye note we wrote in our own blood and not laugh. Help us to be open, man cos we just want to be open. Let us be in the here and now, stop dragging it back down to demi reality. Don't fall asleep in our session, we have high standards so should you. And lastly take our shame and do not add to it

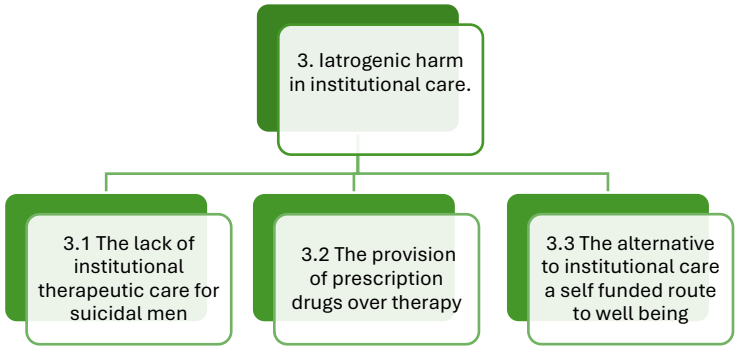
Crystalizing of Themes



Final Themes







Key Quotes and Evidence of Themes Across Data Set.

Participant 1 (Nathaniel)								
Creating the safe space in therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
I know I had a safe space and a place where I could if I wanted to, speak, bring me.	I just went because I was sent.	I didn't feel it was unsafe to talk about it or I was being judged.	I should go and see a female therapist	I won't let anybody do anything for me	Oh, he looks nice Go on then.	I got caught up in conversion therapy		you you obviously know what help you need,
hopefully feel safe enough to talk about what contributing to the source	it was confidential,	They were equally understanding if I can say and non-judgemental and not shocked	I should go and see a female therapist.	He's challenged me and correctly challenge me	it was another easy ride	My church was right and how dare anybody else think that they had another viewpoint		go get whatever help you need. And We will provide.

Participant 2 (Ravi) PHQ – 5 (normal range) BHI – 3 (no difficulty at all)								
Safety in Therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
The venue was quite important; it was quite a nice venue…that helped	So I told what I could afford and she agreed	share my stuff and hoping to get some wisdom	I did choose an older woman	I didn't wanna see a man because he may reinforce that belief	With a younger woman it I may end up getting thoughts for her, or obsessions or might start taking things the wrong way. And then I'd get angry and I get upset.	So I saw a psychiatrist and with him. He was a bit blasé really	They had a massive impact on me you know. I still take them now.	I couldn't afford her but she had a sliding scale
It was nice to get away from my area it was nice to drive half hour, 40 minutes to go and see her		And on the phone I just got a pleasant vibe from her	Because I wanted a partner I wanted someone that's why I didn't see a man.	We mug each other off we take the piss out of each other.	she was a really pretty woman, she was a drinks and drugs counsellor and we stopped	I didn't want to go back,	I don't know if it's a psychological thing or if they are actually doing anything.	I started paying to see a therapist you know. I found it got more, I started looking for more qualified therapists

Participant 3 (Eric). PHQ – 3 BHI – 4

Safety in Therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
feel comfortable with therapist it would be much better to see a person just look in your eye	since we started, she made me sign a no suicide contract	I want to show myself I can have a conversation with anyone as long as the person who's willing to listen.	Class, gender and age - these are major factors that I would choose in choosing a therapist.	men feel that more comfortable being vulnerable with more female	I'm concerned about talking to a female therapist about it because I don't want to make them feel I feel I don't want to make her uncomfortable	If I had known about it (confidentiality break) I would have definitely gone to the hospital and thrashed that person	I would say a year and a half not a long time I feel like I'm in a much better place	I found a therapist who I used to pay £8 pay an hour for the session
it was a professional hospital. I still think about it I think I should sue the therapist but it doesn't really matter to me	I signed in the form as well that she has the right to tell my parents or my brother	I feel like you can't ask yourself those questions you can't do this by yourself	I didn't want someone as young, I want someone who has had some experience.	men feel competitive in a conversation that they want to be the alpha.	I checked with her if she's okay if I talk about sex and to what extent I can talk about.	they tried to ask me and I said I can't so they said if I don't tell us then we're not gonna let you go so I didn't go after that.	I still think that it's not natural for me to be cured with medicines	I spent so much time on LinkedIn and there are … I wasn't earning an a lot so that's when I started talking

Participant 4 (John) - PHQ – 0 BHI – 1-3 (normal range)								
Safety in Therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
We live near a small town not necessarily willing to be bumping into someone	was actually just kind of putting a lid on something that's going to explode subsequently	Safe yes I felt safe with them,	I would say this probably generally goes quite against my normal behaviour is that I just like to go for a man	I was always quite conflicted over this he'd often say the session is that the hill worth dying		when I said to the GP like is there a recovery plan to get me better? or are you just giving me some antidepressants, he said we are just giving them to you there isn't a plan around this	*The NHS: here's a pack of antidepressants there, now fuck off and see how you're doing in six months' time.*	I got up early the next morning I took a load of mushrooms I went into the spare room and with the intention of being better
and so he would always suggest like if at all possible, make sure you like get up and go for a run straight afterwards	I then started purposefully, with his full awareness leaving kind of two or three-week gaps between sessions	it was a kind of terrifying experience I would say we went so quickly kind of through the layers.	I hang out with a lot of female friends always have done and certainly	as I'm saying that it all seems a bit of conflict		My conversation with the GP. Cos It lent my experience credibility	three people in one month had said to me you need to go see your GP for antidepressants.	I started seeing another therapist last year who I then saw for the best part of a year. For the best part of a year

Participant 5 - Kyle PHQ – 3 (no difficulty at all) BHI – 1 (normal range)								
Safety in Therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
sitting in a quiet room and your voice is external. And I found that so helpful having that external voice rather than sitting there and mulling things over	She introduced how we could work together	*So, the first time of doing therapy was ... it was … I loved it, I felt heard, I felt seen. I felt she was just so warming and so compassionate and caring.*	I realise I'm drawn to older women. because I find them quite nurturing	It's safer for me to go with the woman	male therapist and fancy them fall in love with them, whatever have feelings for them.	*I went into hospital, and I said I was going to kill myself …they said 'No, you're fine don't worry,'*	I thought it was coz it would solve all the problems, yeah you could take a pill and it'll be all better	He said that I could probably do with some therapy so he recommend me his therapist and he paid my first ten sessions
when you've got that hour in the room of the therapy contains it again	She introduced how we could work together	She was warm and she was friendly.	there are more female therapists than men. I think that does play into it		Where I don't have a mistress now that is kind of in place	I was on the waiting list for eight years I kept on being pushed back down the first time was three years	I spent about a year trying the different ones about eight different ones, and I said these aren't working I can't function as a human	money was one of them I think that was the main one actually. It was the money

Participant 6 (Victor) - PHQ – 6 (mild range) BHI – 3 (normal range)								
Safety in Therapy			Push and pull of gender proximity			Institutional iatrogenic harm		
The place of therapeutic sanctuary	Contracts in therapy	Relational safety in therapy	Preference for an experienced woman therapist	Rejecting the conflict of masculinity in therapy	Influence of sexuality and erotic transference	Lack of institutional therapeutic care for suicidal men	The provision of prescription drugs over therapy	Selfcare a self-funded route to well being
You can tell it's a place of work but it feels comfortable as well	I haven't got a contract. I know I want to get better so it's a contract for myself	I know it's a safe place where I can talk about it. In a very matter of fact way	*I do think gender plays a **massive** role."*	again is that sort of tapping into the that kind of macho bullshit	You can't be friends with everybody and that's something I've had to learn in therapy.	they got me onto the psychology but it took that took about a year to come through	*I probably started taking antidepressants when I was like 19 and then carried on. So, I've done like the Prozacs, the Celexas, then the Citaloprams*	when you're on your own two feet and able to pay you can pay for it and sort it.
I live in a village with like 1500 people everybody knows everybody's business	First couple therapies that I did… I probably just signed it but didn't take much notice	Yeah there's a huge amount of trust, i have a massive amount of trust	she said you do realise you were just like the typical petulant teenage last week	it's probably more dominant in males , it's sort of how we were brought up, especially the way I was brought up you don't talk about things. You just get on with it.	But i think i've always got on better with women. I can relate and open up to females quite easily	don't wait for an NHS one because you might have to wait too long.	I first had my breakdown they gave me so many drugs, it was like a good two weeks I don't know what the hell I was doing.	I'll get you a therapis the NHS unfortunately is so underfunded t

Scripts for Monologue and Film.

AC—*What you are about to see are three short pieces of work inspired by my research around men's experience of therapy post suicide attempt.*

They serve several functions. Initially, they were a way for me to make sense of hours of recordings, 1362 codes and solidify them into something meaningful. They have become part of my reflexive process in research – is what I am saying what they said, and am I honouring their truths. Finally, my hope is that they connect with you and sit you in their position as a client.

They are an amalgamation of six people, six voices, six chairs, the six other chairs.

Theme 1 – Safety in therapy

I know, I had a safe space … a place where I could, if I wanted to, speak, bring me. (Nathaniel)

Everyman 1 – He is in his late 50s. He drives a motorbike and has struggled for over 30 years with his mental health. He is lucky to be alive as his last suicide attempt was an overdose in a wood and the police had to blue light him to hospital. He is a survivor of coercive control from different partners over the years.
Here's that contract that you were eager for me to sign. Not sure about the no suicide clause, last time I looked dead people can't be sued. Anyway, this place is nice, comfy, calm.
So, I was thinking about how we can do this, 'cos It must be a bit stressful having someone like me in your room – you know 'frequent flier so could be a jumper!'
So, this (pointing backwards and forwards between camera and him) how do we keep it safe. Talking with you, may make me feel bad about myself, what happened, so it may not be such a relief. The embarrassment is tough. I saw my neighbour Geoff yesterday and I could read the fear on his face 'cus I think he knows what happened. So, I'm glad you won't get freaked out like him. I am not looking for answers. I am looking to have a conversation with myself. My younger selves. I am not seeking your validation.
So be my conduit. Hold this space for me, allow my vulnerability. Help us to be open, because we want to be open, and we do want the help. There is no rush. And lastly, recognise my shame, but do not add to it.

Theme 2 The push and pull of gender proximity
"I do think gender plays a massive role." (Victor)

Everyman 2 - This is a mid-aged man, works as a forklift truck driver. He is an ex-addict whose addiction stemmed from sexual abuse as a child and his inability to form intimate connections with women. He's been clean for 16 years and looks to his spirituality to help him keep clean which he does. His therapy was for 6 years and was mainly to challenge his views of women. Kind of no-nonsense bloke.

You know maybe, I saw this as a midlife risis and men's territory. I thought having a man to talk to would be easier, you know, that made sense to me. He would get me easier. But it was an easy ride. I couldn't really let him get too deep. For some reason, I couldn't get it out of my head that this was a competition between us, and we was avoiding that. You know, as men, we mug each other off, we take the piss out of each other, my dick is bigger than your dick, I can fight better… but I needed to be challenged about some of this stuff. So I find it easier to have that challenge with a woman I am not in competition with them so much. And anyway, I've always got on better with females. I did then have a younger woman counsellor, she was really good looking, and if I am honest with you, I did fancy her. It got awkward and we stopped working together. Made me really sad. My last one was older, a bit of a mother figure…It's not that my mum is a bad person or anything but she was emotionally unavailable, so I looked to her for that commitment, to get what I didn't get when I was young.

Theme 3 - Iatrogenic harm in institutional care

I said the GP, like is there a recovery plan to get me better or are you just giving me some antidepressants? He said 'we are just giving them to you, there isn't a plan around this'.

Everyman 3 – Is in his early 40s, bit EMO who works in a healthcare as a care coordinator, but also doing a part time master's degree in philosophy. Well-spoken but Nervous – he keeps biting his nails.

So, I was on the waiting list for eight years, I kept on being pushed back. First, I needed to go to an eating disorders clinic then, because I was on loads of meds I was sleeping too much and had to go to a sleep clinic. All the time I was being told 'you are top of the list', but it never happened.
I was so depressed and so anxious desperate for to help, I went to A & E and they kept saying 'No you're fine, don't worry'. Finally, I said 'If I leave here I will walk in front of a bus' and I was sectioned, like after 8 hours. But even then, all it was, was the chemical cosh, no therapy, no one spoke to me or helped me.
So, I have been on all the drugs when I was 18, I got the SSRIs - citralopram, but then it stopped working, I spent about a year trying about 8 different ones - a real lottery. I asked if there was anything else and they gave me a leaflet on depression and counselling. It's not like they didn't help – at the start they gave me my life back but after 26 years … I cried when I got married - I was happy, but I was medicated at the time so I never fully had the experience. So, it's like men's mental health? Right, go to a shed and build a birdbox and here are the drugs now fuck off and see you in six months' time.

Research Supervision Confirmation of Consent

METANOIA INSTITUTE

Research Supervisor Confirmation of Consent

Name of student: Alastair Coomes

Name of research project: A reflexive thematic analysis of the experiences of psychotherapy of adult men with a history of suicidality

This is to verify that as Research Supervisor for the above research project I have seen proof that appropriate consent has been obtained from the participants used in the project.

Supervisor's name: Dr Joel Vos PhD Msc MA CPsychol FHEA

Signature: 

Date: 28 Aug 2024