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Abstracts

Systematic Review of Research Literature (SRL)

Background: Recent studies reveal non-heterosexual (hereafter 'queer') men are at greater risk of dying by suicide than heterosexual men. This finding makes it important to understand this demographic's experiences in order to design better means of support and reducing risk. This review synthesises qualitative papers to (1) identify themes of factors associated with suicidal thoughts and behaviours in queer men and (2) explore how queer men make sense of these experiences.

Method: Six databases were searched (PsychINFO, Embase, Scopus, Medline, CINAHL, and Web of Science) in October 2023, repeated in May 2024. The studies included were published since 2003, used qualitative methodologies, and aimed to explore suicidal thoughts and behaviours in queer men. The QualSyst quality assessment tool was used to explore study quality. Sixteen papers were synthesised in line with Thomas and Harden's (2008) thematic approach.

Results: Sixteen papers from fourteen datasets were included. All papers were of good to strong quality. Thematic synthesis identified 6 themes: the process of identity development; experience of rejection and isolation; multifaceted experience of stigma; mental health and barriers to support; sociocultural contexts; and belongingness and reasons for living. These themes are discussed in relation to existing literature and in terms of theoretical frameworks.

Conclusions: Risk factors associated with suicidal ideation and action included: experiences of rejection and isolation, stigma and harassment, mental health challenges, and facing barriers to help. Risk factors were experienced within the context of an evolving identity development and in sociocultural contexts in which religion, culture, and societal attitudes to queerness influenced men's experiences. Men identified reasons for living and factors that halted ideation becoming action.

Keywords: Systematic review; qualitative synthesis; queer men; GBTQ+ men; suicide

Service Improvement Project (SIP)

In spinal cord injury inpatient services, the ideal pathway from admission to psychology would be to screen each new patient to determine psychological need. However, the implementation of 'gold standard' guidelines are often not possible due to limited resources, such as understaffing or poor funding. This study examined how best to use resources to increase access to the psychology team where universal screening is not possible.

This mixed methods study had 4 stages. An audit examined 161 inpatients admitted to the National Spinal Injuries Centre (NSIC) over one year; a questionnaire evaluated staff understanding of psychology; focus groups were used to develop a more in depth understanding and recommendations were made.

Results suggested that the psychology team's role was unclear to staff, and they were viewed as separate to other disciplines. Recommendations were made to improve staff and patient access to the team. A need to improve the psychology team's communication was identified, alongside clarifying and simplifying the referral process.

Keywords: Service improvement project; Spinal cord injury; referral and consultation; barriers to referral.

Theory Driven Research Project (TDRP)

Objective: This study aimed to explore the differences in internalised stigma level in people with a functional seizure diagnosis (Non-Epileptic Attack Disorder (NEAD)) compared to people with an organic seizure diagnosis (epilepsy). It also investigated whether there is a difference in disclosure of diagnosis between these two groups. Finally, it explored the relationship between internalised stigma and the factors of self-esteem and self-efficacy.

Design and participants: This study used a cross-sectional survey design to address these questions. Anxiety and depression were measured and controlled for where appropriate. 51 people with

functional seizure diagnoses took part, alongside 47 people with epilepsy and 14 with both epilepsy and functional seizures. The comorbid group was too small to include as an independent group in analysis and were therefore excluded from analysis

Results: People with NEAD reported higher levels of internalised stigma than people with epilepsy (PwE). People with NEAD also reported significantly lower levels of disclosure than PwE. This remained significant after controlling for anxiety and depression. A hierarchical multiple regression analysis indicated that internalised stigma was a significant predictor of both self-esteem and self-efficacy, over and above the amount of variance accounted for by anxiety and depression.

Conclusions and implementation for practice: This research provides context regarding internalised stigma and disclosure of their condition in people with NEAD compared to PwE. Clinicians should be aware of high levels of anxiety and depression in both groups. Self-esteem and self-efficacy could be important targets of intervention. Limitations are discussed. Further research should explore the relationships between these factors, including potential moderators.

Keywords: Non-epileptic seizures, NEAD, epilepsy, internalised stigma, self-esteem, self-efficacy, disclosure

Systematic Review of Research Literature

Understanding Factors Associated with Suicide Ideation and Attempts in GBTQ+ Men: A Qualitative Systematic Review

Word Count: 7152

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Proposed Journal: This paper will be submitted to *Journal of Gay and Lesbian Mental Health*. This is a peer reviewed, open access journal which accepts systematic reviews and has an impact factor of 1.6.

See author guidelines in Appendix A.

Declaration of interest: None

Abstract

Background: Recent studies reveal non-heterosexual (hereafter 'queer') men are at greater risk of dying by suicide than heterosexual men. This finding makes it important to understand this demographic's experiences in order to design better means of support and reducing risk. This review synthesises qualitative papers to (1) identify themes of factors associated with suicidal thoughts and behaviours in queer men and (2) explore how queer men make sense of these experiences.

Method: Six databases were searched (PsychINFO, Embase, Scopus, Medline, CINAHL, and Web of Science) in October 2023, repeated in May 2024. The studies included were published since 2003, used qualitative methodologies, and aimed to explore suicidal thoughts and behaviours in queer men. The QualSyst quality assessment tool was used to explore study quality. Sixteen papers were synthesised in line with Thomas and Harden's (2008) thematic approach.

Results: Sixteen papers from fourteen datasets were included. All papers were of good to strong quality. Thematic synthesis identified 6 themes: the process of identity development; experience of rejection and isolation; multifaceted experience of stigma; mental health and barriers to support; sociocultural contexts; and belongingness and reasons for living. These themes are discussed in relation to existing literature and in terms of theoretical frameworks.

Conclusions: Risk factors associated with suicidal ideation and action included: experiences of rejection and isolation, stigma and harassment, mental health challenges, and facing barriers to help. Risk factors were experienced within the context of an evolving identity development and in sociocultural contexts in which religion, culture, and societal attitudes to queerness influenced men's experiences. Men identified reasons for living and factors that halted ideation becoming action.

Keywords: Systematic review; qualitative synthesis; queer men; GBTQ+ men; suicide

1. Introduction

Suicide is a public health issue, with deaths increasing across populations worldwide (Naghavi & Burden, 2019). The higher incidence of death by suicide in men compared to women occurs worldwide (Naghavi & Burden, 2019) and is particularly prevalent in young men, with suicide accounting for 27% of deaths in men between 20 and 34 years old in the UK between 2001-2018 (Owen-Williams, 2020). Male suicide also typically involves more lethal methods than women (Callanan & Davis, 2015).

This higher rate of male suicidality is exacerbated among male sexual and gender minority (SGM) groups, with gay, bisexual, transgender, and queer men (GBTQ+) displaying higher rates of suicidal ideation, attempts, and death compared to heterosexual men (De Graaf et al., 2006) (see Appendix B for definitions). High lifetime prevalence of suicidal ideation (21%) and attempts (12%) have been found in gay and bisexual men (Paul et al., 2002). This rate appears stable across time and place, with a Chinese meta-analysis in 2020 finding similar prevalence of ideation (21%) and attempt (7%) (Wei et al., 2020). Similarly, 43% of trans men report a suicide attempt (Amand et al., 2011). Research suggests transgender individuals not only show higher rates of suicide ideation and attempt (McNeil et al., 2017) than cisgender populations, but are 150% more likely to have considered suicide compared to lesbian, gay or bisexual individuals (Irwin et al., 2014). Research into the intersectional experiences of queer men is lacking, however, despite rates of suicide being higher in same-sex male relationships than in same-sex female relationships (Cochran & Rabinowitz, 2003), and rates being higher in single queer men than those in relationships (Riley & McLaren, 2019). Only one review into suicide correlates in men who have sex with men (MSM) was found when developing this review (Luong et al., 2018). However, this review searched only 2 databases, included only adolescent men, and excluded trans, asexual men, and many other SGM identities.

'Queer' is used as an umbrella term for people who do not identify as heterosexual or are not cisgender. In this review, this includes MSM but may identify as heterosexual. Although

'queer' has historically been a derogatory term, it is being reclaimed and serves as a 'catch all' term for those identities captured by the acronym LGBTQ+ (Worthen, 2023).

There are several mechanisms underpinning the high level of suicide attempt and ideation in queer men. For example, ideals of masculinity and the perceived importance and conformity with these have been found to be related to suicide (Coleman et al., 2011) and internalised stigma in gay men (Sanchez et al., 2010; Sanchez & Vilain, 2012). Relatedly, strategies to camouflage sexuality and demonstrate masculinity have also been shown to promote unintended consequences of distress and isolation (Fields et al., 2015).

Theories have been applied to findings to provide a framework of understanding. Minority Stress Theory (MST) (Meyer, 2003) is an SGM health disparity model that is frequently applied to this population. The theory posits that experiencing discrimination, prejudice, and stigma contribute to an increased likelihood of developing mental health problems. This model has been applied to suicide ideation in gay men (Michaels et al., 2016) and used alongside theories of masculinity in sexual minorities (Modrakovic et al., 2021).

The Interpersonal Theory of Suicide (IPTS) (Orden et al., 2011) also adds to understanding isolation and exclusion within the queer community, as it has isolation, perceived burdensomeness, and thwarted belongingness at its centre (Parmenter et al., 2021). Belongingness and burdensomeness have been associated with suicide ideation in LGB individuals (Woodward et al., 2014), while social inclusion and support is protective against suicide attempt in trans adults (Moody et al., 2019). This model also introduces the concept of 'acquired capability', often used to understand why men are more likely to act on suicide ideation than women (Witte et al., 2012). MST and IPTS complement one another as each conceptualise how sexual minority individuals' experiences may contribute to suicide ideation and action. They have been combined in previous research (Fulginiti et al., 2020) and used to inform new SGM specific theories (Kaniuka et al., 2024).

1.1 Current Review

This is the first systematic review of qualitative research in suicide in queer men. It addresses this gap in the research by providing a synthesis of others' findings and identifying gaps for future research. Synthesising existing research also provides insights into developing interventions guided by queer men's experiences to address specific challenges faced by this population. This review comes at a time of growing awareness and visibility of queer people and their experiences, including mental health, which reinforces the need for understanding these experiences to better inform services. There has also been an evolving societal and political landscape that may have impacted on the experiences and challenges faced by queer people, such as legalisation of same-sex marriage, whilst also notable violence against the queer community, such as the Pulse nightclub shooting and Colorado Springs shooting. A review of the literature is therefore timely and aims to answer the following:

1. Which factors are associated with suicidal thoughts and behaviours in GBTQ+ men?
2. How do GBTQ+ men make sense of their experiences of suicide thoughts and/or behaviours?

2. Materials and Methods

2.1 Search strategy:

The search strategy and protocol were submitted and published to PROSPERO (registration number CRD42022369978) before the search was conducted. The databases searched were: PsychINFO, Embase, Scopus, Medline, CINAHL, and Web of Science. Backward and forward searching was conducted. A strategy was developed using key words to capture the concepts of 1) sexual and gender identities; 2) men and masculinity; and 3) suicide. (See Appendix C). Database searches were filtered using exclusion criteria (e.g. 2003 onward and English language). This study focusses on a fast-moving field, which uses evolving terminology, and therefore a cut off period was set. It was felt that 2003 represented an important and helpful time point to begin these searches, due to relevant legislation being passed which would be likely to impact men's

experiences. In 2003, Section 28 was repealed in the UK (part of the Local Government Act of 1988, which forbade the promotion of homosexuality or teaching of homosexuality in schools). Over the 15 years that Section 28 was in place, it contributed to the closing of LGBTQ+ support groups and placed limitations on the activities that groups could perform. In the middle of the period captured by this review, the Marriage (Same Sex Couples) Act 2013 was passed, providing legal recognition of queer marriage as well as social acceptance, and was a milestone for LGBTQ+ equality. Other systematic reviews in this area (e.g. Luong et al, 2018), also searched contained periods of time (16 years), to ensure the data gathered was current and relevant to present experiences of men. Using a recent period also assures that contemporary experiences are reflected and therefore are applicable to current social and political climates.

2.2 Inclusion/exclusion criteria

The following inclusion and exclusion criteria were applied during screening.

	Inclusion	**Exclusion**
Papers	- Studies which investigate suicide ideation or behaviour, including attempts or deaths. - Studies published in English. - Published in peer reviewed journals. - Studies using a qualitative methodology or mixed methods (where only qualitative data can be extracted).	- Editorials, commentaries, systematic reviews, meta-analyses, and publications not suitable for data extraction. - Studies written before 2003 (last 20 years). - Quantitative research. - Studies into non-suicidal self-injury or self-harm in GBTQ+ male populations.
Participants	- Studies including men who identify as non-heterosexual or trans-men.	- Studies including samples where over 50% of participants identify as female or trans-women. - Studies including purely heterosexual men. - Studies in which queer male/trans men's data were not separated from other groups in analysis.

Table 1: inclusion and exclusion criteria

2.3 Screening

Searches run in October 2023 across 6 databases identified 419 records. Using reference management software (Zotero), 185 duplications were identified and removed. The remaining 234 were imported into Microsoft Excel for initial screening. All were assessed against inclusion and exclusion criteria by the primary researcher, with 20% (N=46) assessed by an independent rater to ensure reliability. Interrater agreement had a Cohen's Kappa of .83 indicating a 'near perfect' level of agreement as per Landis and Koch's, (1977) criteria. Disagreements were resolved by meeting, re-reading, and discussing reasons for ratings. Two were taken to the project supervisor for further consultation. Criteria were refined accordingly and clarified. Where uncertainty of inclusion was indicated, the record was taken through to the next stage of screening in full text review.

The primary researcher read 56 papers in full and 25% (N=14) were screened by an independent rater. Disagreements (N=2) were resolved through conversation, indicating both were errors or misreading as opposed to disagreements on criteria. Pre-discussion, Cohen's Kappa was .81, indicating 'moderate' agreement (Landis & Koch, 1977). However, after correction of errors, inter-rater agreement was 100%, with a Cohen's Kappa of 1. Following full text screening, the reference lists of each included study was searched, as were lists of papers citing included articles. From this, a further 32 papers were read in full and four included.

Following full text screen, 16 papers were included in the review. Searches were re-run in May 2024. 38 new records were identified, of which 6 were duplicates. Of the 32 titles screened, 9 were taken forward and abstracts were screened. None met the criteria to be included in the review.

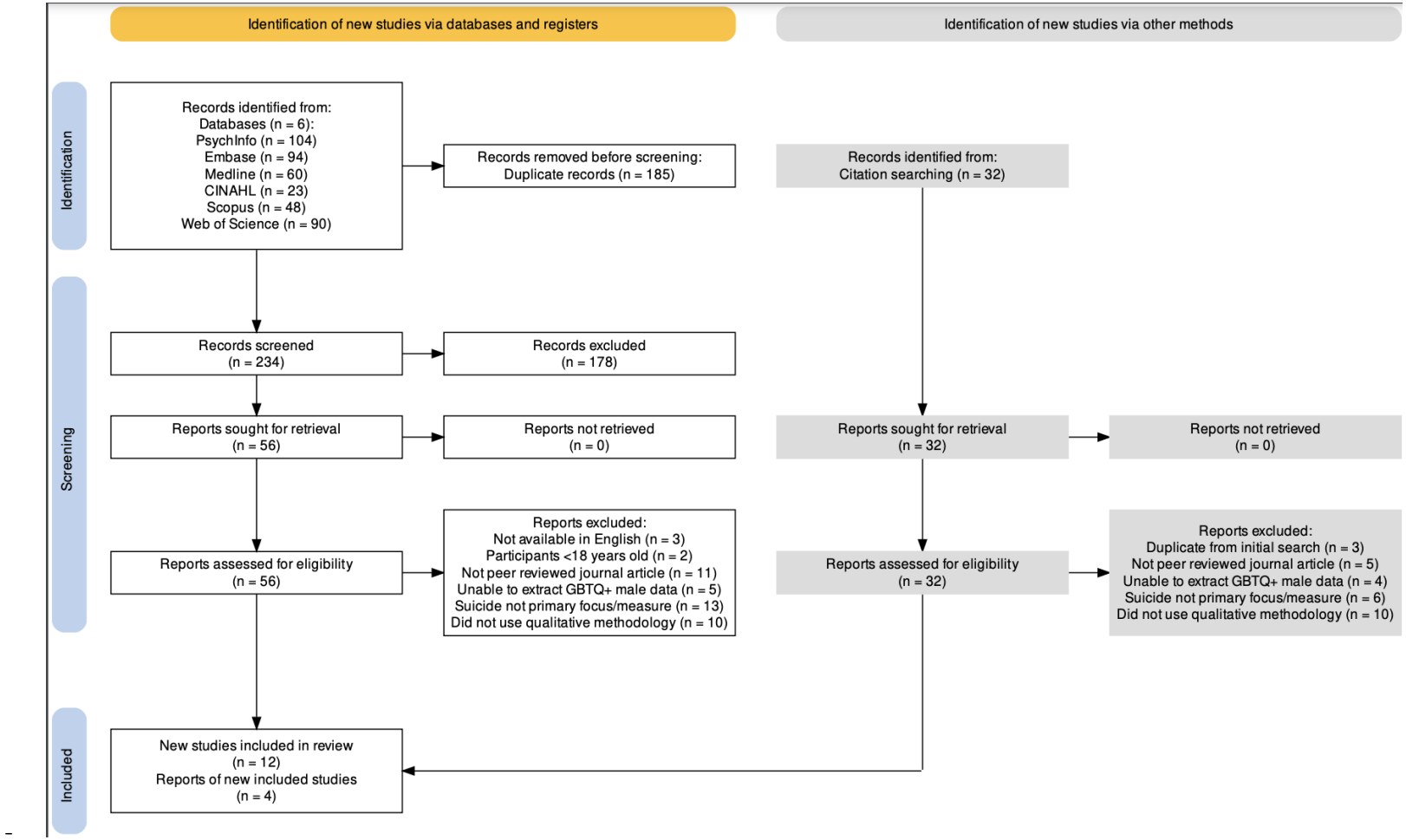


Figure 1: Prisma diagram outlining the screening process. Records = title and abstract; Report = full text (Page et al., 2021).

3. Data extraction and synthesis

Excel spreadsheets were used for data extraction. Study information extracted included: publication year, author, title, journal reference, country of origin, aims and research questions, study design, qualitative methodology, and data analysis. Sample information collected included: sample size, inclusion and exclusion criteria, age, SGM identities. Result information extracted included themes, key quotes, and study limitations.

3.1 Quality analysis

Papers were assessed for quality using the QualSyst quality assessment tool (Kmet et al., 2004) (see Appendix D). This was chosen due to its specific qualitative checklist and capacity to rate partial fulfilment rather than a 'yes/no' rating. A total score can be generated accounting for missing criteria if not applicable to a particular study, allowing for comparison.

This assessment tool uses a checklist of 10 items against which items are scored for not meeting criteria (0), partial fulfilment of criteria (1), or fully meeting criteria (2). Scores are converted into percentages to create summary scores, categorised as strong (>80%), good (70-79%), adequate (50-69%) or limited quality (<50%). The average quality rating was strong (82.5%). Scores ranged from good (70%) (Fenaughty & Harré, 2003) to strong (95%) (Daly et al., 2020). Across the studies, the highest scoring criterion was 'appropriate context given for the study'. The lowest scoring criterion was 'reflexivity', with an average of 0.5 out of 2.

The primary researcher rated all studies, whilst a second rated 50% for comparison. At this point, 20 studies had passed full text screening, with 4 later excluded at the point of data extraction. Any disagreements (four points across 10 studies) were resolved through discussion.

3.2. Data Synthesis

16 papers were synthesised in line with Thomas and Harden's (2008) thematic approach. This approach fit the paper's aims of using a data-driven and systematic approach to explore factors surrounding suicidal thoughts and behaviours and men's experiences of this. Texts were coded to identify key messages and themes from each study. Participant quotes and researcher interpretations were both coded and treated as primary data. As such, they were given equal weight in analysis. Codes were generated (260 codes) and examined for similarities and shared concepts; these were grouped into broader categories and named. These groups were reviewed and developed to create themes which furthered the data from each paper alone.

3.3 Reflexivity

Although an independent interrater was used, all screening, extraction, and coding was conducted by the primary researcher, therefore, the influence on these processes should be considered. The primary researcher was a female, queer identifying Trainee Clinical Psychologist, and this review was submitted as part of their fulfilment of a doctorate in clinical psychology. Their position as part of the LGBTQ+ community impacted their choice of review topic and potentially their approach to the data. Their positioning as a cisgender woman in a review of male experience is also relevant. To consider the impact of their context on interpretation, the researcher kept reflexive notes throughout and discussed this with other researchers.

4. Results

4.1 Study Selection

Although 16 papers were included, these were based on 14 data sets. Papers 7 and 8 shared the same data set (McAndrew & Warne 2010 & 2012), as did papers 11 and 12 (Handlovsky et al 2022, and Ferlatte et al 2022). Despite using the same datasets, these papers were included in the

analysis because each had different aims. The duplication of experiences was considered in the synthesis with an awareness of not overweighting these in analysis.

4.2 Demographics

Datasets represented 10 different countries. Participants ranged from 18-75 years old and included men who identified as gay, bisexual, two spirit, or as MSM. Only one study included transgender men. Some studies also included more specific populations: two only included men who were HIV positive; one included only men who identified as Orthodox Jews; one included men who had been married and had children with a heterosexual spouse.

Number	Author and year	Country	Sample size (men)	Mean age and range of male participants	Sample characteristics (e.g. gender and sexual identity)	Ethnicity (reported verbatim)	Suicidal thoughts/ behaviours	Qualitative methodology	Quality assessment rating (%)
1	Bautista et al, 2017	Philippines	5	Mean: 21 Range: 18-25	Gay men	Unreported	All participants had attempted suicide at least 6 months prior their interview	In-depth interviews and thematic analysis.	75
2	Daly, MacNeela & Sarma, 2020	Ireland	9	Mean: 52.6 Range: 42-65	Gay men who had been married and had children with a heterosexual spouse	Unreported	Attempt and/or ideation	Interpretative phenomenological analysis	95
3	de Baere & Zanello, 2020	Brazil	7	Mean: 24 Range: 19-28	Gay men (4), bisexual men (3).	Black (14%) 'Probably brown/white' (86%)	Attempt and/or ideation	Thematic content analysis.	75
4	Fenaughty & Harre, 2003	New Zealand	8	Mean: 19.9 Range: 19-23	Gay men	New Zealand European/Pakeha (50%) South African Indian/New Zealander (12.5%) Maori/New Zealander (25%), Maori/Scottish and Chinese (12.5%)	Attempt and/or ideation	Interviews	70
5	Ferlatte et al (1), 2019	Canada	37	Mean: 45 Range: 23-71	Gay (22) bisexual (5) or two spirit (2) cisgender men.	Unreported	Personal experience of attempt and/or ideation (29), or loss	Interviews and photovoice methodology	85

							of a GBTSM loved one (8).		
6	Ferlatte et al (2), 2019	Canada	21	Mean: 46 Range: 23-71	Gay (16) bisexual (3), two-spirit (2) cisgender men	Asian (14%) Indigenous (14%) Caucasian (71%)	Attempt and/or ideation	Interviews and photovoice methodology and thematic analysis	90
7	Ferlatte et al, 2022 *	Canada	22	Mean: 50 Range: 24-71	Gay men with an HIV diagnosis	White (68%) Indigenous (5%) Mixed ethnicity (18%) Latino (9%)	History of suicide attempt and/or plan	Photovoice and thematic content analysis	90
8	Handlovsky et al, 2022 *	Canada	22	Mean: 50 Range: 24-71	Gay men with an HIV diagnosis	White (68%) Indigenous (5%) Mixed ethnicity (18%) Latino (9%)	History of suicide attempt and/or plan	Photovoice and grounded theory	90
9	Itzhaky & Kissil, 2015	United States of America	22	Range: 18-48	Orthodox Jewish gay men	Unreported	Attempt and/or ideation	In-depth interviews and content analysis	80
10	Li et al, 2017	China	31	Range: 18-40	Homosexual and bisexual cisgender men, newly diagnosed (last 6 months) with HIV	Unreported	History of suicidal ideation	In-depth interviews and thematic content analysis	75
11	McAndrew & Warne, 2010**	England	4	Range: 35 - 41	Gay men	White British (100%)	History of suicidal ideation	Free Association Narrative Interviewing (FANI)	75
12	McAndrew & Warne, 2012**	England	4	Range: 35 - 41	Gay men	White British (100%)	History of suicidal ideation	Free Association Narrative Interviewing (FANI)	85
13	Moody et al, 2015	Canada	56	Mean: 36.7 Range: 18-75	Transgender men	Ethnicity not separated by gender identity (original sample included trans women)	Attempt and/or ideation	Case study through online survey	90

14	Salway & Gesink, 2018	Canada	7	Range: 30-75	Gay men	White (86%) Other (14%)	All participants had attempted suicide between 2 and 4 times.	Unstructured interviews and dialogical narrative analysis	90
15	Tomori et al, 2016	India	363	Mean: 25	Gay or bisexual men	Unreported	Attempt and/or ideation	Focus groups, in-depth interview and thematic content analysis	75
16	Wang et al, 2015	Switzerland	762	Mean: 37.2	Gay men / men who have sex with men	Unreported	Attempt and/or ideation	Structured online survey with open questions. Content analysis	80

Table 2: Characteristics of included studies. Studies marked with an asterisk indicate a shared sample (papers 7&8 and 11&12)

5. Thematic Synthesis

Six themes were identified through analysis (see Table 3 for key quotes and thematic loading). Themes captured an experience of a 'journey' from recognising gender and/or sexual identity toward integration into self. At different points in this journey men experienced rejection and isolation from loved ones and their wider communities. Rejection was also experienced by some from within the queer community. Stigma was experienced through harassment and traumatic experiences, with some men internalising these stigmatising attitudes, negatively impacting self-worth. Intersectional stigma was an important part of men's experiences, acknowledging interaction with factors such as race or health diagnoses. Men shared experiences of poor mental health both related to these experiences, as well as pre-existing challenges. Men faced barriers to accessing support around mental health, with some turning to maladaptive coping strategies as a means of surviving. The impact of sociocultural context was important in men's experiences, with religion and culture emerging as key factors. Men identified reasons for living, with purpose and meaning as particularly key. A feeling of belongingness and acceptance with others was also important, as was being able to live aligned to SGM identity.

Themes	Sub-themes	Number of studies represented N=16	Illustrative Quotes
The Process of Identity Development		**15 (93.7%)**	
	Realisation, confusion, and uncertainty.	8 (50%)	*Realizing I was gay was horrible ... I wanted to die ... (Itzhaky et al, 2015)* *Just the confusion, it's so bad sometimes that you just want it to stop, I think . . . it's feeling that you're a particular way and that you shouldn't be that way because it's not right and so you want it to stop (McAndrew 2010)*
	Denial, concealment and attempts to change.	14 (87.5%)	*I believed that I would be able to pretend to be straight forever and that I would be happy with that (de Baere 2020)* *Why me? What do I do with this? How can I hide it from the world? (Itzhaky et al 2015)*
	Risk and Disclosure	10 (62.5%)	*For me, that was probably one of the most terrible phases of my life. That was one of the absolute lowest points... really horrible (McAndrew 2010)*
	Integration into self-identity	6 (37.5%)	*If I had not transitioned, I would probably not been able to break intensive cycles of suicidality and depression (Moody et al, 2015)* *. . . And now, if someone walked up to me on the street and said, "are you gay?" "Yah I am." I'm not ashamed of it. I'm not afraid of it (Salway et al 2018)*
Experiences of rejection and isolation		**15 (93.7%)**	
	Rejection and loss of support systems	14 (87.5%)	*I could not bear to see disappointment in my father's eyes. I was a shame, a disappointment. (Bautista et al 2017)* *there was a pause, and [Mom is] like, "no, I don't give birth to fags, you're not my fucking child, don't ever call me again," (Salway et al 2018)* *If I am kicked out from home, I go out the window, not the door (de Baere et al 2020)*
	Rejection and non-belonging within the queer community.	8 (50%)	*Within this acronym (LGBT), I don't feel included. I don't even know many bisexual activists (de Baere et al 2020)*

			the gay scene actually can be the worst abuse that anyone can actually tolerate […] Gays can be really bitchy and very judgmental. (Ferlatte et al 2019b)
	'Outsiderness' and self-isolation	13 (81.3%)	*Huge numbers of our gay-male friends, who would be elder gays in their own right, died of natural causes, suicide, AIDS, or other factors; many of us are alone. (Salway et al 2018)* *"No one is talking to me. My friends are avoiding me. Why should I live?", and there are chances for them to commit suicide also (Tomori et al 2016)*
Multifaceted experience of stigma		**12 (75%)**	
	Consequences of stigma: trauma and harassment	10 (62.5%)	*We were beaten, raped and tortured because of who we were. (Ferlatte et al 2019b)* *I was verbally abused by my family, including my mom. (Bautista et al 2017)* *I was swarmed by five guys and stoned and chased out of a park. And that was devastating, and that brought me into a depression (Ferlatte et al 2019b)* *I was more afraid of living than of dying (de Baere et al 2020)*
	Masculine gender norms	7 (43.7%)	*I did a production of Grease at school […] and [Dad] said, "Yes, it was good, but I think that you should try and get more angry, more like a man". (McAndrew et al 2012)* *My being gay was a double whammy in that (1) I felt I wasn't a real man and (2) now that [my wife] had some experience of other men I wasn't shaping up. (Daly et al 2020)*
	Internalised stigma and negative self-worth	11 (68.8%)	*Slowly, slowly, I had all the signs that this was it ... I was a sinner ... it was horrible ... I looked for ways to punish myself ... I ran to the road without checking if a car was coming ... I took risks ... (Itzhaky et al 2015)* *When I first had the [HIV] diagnosis, I expected my blood and my ejaculate to be like black, pitch black or something. Or viscous, or kind of acrid or something. Because I almost wanted to have the confirmation of my sulliedness (Ferlatte et al, 2022)* *I think I'd learnt how to really hate myself and be disgusted with myself. I just wanted to destroy myself. (McAndrew et al, 2012)*
	Compounded intersectional stigma	5 (31.2%)	*I'm withholding a big major secret. Ok. There's a stress there. And then I'm withholding a secret of being gay. And that's layered by, I'm withholding a secret about my career, my*

			profession, another layer is that I'm withholding my secret about being bipolar—it's called stigma (Salway et al 2018)
Mental health challenges and barriers to support.		**14 (87.5)**	
	Mental health challenges and hopelessness	10 (62.5%)	*I should kill myself. How do you recover from HIV? It leads to death. It doesn't lead to a better future. It's like assisted suicide […] And the rejection was relentless. (Ferlatte et al 2022)* *There is no use of me living in this world once people come to know about me. My family […] will be ashamed of me and in the society, they will be tortured and so I have decided to commit suicide once they come to know. (Tomori et al, 2016)*
	Barriers to accessing support and maladaptive coping strategies.	12 (75%)	*Psychologists cost a lot of money and a lot of people cannot afford it (Ferlatte et al 2019)*
Sociocultural contexts		**11 (68.8%)**	
	Societal contexts shaping experience	9 (56.3%)	*We survived three holocausts already—family rejection, AIDS, and now young queers who want us dead (Salway et al 2018)*
	Conflict with cultural and religious norms	10 (62.5%)	*I despise myself because of my sins ... (Itzhaky et al 2015)* *You can't stop believing in God but, at the same time, you can't stop yourself being attracted to other men. I suppose it's because you've been told all your life that it is wrong, and that God can't accept gay relationships […] it's a dead end (McAndrew et al 2012)*
Reasons for living and belongingness		**11 (68.8%)**	
	Reasons for living: purpose and meaning.	8 (50%)	*[suicide] is not an option because my Mom needs my help. I'm the kind of person that needs to feel needed. (Handlovsky 2022)* *"If I die, how my mum can survive? I told myself that I should not think about it [suicide] anymore (Li et al, 2017)* *Knowing that dead trans folk cannot change the world keeps me from doing it. […] I would do my trans brethren a great disservice to end my life and not exercise my access to resources for social change. (Moody, et al 2015)*

	Belonging to queer community	8 (50%)	*As I play a leadership role in trans communities, I have a responsibility to others to model good self-care. I cannot steal other people's hope, and I wouldn't want to take others with me by killing myself (Moody et al 2015)* *The support of other gay people is really important (Fenaughty et al, 2003)*
	Positive narratives around queerness and acceptance from others	7 (43.8%)	*...I knew there were stable gay people out there who lead full on lifestyles, and that they could be out and happy, and live like that and not be closeted... like it provides you with an option, and, and um, a role model (Fenaughty et al 2003)*

Table 3: Themes, subthemes, thematic loading and key quotes.

1) The process of identity development

a) Realisation, confusion, and uncertainty: Men described their experiences with their sexual/gender identity as a journey, which mapped onto Cass' (1979) identity model. Realizing their sexuality differed to others, provoked feelings of confusion and uncertainty. Trans men experienced this as a sense of difference and described trouble identifying the source of this difference, like lacking the language to name this. The experience of realizing their sexuality or gender identity was often described as 'exhausting' or a time of 'emotional turmoil' (McAndrew et al 2012).

b) Denial, concealment and attempts to change: For some, this confusion was followed by denial, concealment, and even attempts to change sexuality. Many recognised these strategies were ineffective but felt compelled to 'try' to change. When denial was ineffective, men turned to concealment, changing their behaviour and imitating what they perceived to be 'masculine' traits, having heterosexual partners (or in some cases, wives), or moving cities frequently. The effort of leading a 'double life' could foster further distress. Those who tried to change their sexuality also experienced distress and a sense of failure. Their efforts included praying not to be gay, getting married to a member of the opposite sex, cleansing rituals, and engaging in conversion therapy. Men in six papers described 'wishing' to be straight. But many men simply reached a point of overwhelm and recognised the ineffectiveness of these strategies.

c) Risk and Disclosure: When contemplating coming out, people considered the risks and losses associated with this. The experiences of choosing to come out differed from the experience of being 'outed' and the increased suicide risk associated with this time. Narratives spoke to a worry of being 'discovered' or 'found out', leaving some men to feel suicide was the only option, since living as an outwardly queer man did not feel possible. This sense of feeling trapped, between coming out and losing their support

system, but exhausted of living a 'double life', was evident in people's decision making. The context for some of seroconverting to HIV positive was felt to 'out' them to others. Others' reactions to this disclosure were key in how it was experienced.

d) *Integration into self-identity:* Some who had come out to others described reaching a point of integrating their sexual or gender identity with their sense of self. Participants spoke of living as 'wholly themselves'. This sense of self-acceptance was increased by living aligned to gender, whether by being with a same-sex partner, physical change, or others' use of preferred pronouns. Being in affirming spaces after coming out was also protective against suicidal ideation. Some narratives shared their pride in their self-identity and a shift toward self-acceptance. Understanding was key in this experience, with one trans man sharing that "now that I understand who I am, I don't want to think about not being here" (Moody et al, 2015).

2) Experiences of rejection and isolation

a) *Rejection and loss of support systems:* The experience of rejection and isolation centred the lived experiences of participants in the studies. Individuals described experiences of rejection from friends and family as well as from the wider community. Rejection from family was immensely painful and experienced as a loss of support system; in some cases serving as a direct trigger for suicide attempt. Paternal approval deemed particularly important and, thus, distressing when withheld. The ending of romantic relationships was also cited as a precursor to a suicide attempt. Although this romantic rejection was often not specifically related to sexuality, the experience of feeling alone and experiencing a loss of support was a key experience in many narratives.

b) *Rejection and non-belonging within queer community:* Some spoke to feeling rejected or not belonging to the queer community, with bisexual men in particular feeling outsiders to both straight and queer communities. For some queer men, the expected connection with queer peers never materialized, conflicting with hopes men may have held about

what this community may provide. Some men who were HIV positive described experiencing a loss of their queer communities due to stigmatized views of the condition. This change in HIV status was felt to be a 'demotion' to "a lower caste of gay people" (Ferlatte et al, 2022), reflecting a felt sense of stigma within the queer community. Experiencing rejection from a group one saw as a supportive 'family' was described as "raw hell" (Ferlatte et al, 2022).

c) *'Outsiderness' and self-isolation:* Social isolation and a sense of feeling like an 'outsider' emerged in many narratives and was a key theme in suicidal ideation. Isolation appeared in two ways: 1) an imposed isolation due to rejection, stigma, and a loss of relationships; and 2) self-isolation. Self-isolation was often seen in withdrawing from others as a means of coping and introducing a sense of control and safety. While describing their experiences of self-isolation, men also recognised that withdrawing from friends and family was a warning sign for suicide that preceded their mental health worsening. However, many faced barriers to seeking help at this time.

3) Multifaceted experience of stigma

a) *Consequences of stigma: trauma and harassment:* Men discussed experiences of stigma, bullying, harassment, and trauma across their lifespan. They described widespread and violent bullying and harassment in school, as well as lifespan experiences of homophobia and prejudice. These experiences impacted self-beliefs about sexuality, with internalised stigma seen in men of different SGM identities.

b) *Masculine gender norms:* Men shared the impact of narratives around masculinity experienced as a child, particularly those shared by fathers and reinforced in school. What it means to be 'masculine' was raised in the context of living up to fathers' expectations, and men felt a 'failure' to meet these contributed to rejection. Masculinity was generally perceived as valuable to others, many consequently described needing to

feel more masculine; others expressed fears and experiences of being 'punished' for displaying non-masculine traits.

c) *Internalised stigma and negative self-worth:* Men linked these experiences with reference to self-hatred and a sense of worthlessness. Narratives around a need to 'atone' for their sexuality also spoke to this theme. Words expressing 'contamination' were common in narratives, with terms like 'dirty' or 'tainted' used by men to describe their experience of internalised stigma.

d) *Compounded intersectional stigma*: Men experienced 'layers' of stigma including HIV status, mental health, cultural background, and ethnic group. This was felt to exacerbate isolation and impede access to resources. HIV positive males felt especially guilty or blamed for their status, experiencing stigma from the general population and queer community.

4) Mental health and barriers to support

a) *Mental health challenges and hopelessness:* Men spoke about experiences of depression, anxiety, bipolar disorder, and PTSD and the impact of these on suicidal ideation and behaviour. Many narratives also addressed a sense of hopelessness for the future and an inevitability of acting on their thoughts. Suicide attempts were framed by some as a desire to end psychological pain, while HIV positive men spoke more about suicide as hastening an 'inevitable' death. Others could not foresee living a life aligned to their gender or sexual identity. Participants across studies described an accumulation of negative emotion prior to attempts (e.g. "everything just piled up all at once"; Wang et al, 2015). This was often followed by a triggering event, such as a relationship breakdown, bereavement, or rejection from admired individual. Some who spoke about their experiences of making a suicide attempt, described an experience of 'numbness' or changing their mind during the attempt.

b) *Barriers to accessing support and maladaptive coping strategies:* This theme also incorporates men's efforts to respond to their experiences of mental health. These included some strategies which maintained or compounded problems or created more, such as alcohol consumption and 'risky' sexual behaviour. Key factors inhibiting access to support included stigma around discussing mental health, a lack of culturally safe services, and the financial burden of paying for antidepressants or counselling. Partners also described feeling unable to navigate the system or find help for their loved one. In some cases, these barriers led to further maladaptive coping strategies, such as engaging in gambling to pay for medication.

5) Sociocultural contexts

a) *Societal contexts shaping experience:* This theme focused on the context in which these experiences took place and its impact on men's perceptions of their sexual and gender identities and ways of coping. Papers including older age groups acknowledged how these men lived through a time when homosexuality was illegal, as well as the experiences of fear and loss during the AIDS pandemic. Some countries included in this review continue to criminalise homosexuality, such as the Philippines and parts of India. These men spoke about living through the context of queerness becoming more widely accepted and the impact that this had on the status of gay men within society. A wider context of men's lives was also important in their experience of suicidality, often acting as a trigger for attempts alongside the 'emotional turmoil' leading up to it. Men spoke about job loss, financial struggles, bereavement, infidelity, and operating as a queer man within an 'unjust system'. They described hopelessness and a negative perception of the future, a sense of inevitability heighted by a normalization of suicide on social media groups of queer men.

b) *Conflict with cultural and religious norms:* Some men described their sexuality as a 'sin' for which they felt a need to atone or to die. Scripts around heterosexual marriage as the

'right' thing to do was also prevalent, in some cases heightening the conflict between private and public selves. The process of coming out was made more difficult when the risk of loss involved children and a wife, who were often a key support. Since withdrawal from religion or culture could exacerbate experiences of isolation, some remained closeted within their communities rather than risk losing their support network.

6) Reasons for living and belongingness.

a) *Reasons for living: purpose and meaning:* This theme was distinct from coping strategies, focusing instead on things men felt were protective against further ideation or attempt. Whereas coping strategies presented barriers to help and maladaptive strategies to manage stigma and mental health, this theme directed attention to the positive experience of incorporating sexuality into one's life and identity. Identified reasons for living included connecting to children, family, and friends. Many found purpose and meaning in caring for others, or in taking an active part in advocacy and support in queer organizations. Hope of transitioning or beginning transition also introduced hope for the future and living aligned to gender was felt to give people a reason to live.

b) *Belonging to queer community:* Connecting to the queer community and a sense of belonging to this offered support and reducing a sense of isolation. For some, it helped them find or become queer role models themselves. Engaging in advocacy empowered many, introducing purpose and enabling them to share their experiences with others. Men spoke about this increasing self-esteem and being a support when problems are experienced in life.

c) *Positive narratives around queerness and acceptance from others:* Men spoke about the importance of positive narratives around queer identity from the community, but also of positive representations in the media and exposure to non-heterosexual narratives and scripts. Such narratives challenged feelings of hopelessness of a life living aligned to SGM identity. Another protective factor was acceptance from others. Social support, whether

from teachers, family, friends, or mental health professionals was credited as being 'lifesaving'. Opportunities to repair relationships with family were also valued.

6. Discussion

This review synthesised 16 qualitative studies exploring queer men's experiences surrounding suicide ideation and behaviour. Studies were all published since 2003 and of good to strong quality. 'Isolation and rejection' was a theme captured by 94% of papers and recurred in men's discussions around suicidal ideation and attempt. While experiences of rejection (Theme 2) were related to the experiences of stigma (Theme 3), each had distinct focuses, with Theme 3 representing the impact of stigma beyond social isolation, reflecting distal minority stress processes. Men experienced physical and verbal harassment and trauma due to their sexual or gender identity. The impact of public and felt stigma was evident in the internalisation of some of these narratives and negative impact on self-worth, which reflected proximal minority stress processes. Intersecting stigmas (e.g. around mental health, HIV status) were also acknowledged to impact experience and contribute to suicidal ideation and attempt. Sociocultural contexts (Theme 5) were key in framing men's experiences of stigma (Theme 3) and rejection (Theme 2) within historical, societal, cultural, and religious contexts considering how these combined with minority status in relation to suicidality. Men discussed efforts to cope with mental health challenges and suicidality, however 75% of papers also captured the barriers encountered in seeking help. Feelings of belongingness, integration of identity to self and finding meaning and purpose in life were considered to be protective.

Factors associated with men's experiences around suicidal ideation or attempt were in line with previous research. The theme of identity development and a 'journey' of sexual or gender identity is well recognised in the literature. Codes indicated both suicidality and sexuality were seen as 'multi-step processes' experienced through stages rather than as fixed states. This perspective appeared across the papers, demonstrating that people went through a process of acknowledging and accepting sexuality. Likewise, the experience of suicidality was also a journey,

moving from ideation to plan to attempt, and in some cases, followed by a life with optimism for the future. These two processes interacted with one another, with suicidal ideation discussed at key times, such as the time between recognizing own sexual/gender identity and disclosing this to others. Research has suggested that where an individual is in the process of sexual/gender minority identity development is key in their risk of experiencing suicidal ideation, with risk decreasing as identity is integrated into self (Dirkes et al., 2016). Recent research has also found the age at which SGM individuals experienced suicidal ideation and attempts was closely related to the realisation of their SGM identity (Meyer et al., 2021). This implies men's experiences represented by Themes 2-6 should be framed within their stage of SGM identity development (Theme 1).

The theme of rejection and isolation is represented by many models of suicide (e.g. The Interpersonal Theory of Suicide (IPTS) (Orden et al., 2011) and the Integrated Motivational-Volitional Model (IMVM) (O'Connor & Kirtley, 2018). A recent systematic review of risk factors in male suicide found almost a quarter of studies (23%) identified social isolation, loneliness, and lack of belonging as key drivers of suicidal behaviour (Bennett et al., 2023). The present review found this was also a key factor in queer male experience. It has been suggested that masculine norms around autonomy and self-reliance contribute to the experience of isolation; indeed, cultural norms of masculinity and suicide have been found to be associated (Bennett et al., 2023). This would prove a useful starting point for future research in the queer male community. Isolation and a lack of belonging has also been found to be a risk factor for depression in LGBTQ+ youth, and paternal rejection a strong risk factor (Hall, 2018). Intersecting minority identities was also theme in this study, with a focus on experiences of multi-layered stigma. Besides exacerbating experiences of isolation in men (Bennett et al., 2023) intersectional stigma has been associated with suicide risk, particularly around isolation from family and acculturation, with people from global majority ethnic groups also experiencing barriers to help in relation to suicide (Forte et al., 2018). This study captured the duality of the queer community as a source of

support and painful rejection. Mental health and a hopelessness of the future were key factors present in suicide models (e.g. IMVM (O'Connor & Kirtley, 2018) reflected in this review. Hopelessness and feeling 'trapped' have been suggested to be drivers of suicide action in men (Bennett et al., 2023); in this review, men described these feelings as not foreseeing a life after coming out especially in the context of marriage or religion. Again, further research into such hopelessness would tailor formulation and intervention to the process of coming out.

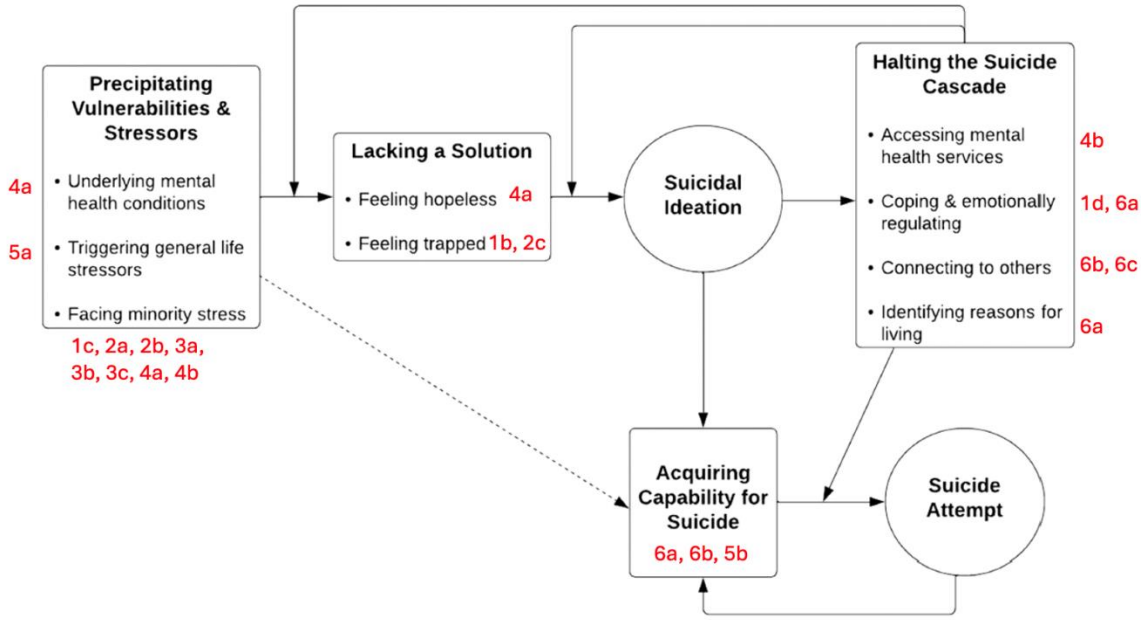
Research into suicide in transgender people has found similar protective factors to those in this review. Social support, acceptance from parents, reduced exposure to stigmatised views, and living aligned to gender through social, legal, or medical transitions are all protective factors (Bauer et al., 2015) that also arose in the subthemes of this review.

6.1 Relationships with Theoretical Models

When situating these findings in the existing literature it is beneficial to consider how these relate to existing theories. Minority Stress Theory (MST) (Meyer, 2003) and Interpersonal Theory of Suicide (IPTS) (Orden et al., 2011) provide helpful models with a focus on SGM experience and suicide respectively. The SGM suicide risk and protection (SuRAP) model developed by Kaniuka et al., (2024) integrates elements of both theories. As an ideation-to-action model of suicide specific to a SGM population, it posits that suicide ideation is distinct from a pathway in which that ideation becomes an attempt.

Similarities were identified between the themes presented in this study and the concepts identified by Kaniuka et al., (2024). Themes were then mapped onto the SGM SuRAP model in Figure 2. Themes 1a and 3d were not represented in the model. Theme 1a (Realisation, confusion, and uncertainty) was not fully represented in this model, since it presupposes a self-knowledge of SGM identity and Theme 1a describes the stage of this realisation. While Theme 3d (compounded intersectional stigma) was not represented fully by this model, it could be introduced under 'precipitating vulnerabilities and stressors' to capture this experience.

Themes around isolation, rejection, and experiences of stigma were represented under the experience of minority stress, as men attributed these experiences directly to their SGM identity. These experiences sat within the concept of precipitating vulnerabilities and stressors. Feelings of hopelessness, the theme of denial and concealment and self-isolation were represented in 'lacking a solution'. Factors which 'halt' the suicide cascade incorporated themes around access to mental health, coping, connection, and reasons for living. These factors are also seen in MST, in coping and social support on both individual and community levels (Meyer, 2003). The SGM SuRAP model demonstrates the utility of having models which are centred around SGM experience rather than holding this experience as secondary to suicidal thoughts and behaviours. The acquired capability for suicide, taken from the IPTS model, was less explicit in men's narratives than other elements. Capability was spoken about in terms of something which was developing but was halted by something present in men's experiences. Although somewhat overlapping with 'halting the suicide cascade', it focused on men's beliefs around what acting on ideation would mean. Purpose and meaning were central to these narratives. They spoke about being needed by family or as a queer role model for others, which prevented them acting on ideation. Men's relationship with religion and cultural beliefs around suicide being 'not an option' was also something which halted acquired capability. Further research on acquired capability for suicide in queer men would add to our understanding of this element of the model.



Note. Rectangular boxes denote risk and protective factors; suicide outcomes (i.e., ideation and attempt) are enclosed by circles. Solid lines represent progression through the SuRAP model. Dashed line denotes direct path from facing minority stress to acquiring capability for suicide. SGM = sexual and gender minority; SuRAP = suicide risk and protection.

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Figure 2: SGM SuRAP model taken from (Kaniuka et al., 2024). *Themes from present study illustrated in red.*

6.2 Limitations

Limitations of papers

Although papers were generally of a high quality, only two papers fully met the reflexivity criteria. Reflexivity is an important part of qualitative research, considering the interaction between participant and researcher (Yardley, 2000), and identifying the biases that inevitably occur when data is interpreted through individual experience. While triangulation and inter-rater work are means of minimising bias, acknowledgment of the relational nature of qualitative research was lacking. Another recurring limitation was a failure to report ethnicity. Seven papers omitted participant ethnicity, with four of these only reporting on nationality (Indian, Chinese and Filipino respectively). Other papers provided broad categories (e.g. 'White' and 'other'), whilst one assumed that those who did not spontaneously disclose ethnicity were "probably" not black. When researching experiences of those within a minority group, consideration of different

experiences between people with multiple minoritised identities is important in both considering intersectionality and generalisation of findings. Studies were predominantly cross sectional in design, which limits the conclusions which can be drawn.

Although many papers stated an ambition to recruit men of GBTQ+ identities, the experiences of trans men and two-spirit persons were underrepresented, as well as other identities such as demisexual, demiboy, pansexual, and other SGM identities. Datasets included men who identified as gay (n=13), bisexual (n=5), MSM (n=1), trans (n=1), and two-spirit (n=1). This reduces generalisability of findings to men of identities not represented by these studies. As many studies also focussed on one SGM identity (e.g. trans men, gay men with an HIV diagnosis), it is important to consider whether these themes can be applied to men of other SGM identities. Apart from one paper, all participants were 'out', a factor that also impacts generalisability to men who are at different stages of identity development and disclosure. The volunteer sampling used by most studies may also have selected for men who are part of support groups or have come to a place of integration of SGM identity to self.

Limitations of the review process:

The exclusion of studies not in English is a limitation of this review, as is excluding non-peer-reviewed papers, which may have excluded important findings from dissertations etc. Of the 16 papers included, two datasets were represented twice. Although studies had distinct aims, it was important not to let them over influence thematic loading.

To reduce the influence of bias in this review, established processes and measures were used (e.g. quality assessment, thematic synthesis), as well as triangulation (Noble & Smith, 2015). Furthermore, a clear audit trail was kept, and the position of the researcher considered (see Appendix D).

6.3 Implications for research and practice

This review's findings demonstrate the importance of developing evidence-based mental health interventions tailored for queer men. These should be developed in collaboration with those with lived experiences. Currently, evidence-based interventions for queer youth are 'virtually non-existent' (Hall, 2018). Developing SGM focussed formulations for queer men could help to provide interventions focused on those factors men shared in their experiences of suicidal ideation and attempts. Incorporating key themes from this review, such as rejection, isolation, stigma, and harassment, might enhance the focus of CBT formulations, particularly in developing rules for living and core beliefs. Experiences of trauma, harassment, and internalised stigma should also be considered when delivering therapeutic work with queer men, with a trauma informed approach in mind.

Findings demonstrated the importance of increasing social inclusion in queer men, fostering a sense of purpose and meaning, and the exposure to positive narratives around queer identity. Where appropriate, access to medical and social transition has potential to reduce prevalence of suicide ideation and attempt, something encouraged by other research in trans men (Bauer et al., 2015; Budge et al., 2015). Men noted a lack of positive narratives around queerness in the media and found role models to be powerful, especially those from their own culture or religion. This representation and narratives of men and queer male relationships are something that sports, television, film, and other media representations should give a platform to.

The value men placed on finding purpose and meaning was evident as protective against suicide. They also spoke about advocacy, sharing stories, and feeling privileged to be a role model to others. Providing opportunities for these through inclusive community groups may ensure men can engage in activities which 'halt the suicide cascade'.

In addition to recommendations implemented at an individual level, many indicated the need for wider policy change. Policies that foster community inclusion, 'safe' environments for

disclosure, access to support for physical (e.g. HIV treatment) and mental healthcare and SGM identity affirmation (e.g. in schools) could reduce factors associated with suicidal thoughts and behaviours. Likewise, removing barriers to support would reduce feelings of isolation and could be achieved through reducing mental health stigma, providing support in navigating systems, increasing culturally safe services, and providing funding for medication or counselling where this is not provided. Increasing access to SGM affirming psychological services is an area of particular importance.

Theme 1 (the process of identity development) also emphasised the importance of applying intervention and being proactive at times. The process of realising SGM identity, naming this and accepting its potential impact was experienced by men as a challenging time with consequent peaks in risk. Receiving a diagnosis of HIV and experiencing a relationship breakdown were also times at which men experienced increased in suicidal ideation and behaviour. Services and clinicians should be aware of this and have additional supports and processes in place.

It is important to continue qualitative research in this area to increase understanding of SGM men's experiences of suicidal thoughts and behaviours. These experiences are varied and individual, each deepening understanding of how to support this population. Exploring experiences across different cultures, age groups, and identities would also be beneficial.

7. Conclusion:

The results of this review indicated several risk factors associated with suicidal thoughts and behaviours in queer men. These included rejection and isolation, experiences of stigma and harassment, mental health challenges, and barriers to support. These factors were experienced in the context of a process of identity development, which occurred in social, religious, and cultural contexts that could exacerbate feelings of isolation and internalised stigma. Men also identified reasons for living and factors which acted as barriers from the conversion of ideation to action.

It highlights the need for SGM focussed formulations and interventions, and reducing barriers to services which can provide this.

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Service Improvement Project

Optimising referrals to a psychology team within a specialist spinal cord injury service

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Abstract

In spinal cord injury inpatient services, the ideal pathway from admission to accessing psychological support would be to screen each new patient to determine psychological need. However, the implementation of 'gold standard' guidelines are often not possible due to limited resources, such as understaffing or poor funding. This study examined how best to use available resources to increase access to the psychology team where universal screening is not possible.

This mixed methods study had 4 stages. An audit examined 161 inpatients admitted to the National Spinal Injuries Centre (NSIC) over one year; a questionnaire evaluated staff understanding of psychology; focus groups were used to develop a more in depth understanding and recommendations were made.

Results suggested that the psychology team's role was unclear to staff, and they were viewed as separate to other disciplines. Recommendations were made to improve staff and patient access to the team. A need to improve the psychology team's communication was identified, alongside clarifying and simplifying the referral process.

Keywords: Service improvement project; Spinal cord injury; referral and consultation; barriers to referral.

1. **Introduction**

Spinal cord injury (SCI) is a life-altering event with wide ranging impacts on physical, cognitive, emotional (Murray et al., 2007), and social domains (Guilcher et al., 2021), for individuals and their families (Lynch & Cahalan, 2017). In the UK, the annual incidence of SCI is estimated to be 19 per million population with approximately 50,000 people currently living with SCI (Patek & Stewart, 2020).

SCI is traumatic and therefore service users (SUs) may experience high emotional and psychological demands, which should be addressed during rehabilitation. Rates of anxiety and depression are elevated in SCI populations (Williams & Murray, 2015), and it is suggested that psychological input during rehabilitation may aid adaptation following discharge (Aparicio et al., 2020). An individuals' coping and appraisals during rehabilitation also influence levels of anxiety and depression, as well as their longer-term recovery trajectories (Bonanno et al., 2012). Work around psychological adjustment to SCI and emotional support is therefore a central part of care.

UK guidelines recommend people with SCI be treated in a specialist Spinal Cord Injury Centre (SCIC) (NICE, 2016) and that a Clinical Psychologist should be part of an SCIC multidisciplinary team (MDT) (NHS England, 2013). National Spinal Injuries Centre (NSIC) at Stoke Mandeville is one of eight in the UK commissioned by NHS England. Although guidelines exist in other countries, there are currently no UK service standards. Consequently, significant variation between models, staffing and service provision exists, ranging from 100:1 – 15:1 staff-to-patient ratio, with a ratio of 32:1 at NSIC. Recommendations for screening and intervention standards exist in the US (Russell et al., 2016), Australia (Craig et al., 2014), and Canada (Mehta et al., 2020). Introducing routine screening for psychological distress has been

implemented in some areas to address under-confidence in referring to psychology (Lee et al., 2010). The SCI clinical reference group has recently agreed standardised measures on admission and discharge from the NSIC, and made recommendations for service standardisation, which are under consultation (Duff, 2023).

In inpatient settings, psychologists are often not ward-based, and can be perceived as 'distant' from the team (Edwards & Venn, 2017). This perceived distance may contribute to misunderstandings of the role of psychology and may impact approachability and team cohesion. The team at NSIC considered whether these factors may act as barriers to psychological referral from MDT staff. Research is required to clarify this.

Barriers also exist regarding staff access to indirect consultation support. Information on staff use of indirect consultation is currently not well understood due to lack of routine recording. An NSIC audit in 2017-18 revealed that 31% of Datix reports for behaviour that challenges (BtC) were from patients not referred to psychology. This suggests that staff recognition of and response to early signs of BtC could be improved. It also implies the existence of barriers to consultation and accessibility to the psychology team. MDT staff in inpatient rehabilitation settings are unlikely to receive routine supervision. Indeed, clinical supervision in some contexts has not been found to impact patient outcomes, therefore has not been implemented as regular provision (Snowdon et al., 2020).

1.1 Service Context

At NSIC, the psychology team sit within the MDT and work with SUs and families in an evidence-based way around adjustment and management of their injury and act as key workers. The psychology service is tiered, according to considerations such as pre-existing

mental health conditions, cognitive difficulties or intensity/duration of distress. Both group and 1:1 interventions are delivered, and include therapy, goal planning, and psychoeducation.

1.2 Current study

All patients should receive psychological screening on admission, as recommended by the SCI clinical reference group (CRG) standards. This has also been evidenced by findings within the service that screening more accurately identifies psychological need than referral (Wallace et al., 2023). Due to limited resources however, referrals currently come through MDT staff.

Issues with the current process by which referrals are made have been identified, including a delay in referral, duplicate referrals, and inappropriate referrals. To mitigate these issues, the team offer staff consultation, attend MDT reviews, and provide patient education sessions to promote self-referral access. These offerings are currently felt to be under-utilised.

Self-referrals are possible but rarely used, meaning MDT staff often act as 'gatekeepers' to the psychology service, making the majority of referrals to the team. Staff understanding of the psychology team therefore likely to influence who is referred to psychology and when. Improvements to the referral process and staff understanding may therefore help increase SU access to the psychology team and improve the suitability of referrals.

The study aimed to:

1. Examine the profile of those currently referred to the psychology service.
2. Examine MDT staff understanding of the psychology service.
3. Explore staff perceptions of barriers to referral and access to the psychology service.
4. Develop practical recommendations targeted on reducing barriers identified.

This study adopted a phased structure to allow for regular review and analysis. An audit (phase 1), questionnaire (phase 2), focus groups (phase 3) and recommendations (phase 4) were conducted. Implementation of recommendations (phase 5) and review of their effectiveness (phase 6) complete the Plan-Do-Study-Act (PDSA) cycle (Gillam & Siriwardena, 2013). Phases 5 and 6 were beyond the scope of the current project but were discussed with lead clinicians and an implementation plan discussed.

2. Phase One (Audit)

A clear picture of the current referral process was examined through audit. This audit provides a context for those currently seen by psychology as well as a baseline which can be used for comparison following the implementation of recommendations. Information around indirect consultation is not currently collected so is not represented.

2.1 Participants

Records for all individuals admitted to NSIC from March 2021 - end of April 2022 were analysed. Readmissions and short stay admissions (<21 days) were removed, as limited resource prevents the psychology team from seeing these patient groups. A core sample of those who remained was used for analysis (Figure 1)

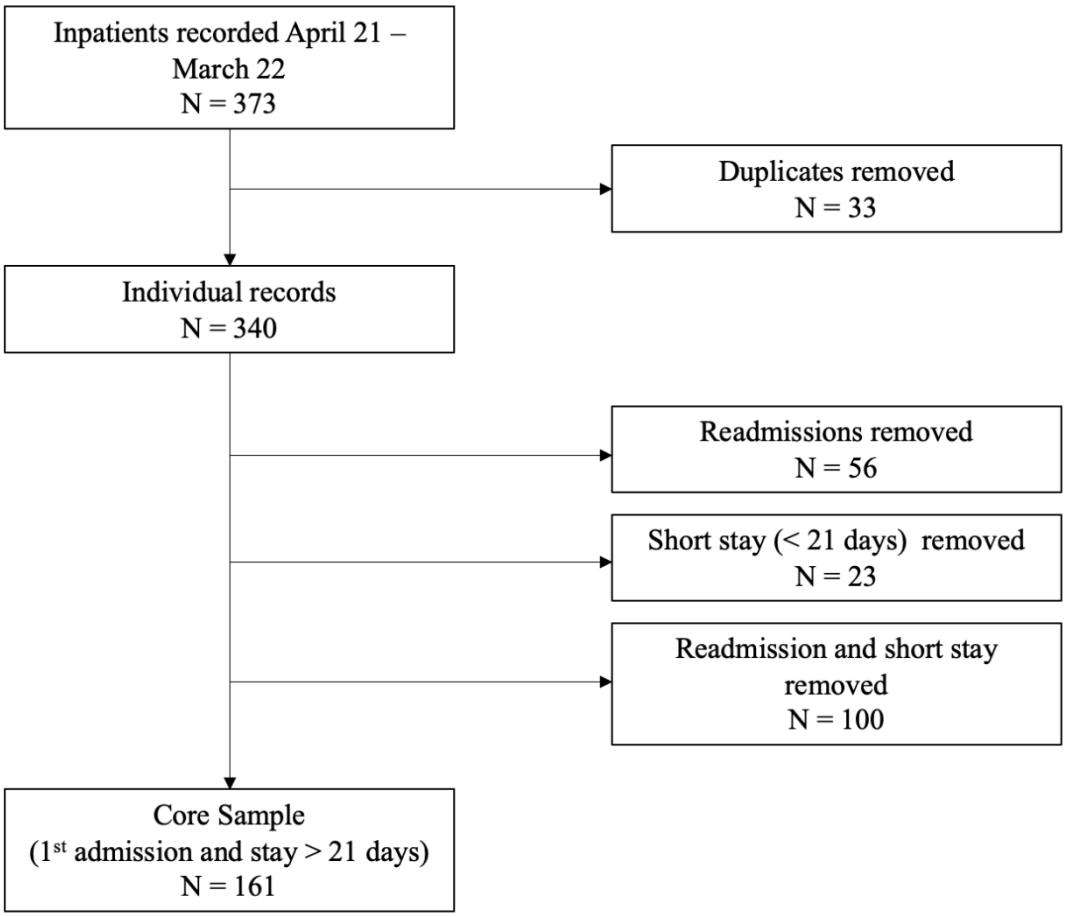


Figure 1: Audit sample flowchart

The core sample consisted of 56 females (34.8%) and 105 males (65.2%). Patient age at injury ranged from 0.3 to 91.4 years old (M = 56.8 years, SD = 16.9). The majority of inpatients reported their ethnicity to be White British (65%). Level of injury ranged from C1 – T12 (cervical vertebrae 1 - thoracic vertebrae 12) with the most common level C4 (cervical vertebrae 4) (14.6%). Most SCIs were incomplete (79.3%) as opposed to complete (20.7%).

2.2 Design

Data was accessed through existing databases and electronic records. This study was approved by the Buckinghamshire Healthcare NHS Trust Research and Innovation team and project coordination group as a quality improvement project.

2.3 Procedure

Data was amalgamated from two databases to gain records of all patients admitted as inpatients between 01/04/21 – 31/03/22. Any mismatch between databases was identified and followed-up using electronic records to obtain a comprehensive list. Duplicates were removed and data cross-checked with further databases held by the team to ensure accuracy. Any missing data was found and populated using the electronic records system.

The following information was gathered: date of birth; gender; ethnicity; age at injury; civic status; admission date; level of injury; completeness of injury; PHQ-9, GAD-7 and ADAPSS score; complexity; whether referred to psychology; number of sessions (if seen); short stay and readmission. Psychometrics were completed for 137 (85%) of the core sample as part of the Stoke Mandeville Spinal Needs Assessment Checklist (NAC). This is administered at admission, unless considered not appropriate.

2.4 Analysis

Descriptive statistics were calculated using Jamovi. Differences between the two groups of 1) not referred to psychology and 2) referred to psychology were compared. Independent sample t-tests were used where assumptions of normality were met, otherwise Mann Whitney U was used, and Chi Square tests were used for categorical variables.

2.5 Results

The core sample consisted of 161 first-time admissions to the service with a stay of >21 days. Demographics are presented in Table 1.

Characteristic	Full sample		Not referred to psychology		Referred to psychology	
	n	%	*n*	%	*n*	%
Total	161	100	59	100	93	100
Gender						
Female	56	34.8	23	39.0	32	34.4
Male	105	65.2	36	61.0	61	65.6
Civic status						
Single	27	16.8	12	20.3	14	15.1
Married	62	38.5	25	42.3	31	33.3
Widowed	3	1.86	1	1.7	2	2.2
Cohabiting	5	3.1	0	0	4	4.3
Not Stated	64	39.8	21	35.6	42	45.2
Ethnicity						
Asian or Asian British	10	6.2	5	8.5	5	5.4
Black or Black British	12	7.5	7	11.9	4	4.3
White British	104	64.6	39	66.1	59	63.4
White Other	7	4.3	1	1.7	6	6.5
Not Stated	27	16.8	7	11.9	19	20.4
Level of Injury						
Cervical	71	44.1	25	42.4	40	43.0
Thoracic	67	41.6	29	49.2	35	37.6
Lumbar	20	12.4	5	8.5	15	16.1
Not Stated	3	1.9	0	0	3	3.2
Completeness of Injury						
Complete	31	19.3	7	11.9	22	23.7
Incomplete	119	73.9	50	84.7	63	67.7
Not recorded	11	6.8	2	3.4	8	8.6

Table 1: core sample demographics

The two groups were not found to be statistically different in terms of Appraisals of DisAbility Primary and Secondary Scale (ADAPSS) score ($t(126) = -1.38$, $p = .169$), age ($U = -2296$, $p = .102$) or gender (χ^2 (1, N=161) = 0.33, $p = .567$). Fishers exact test found no significant difference in civil status ($p = .325$) or ethnicity ($p = .161$) between the two groups.

The groups differed significantly with respect to completeness of injury (χ^2 (1, N=142) = 3.88, $p = .049$), with those with a complete injury significantly more likely be referred to psychology than those with an incomplete injury.

Scores on the General Anxiety Disorder-7 (GAD-7) also significantly differed between the two groups (U = 1115, p = <.001): Those referred to psychology scored significantly higher on the GAD-7 (M = 4.89, SD = 5.19) than those who were not (M = 1.91, SD = 3.25).

Finally, Patient Health Questionnaire-9 (PHQ-9) scores differed significantly (U = 1199, p = <.001). People referred to psychology scored significantly higher on the PHQ-9 (M = 6.84, SD = 5.59) than those who were not referred (M= 3.73, SD = 3.96).

3. **Phase Two (Questionnaire)**

A questionnaire was developed and distributed following the audit. This aimed to identify staff understanding of the role of the psychology team and to identify key barriers to referral, consultation and access to the team.

3.1 Participants

All staff were provided the opportunity to complete the questionnaire. Posters with QR codes were developed and displayed in staff areas. Emails with hyperlinks to the questionnaire were sent to teams to optimise staff awareness and access. The researcher approached staff teams in person.

29 people took the survey, however 6 were incomplete, leaving 23 competed. Seven professions were represented including Physiotherapists (26.1%), Health Care Assistants (21.7%), Nurses (17.4%), Occupational Therapists (13.0%), Medics (8.7%), Speech and Language Therapists (4.3%), Patient Educators (4.3%) and Other (not stated) (4.3%). Around two thirds (65.2%) of respondents had worked at NSIC for more than 5 years.

3.2 Measures

The questionnaire (Appendix F) was delivered using Qualtrics. It consisted of 15 questions, covering the role of psychology, how they gained this understanding, and their experiences in

accessing the team. Questions were developed based on the project's aims and refined with the involvement of two experts by experience (EbEs).

Although primarily focussed on staff understanding and barriers, the project ultimately aims to improve psychology access for SUs. Therefore, involving individuals with experience of an inpatient SCI service was important for incorporating different perspectives and keeping SUs central to the project aim.

3.3 Analysis and Results

Data was analysed descriptively, using frequency counts to determine the commonly identified barriers.

Access to psychology:

Rates of referral were low, indeed 39% of respondents had not made any referrals to the psychology team and 48% had made 4 referrals or fewer. This is lower than may be expected given most respondents had worked in the service for more than 5 years. Half of respondents reported joint working with the psychology team, although only 20% reported this to be 'very' or 'quite' often.

Consultation or discussion with the psychology team was rarely utilised, with 30% of respondents saying they did not find the team easy to access. A further 17% had not attempted to access the team.

Understanding of psychology role:

Understanding of psychology was variable. Participants most frequently reported that psychologists 'work around acceptance and adjustment' with patients, followed by 'working with people with suicidal ideation'. Nine percent said they did not know what the psychology team do for patients. Regarding psychology's role for staff, 'providing consultation' was selected most, followed by 'training and education'. A quarter of respondents (26%) selected 'I

don't know', suggesting staff understand the role of psychology more clearly for patients than for staff.

Staff understanding was developed mainly through 'informal discussion' with the psychology team. Induction, training, goal planning meetings and from non-psychology staff members were also cited. Despite these opportunities, 35% reported that they did not receive any input at all to guide their understanding of psychology.

Staff rated their confidence in their understanding of the role of psychology at an average of 5.8/10 where 10 is most confident. They also rated confidence in their ability to communicate the role of psychology to patients with an average of 5.8.

Barriers to accessing psychology:

The most commonly cited barrier to access was the patient declining the referral (28%). Other reasons included long waiting lists (10%) being too busy to refer (10%), not knowing how to refer (10%), being unsure if appropriate (10%) and feeling that a paper form is 'outdated' and time consuming (5%). Only 8% of respondents felt there were no barriers to referral. For those that had referred, 18% reported a 'negative' or 'very negative' experience; 47% reported a 'good' experience and 0% an 'excellent' experience. Positive experiences highlighted support and understanding, while negative experiences referenced delays, chasing and the use of written forms.

Service development:

Staff were asked about how the service could improve or develop. From provided options around key areas, 35% of respondents selected 1:1 patient therapy session , 25% selected staff consultation, 17% selected group work and 4% selected education and training. The most important contribution made by psychology was reported as supporting inpatients (59%), followed by providing families and patients with support to improve outcomes for the future

(18%). 'Supporting staff' was selected by 5% of respondents and none chose 'providing leadership and management' or 'audits and research'.

4. **Phase Three (Focus Groups)**

Phase three consisted of one focus group with the psychology team and one with MDT staff members. This aimed to examine barriers in greater detail, identifying areas for service improvement.

4.1 Participants

All clinical and admin members of the psychology team were invited to the psychology focus group. 5 members of the psychology team participated, out of 6 in the team.

Participants who completed the questionnaire were invited to attend a focus group. 1 MDT participant was recruited via this method. Additionally, staff leads of each discipline were requested to nominate a colleague to attend. This ensured different teams and bands were represented. The MDT focus group included 6 participants: case manager, health care assistant, staff nurse, physiotherapist, occupational therapist and medic.

4.2 Design and Materials

Krueger and Casey's (2002) guidance on focus group design and delivery was used to inform group structure. Questions were developed based on study aims, and areas highlighted in questionnaire responses. The questions were developed with supervisors and discussed with and refined by EbEs. The same open questions were used for both focus groups to promote discussion.

4.3 Procedure

The focus groups followed a semi-structured schedule (Appendix G) and were conducted over MSTeams. Participants verbally consented to recording and transcription. NVivo was used for coding.

4.4 Analysis

Thematic Analysis was used and followed the 6 stages outlined in Braun & Clarke (2006). Each focus group transcript was coded and themed independently of one another in line with the project aim to capture the experience of MDT staff. Analysis began with familiarisation, followed by generating codes, developing and defining themes. Each stage was revisited and reviewed throughout. Themes were discussed with supervising researchers and refined accordingly. The process of coding and developing themes was discussed with other researchers conducting thematic analysis. These discussions included credibility checks, role of reflexivity and reflections on the process of analysis.

4.5 Results

Themes are presented for the MDT (Figure 2) and the psychology team (Figure 3) below. Quotes for all MDT themes are presented in Table 2.

Themes arising from MDT focus group

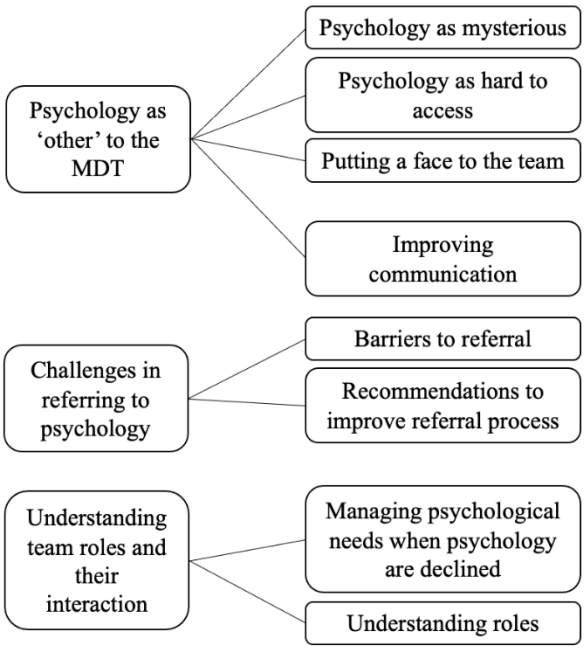


Figure 2: Themes and subthemes arising from MDT focus group.

Psychology as 'other' to the MDT:

Psychology as mysterious. Staff described the process of accessing psychology as "mysterious", reporting that they often aren't aware of whether a referral is accepted. They also spoke about mystery of psychology sessions, being unclear on what happens in sessions and why.

Psychology as hard to access. Staff identified obstacles in accessing the psychology team such as distance from the ward and not answering phone calls. This was exacerbated for staff on rotational shifts as hours and workload prevent them from leaving the ward to seek out psychology.

Putting a face to the team. Staff shared the positive impact of getting to know the psychology team as people, increasing their approachability and helping staff feel more comfortable when discussing SU's mental health.

Improving communication. Staff identified communication between psychology and the MDT as an area for improvement. They discussed current issues of duplicating or missing referrals due to an absence of feedback on referral status, leading to an increased work for both psychology and MDT. Patients were often asked for information about their psychology sessions by staff directly rather than approaching the psychology team.

Challenges in referring to Psychology:

Barriers to referral. Several barriers to referral were identified. Using paper copies was felt to be time-consuming and effortful, which can lead to delays in referring. Staff were unclear about referral criteria, potentially leading to under- or over-referring.

Recommendations to improve referral process. When identifying barriers, staff spontaneously provided recommendations for improvement, such as relying less on free text responses and clarifying definitions of urgency etc.

Understanding team roles and their interaction:

Managing psychological needs when psychology is declined. Staff were uncertain of procedure and their role when patients decline a psychology referral. They described feeling that they were holding the psychological needs of the individual without support from psychology.

Understanding roles. Staff described developing an understanding of the psychology role, moving from helping 'upset' SUs toward understanding psychology as having a more nuanced role. Staff explored questions around their role in relation to psychology.

MDT THEMES	
Subtheme	Quote
Theme: Psychology as 'other' to the MDT	
Psychology as mysterious	*Then you know these things are quite abstract, aren't they? […], we want a bit of demystification sometimes.* *I don't really know what the therapy's gonna be or what's gonna happen next* *I think there is a certain mystery about psychology*
Psychology as hard to access	*You have to have free time in your timetable to keep going and keep searching, searching for them and seeking them out.* *I will make a special effort to go up to the psychology office to hunt down the psychologist, to have a chat with them, which is always really helpful, but obviously very time-consuming.* *We know where the psychologists are, but often they are with patients, or you ring their numbers and there's no answer whether they're with a patient or finished for the day or whatever it might be. So, I do actually find them quite difficult to get hold of.*
Putting a face to the team	*You have to establish a relationship where you feel comfortable to talk about the issue.* *She was coming as a psychologist, but she was coming there as a resource and a person that you got to know. So therefore, the interactions and the experience became more easy* *The psychologist wasn't somebody receiving a piece of paper, they were flesh and blood.*
Improving communication	*Communication and awareness of 'has someone else referred' because again there's nothing, there's nowhere other than going up and speaking to psychology or sending an e-mail and there's no way of finding that out. So, I think there's been times where there's been delays because someone thought someone else was referring* *I think we do feel a lack of communication* *All we have is the saying to the patient. Are you meeting the psychology? Yes, I am. And you're only getting your feedback through the patient.*
Theme: Challenges in referring to Psychology	
Barriers to referral	*To do the paper copy, you have to go at a time when [the] office is open to then pick up the form to then do it. […] online saves you that walk up the stairs to then find that the door is not open.* *There are sometimes a few obstacles to get there because like the referrals and everything like that. It's quite an effort to refer.* *There are questions about referrals and what's suitable and why and who aren't?*
Recommendations to improve referral process	*With the referral form, if we were to stick with that is and the bit about how urgent it is. So how urgent is urgent?* *I think if we are going to keep the referral system then to make it as streamlined as possible. So, it's more of a tick box exercise rather than expanding with lots of detail.*
Theme: Understanding team roles and their interaction	
Managing psychological needs when psychology is declined	*We have patients … who have been referred to psychology and psychology have been told that they're not needed. So, what is the action then? That they don't see them, but the rest of the team do. So, we amateur psychologists… what do we do? Psychologists won't be helping them because they've said they don't want help and do our patients realize they've got a serious problem*

Understanding roles	*What is our role then? Are we just to ignore the problems, the addictions and the strange behaviours?* *When I first arrived and for a very long time, I thought if people were upset then a psychologist would help. And it's a much more specific thing than that*

Table 2: Quotes corresponding to MDT themes.

Themes arising from psychology focus group.

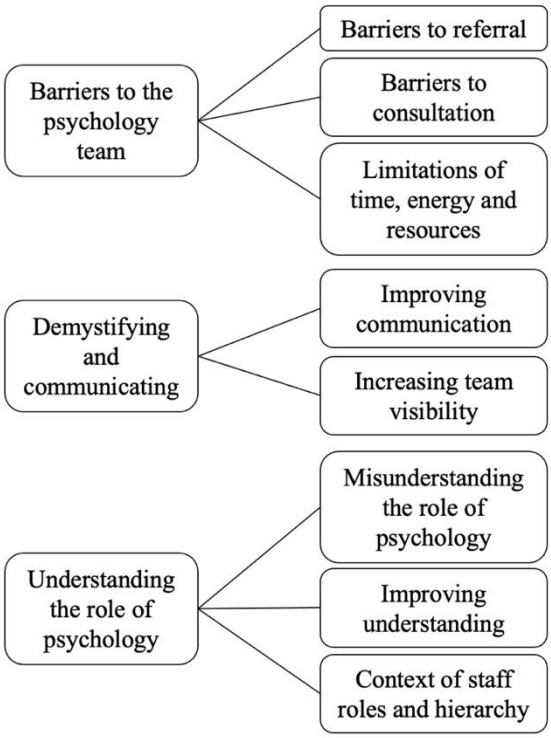


Figure 3: Themes and subthemes arising from psychology team focus group.

Barriers to the psychology team

Barriers to referral. The psychology team identified that a lack of knowledge of referral process and a lack of confidence in discussing mental health with patients were potential barriers to referral. Clinicians displayed an awareness of staff dislike of the current format and form and hypothesises that this acts as a further barrier.

Barriers to consultation. Lack of confidence was also identified as a barrier to accessing consultation. The psychology team also expressed a feeling of 'otherness' and considered whether this made it harder for MDT to approach them.

Limitations of time, energy and resources. Time limitations and staff volume of work were recognised as impacting referral form completion as well as consultation and joint work. Limited psychology resource was also acknowledged, at times resulting in referrals being delayed or refused due to stretched capacity.

Demystifying and communication

Improving communication. The team discussed the importance of psychology referrals being first discussed with the patient as it was not felt that this is not currently done. Communicating referrals as received, accepted or rejected was highlighted as a means of reducing missed or duplicated referrals.

Increasing team visibility. The team discussed the impact of being in an office away from other staff impacted on informal conversation opportunities and being seen as part of the MDT. They were enthusiastic about spending more time on wards or in staff areas to increase visibility. Use of videos and posters was also discussed.

Understanding the role of psychology

Misunderstanding the role of psychology. The psychology team identified misunderstandings and assumptions staff may have about psychology and when it may be helpful. It was suggested that psychology is seen as an 'extreme measure' rather than integrated into typical MDT input. This may act as a barrier to staff discussing psychology openly with patients.

Improving understanding. The team shared an enthusiasm for improving understanding of their role. Ideas regarding psychology 'myth-busting' were discussed, such as providing example referrals and information boards in accessible areas.

Context of staff roles and hierarchy. Discussions around role, communication and barriers were held within a broader awareness of team roles and psychology's position within perceived

hierarchies . Shift patterns, lack of access to laptops and new starters were recognised as key considerations in ensuring the effectiveness of any implementations.

PSYCHOLOGY THEMES	
Subtheme	Quote
Theme: Barriers to the psychology team	
Barriers to referral	*people don't like filling forms in* *maybe the staff have a lack of knowledge of how to refer because other services are doing, or other teams are doing it differently?* *just lacking the confidence to raise those kinds of things with patients*
Barriers to consultation	*there are probably more junior members of staff, newer members of staff that wouldn't have the confidence.* *Whether they're sort of not wanting to kind of… Not sort of not waste our time but kind of come and talk to us about things that maybe they think we're not going to have the time for or say or, you know, e-mail it or you know something like that.* *we used to be able to provide supervision to the ward […] they say they want it, but they don't come, has kind of been our experience.* *So that maybe feeds into why it seems as though we're like this distinct group and people feel like they can't approach us.*
Limitations of time, energy and resources	*It's not having enough time, not making a note of it and therefore just never gets done. So, there might be the will and the intention just never translate to a piece of paper.* *[An information board] would save a lot of time and energy.* *You don't want to put people off referring because you don't want to miss people who need it. But at the same time, because the resource is so limited, you can't, and you can't afford to see absolutely everyone, and you have to prioritize the more complex ones* *Is it just lack time? Busy, busy, busy. Just do the referral?*
Theme: Demystifying and communicating	
Improving communication	*I do think in an ideal world the patient would know that that referral has been put in.* *in terms of kind of professional duty to ensure that when you're referring a patient for a service, you've actually discussed it with them.* *by that point, you might have received […] an extra referral for the same person just because people don't know yet that we've received it or that they've been seen.*
Increasing team visibility	*I think trying to make ourselves more visible in areas where we don't go very much* *I think because we have to use our office space for confidentiality reasons. But that also then kind of takes us away from other people.* *(re poster and information) That kind of gives them some backup that 'this is a normal thing to do, this is there's a poster about it' […] It's visibility, I guess it's indirect, but […] it feels important.*
Theme: Understanding the role of the psychology team	
Misunderstanding the role of psychology	*you know the fear of if they bring something like that up that it'll make it worse for the patient or that it'll create something that wasn't there before or something.*

	I think there's a lot of assumptions around levels of injury, completeness, and things like that really. And also, people thinking that somebody's bound to struggle and perhaps therefore not referring, whereas our preference would be to refer. *they probably kind of project their own sense of stigma onto the patient situation perhaps if they see psychology as kind of a…. You know an extreme response to the situation rather than kind of a natural part of the MDT input.*
Improving understanding	*Myth busting as well maybe. not going to ask about your childhood necessarily, or make you lie on a couch.* *Examples of what we want, like a few different kinds of examples of referrals that we might get and the level of information. Yes, some way of encouraging people to include the information were sort of looking for.* *In terms of those discussions about what psychology is and what we do and more of a kind of tangible presence. The tissue viability nurses have a board on the ward saying what tissue viability is, so why don't we have a board on the ward? Saying what psychology is for both patients and staff.*
Context of staff roles and hierarchy	*especially with like different shift patterns for certain staff as well, especially nurses. And I think sometimes just that kind of trickle-down effect can be quite slow,*

Table 3: Quotes corresponding to psychology team focus group

Feedback and Service Improvement

Areas with potential for service improvement identified through the questionnaire were followed up in focus groups. During discussion both groups unprompted began to share and shape recommendations related to the problems identified. Several recommendations came directly from the teams themselves while others were developed from the themes identified. Findings and subsequent recommendations were fed back to the psychology team and discussed in terms of feasibility, resourcing and expected impact. Recommendations were categorised into the areas they target for improvement (Table 4). Low resource but high impact interventions were favoured. Those selected by the team as recommendations to implement are shown in bold. It was important that staff were consulted around those which could be implemented with immediate effect and felt practical and feasible. The recommendations listed not in bold were also planned to be implemented but were felt to require either more time for consultation, more resources or active involvement from other teams (e.g. a new staff induction process, leaflets for patients, hosting ward drop-in sessions).

This second phase of implementing recommendations was planned and will be reviewed in the 'study' phase of the PDSA cycle. It is hoped that by taking time to consult on recommendations with key stakeholders they will be implemented in a way which is sustainable and appropriate to those who are accessing them.

Following this, recommendations were fed back to the wider MDT through email and posters developed with experts by experience (EbEs).

There was a positive response from both psychology and the MDT to recommendations, with excitement around potential changes. There was a recognition of the practicalities of implementation, with an importance that recommendations were made across all departments and were sustainable. There was a recognition of potential difficulties, such as the logistics of online referral forms with limited access to computers on wards.

Aim	Recommendations
Improve referral content and process	- Providing examples of completed referrals (P) - **Clarifying what levels of urgency mean (MDT)** - **Referral form online (MDT)** - **Referral form as more tick box focused (MDT)** - **Patients being able to self-refer (MDT)** - Having a different referral process (MDT)
Improve understanding of the role of psychology	- **Accessible summary of psychology role for patients (P)** - **A board explaining the role of psychology for staff (P)** - **A poster for staff, patients and families (P + MDT)** - **A video explaining role of psychology (P + MDT)** - **Myth busting around psychology (P)** - Leaflet for patients (MDT) - Overview of psychology role for all staff (MDT) - Induction for new staff understanding (MDT)
Improve visibility of psychology team / approachableness	- Increasing visibility (P) - Psychology dropping into ward (P + MDT) - Drop-in sessions to increase accessibility to the team (P) - More time slots to access psychology – potential problems with doing during lunch breaks (MDT) - Having a link psychologist to put a face to a name (MDT)

	- Psychology presence at huddles on the ward (MDT)
Improving communication (between psychology team, MDT staff and patients)	- Improving communication with patients about referral and pathway (P) - Referring people for an explanation of what psychology do if they are unsure if they want to access psychology or not (P) - Patients to be aware of referrals being made (P) - **Improve feedback on referrals to staff (P)**

Table 4: Recommendations taken from focus groups. (P) indicates it arose from the psychology team focus group, and (MDT) from the MDT group.

Discussion

The audit completed showed that those referred to psychology differed significantly from those who were not referred in terms of completeness of SCI, and higher levels of anxiety and depression. Higher scores on psychometrics may be expected from a well-functioning referral process and suggests that MDT staff were correctly identifying and referring SUs with greater psychological need. There were no differences between the groups in age, gender, ethnicity or civil status. Previous research has found younger patients in healthcare settings to be referred to psychology more (Alexander, 2004), however others echo the findings of this study and have found no relationship between age and mental health in people who have experienced SCI (Putzke et al., 2003). Groups did not differ significantly regarding adjustment to injury (as measured by Appraisals of DisAbility Primary and Secondary Scale ADAPSS). This is contrary to previous research which has suggested higher levels of acceptance and positive appraisals of SCI are associated with lower levels of depression and anxiety (Aaby et al., 2020). However, as this is an inpatient service and measures were taken at admission, it may be too soon after injury to allow for positive adjustment, as evidence suggests that appraisals change over time (Chevalier et al., 2009).

Although groups differed in mean anxiety, General Anxiety Disorder-7 (GAD-7) scores for both groups were below the threshold for mild generalised anxiety disorder (Spitzer

et al., 2006). Similarly, mean Patient Health Questionnaire-9 (PHQ-9) scores for those referred to psychology just exceeded the threshold for 'mild' depression (Kroenke et al., 2001). Previous research has suggested that 30% of people report clinical levels of depression or anxiety after SCI (Migliorini et al., 2009). Other research, however, supports this findings and suggests that rates of anxiety and depression are relatively low in this population (Bonanno et al., 2012). The false expectation that people will inevitably struggle psychologically after a SCI was also highlighted in focus group discussion and suggested as an area for potential 'myth-busting'.

The questionnaire explored barriers to referral and access to psychology. Identified barriers included long waiting lists, lack of time, uncertainty about how to refer and who to refer to, and the use of a paper form. Paper referral forms have been found to be inefficient in other healthcare services, while online forms which provide feedback and tracking are time-saving, efficient and safer (Shephard et al., 2018). Understanding of the role of psychology was variable, with some staff reporting; 'I don't know'. Reported confidence in their understanding and explanation of the role of psychology was also varied, with an average of 5.8/10, suggesting a target area for intervention and education. Staff cited 'informal discussion' as the most common means of understanding and accessing psychology. Christofides et al, (2012) similarly found that informally sharing psychological hypotheses with MDTs was valued by staff and encouraged accessing psychology in future. Given psychology's physical distance from the wards, a means of promoting opportunities for informal conversation is therefore recommended.

The focus group expanded on and explored these themes. Similar themes were identified across both groups, highlighting issues in understanding of the psychology role, and how this intersects with other disciplines. Staff understanding of the team's role, as well as

psychology more broadly, is critical to ensuring appropriate referrals are made. Research suggests that staff act as gatekeepers to referral, but may inadvertently prevent help from being sought due to misinformation e.g. talking about suicide increases risk (Awenat et al., 2019). Communication was also a theme which arose in both groups, particularly concerning feedback from referrals. Both considered the 'trickle-down effect' and how to pass information to staff who were not on shift or unable to attend meetings where psychology is present. Research into communication in an inpatient neurorehabilitation setting (Franz et al., 2020) suggests that good communication is facilitated by an understanding of the role of different disciplines and communication styles.

The focus groups generated recommendations, with staff being keen to share ideas as well as developing or challenging those put forward by others. The group provided a forum in which to share these, potentially encouraged by the fact that they were facilitated by someone not affiliated with the service. The readiness with which people engaged in conversation around improvement suggests that it might be helpful to consider focus groups for service development in the future.

6.1 Clinical Implications

This study identified how services can approach service improvement while recognising limited resources may mean 'gold standards' are unattainable. It identified, explored, and presented recommendations to address barriers within the constraints of service pressures. It is recommended that staff understanding of psychology be promoted by through use of a notice board with QR codes to videos and leaflets. It is recommended that the referral process be adapted by developing an online referral form, incorporating additional MDT suggestions such as tick-boxes and less free-text. This form should also be easily accessible for patients to complete.

These recommendations will be implemented by the NSIC psychology team. A written report was provided to the service outlining recommendations, alongside more accessible posters outlining key points for staff (Appendix I).

6.2 Strengths and Limitations

This project was rooted in service need, originating from observed issues, and therefore resulting recommendations focus on practicality and feasibility. This increases the likelihood of recommendations being implemented and maintained. A further strength was the comprehensive audit, compiling data from multiple sources and cross-referenced with team records. However, a limitation of the data is that it was collected shortly after the UK exited a COVID-19 'lockdown'. The pandemic impacted inpatient services such as NSIC long beyond national lockdowns, which may have impacted rates of psychological need captured by the audit.

A further limitation was the size of the focus group, only using one member from each discipline. Additional focus groups would have expanded perspectives and provided greater depth. The questionnaire aimed to obtain broader views, however there was a low response rate, despite trialling different recruitment methods. It would also have been beneficial to have data on the use of indirect consultation, to explore this key role of psychology more fully. Finally, generalisability to other SCI services is limited, as the aims and recommendations focussed on the barriers identified in one specific service. Future research could therefore focus on inpatient MDT understanding of psychology, access to psychology and impact on referrals in different services, including a wider range of clinicians.

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Theory Driven Research Project

Internalised Stigma in Individuals with Non-Epileptic Seizures: The role of disclosure and impact on self-esteem and self-efficacy

Word Count: 5498

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Proposed Journal: This paper will be submitted to *Epilepsy and Behavior*. This is a peer reviewed, open access journal and has an impact factor of 2.6. This journal publishes work primarily on epilepsy, however other seizure disorders are also covered, and research into experiences of people with non-epileptic seizures has been published. It was therefore chosen as an appropriate journal for this piece of research.

See author guidelines in Appendix K.

Declaration of interest: None

Abstract

Objective: This study compared the differences in levels of internalised stigma in people with a functional seizure diagnosis (Non-Epileptic Attack Disorder (NEAD)) to people with an organic seizure diagnosis (epilepsy). It also investigated whether there is a difference in disclosure of diagnosis. Finally, it explored the relationship between internalised stigma and the factors of self-esteem and self-efficacy.

Design and participants: This study used a cross-sectional survey design to address these questions. 98 people took part (51 with NEAD and 47 people with epilepsy (PwE).

Results: People with NEAD (PwNEAD) reported higher levels of internalised stigma than PwE. PwNEAD reported significantly lower levels of disclosure of diagnosis than PwE, which remained significant after controlling for anxiety and depression. A hierarchical multiple regression analysis indicated that internalised stigma was a significant predictor of both self-esteem and self-efficacy, above the amount of variance accounted for by anxiety and depression.

Conclusions: Clinicians should be aware of high levels of anxiety and depression in both groups. Self-esteem and self-efficacy could be important targets of intervention. Limitations are discussed. Further research should explore the relationships between these factors, including potential moderators.

Keywords: Non-epileptic seizures, NEAD, PNES, epilepsy, FND, internalised stigma, self-esteem, self-efficacy, disclosure

1. Introduction

Stigma, Internalised Stigma and Seizures:

This study compares internalised stigma experienced by people with non-epileptic attack disorder (PwNEAD) (a seizure-based subtype of functional neurological disorder (FND)) with those with an organic seizure diagnosis (epilepsy).

Stigma is a set of negative beliefs held by people around a characteristic or circumstance. Awareness of being the subject of stigma can adversely influence health and wellbeing, having social, psychological, and economic impacts (1). Stigma occurs across different levels, including the structural level (when laws and policies perpetuate stigma) and the public level (where discriminatory behaviours and prejudices can introduce barriers and contribute to exclusion). This study addresses a third level: the internal level (when people with a stigmatised condition endorse and apply negative attitudes to themselves). This focus is important as high levels of internalised stigma are associated with lower levels of help-seeking (2), health (3) treatment outcomes (4) and quality of life (5). To develop formulations and interventions that improve outcomes for those with seizure disorders, it is crucial therefore to understand the prevalence and impact of internalised stigma.

Seizures have a historical and ongoing association with stigma (6,7). A recent study across 15 European countries found 51% of people with epilepsy (PwE) felt stigmatised by their condition (8). While stigma is relevant in functional seizure conditions, differences in its manifestation compared to organic conditions have not been extensively researched.

Organic conditions have biological, measurable changes in the body, causing symptoms (e.g. epilepsy), whilst functional conditions produce symptoms inconsistent with any measurable disease to tissue or organs (e.g. FND) (9). Research matching functional somatic conditions to controls found the former reported higher levels of perceived stigma

than those with comparable organic diagnoses (3,10). This research illuminates a key aspect of internalised stigma in FND, namely, that the conditions' lack of biomarkers can undermine an individual's confidence in the validity of their condition (11). Functional seizures are often delegitimised and described as 'false', 'pseudo', and 'hysterical' (12). Existing research has focused on stigma from healthcare professionals toward individuals with FND, finding levels to be consistently higher than in organic conditions.

This study compares epilepsy to NEAD (a sub-type of FND). This comparison is well established in research (13), as their symptoms are similar, allowing researchers to compare people with NEAD to those who have a similar condition but of organic aetiology. This approach is preferable than comparing to a healthy population, as it focuses on the experiences of symptoms across both groups.

NEAD is characterised by seizures, sometimes referred to as 'psychogenic non-epileptic seizures' (PNES). The incidence of NEAD is four-times higher in women than men, with an estimated prevalence of 4.90/100,000 year in the UK (14). NEAD lends itself well to stigma research for several reasons. Firstly, because FND is so heterogeneous in presentation, using a well-defined subtype affords a clear comparison to PH conditions. Secondly, research has shown some medical professionals lack an understanding of NEAD and hold high levels of stigma (15). Rommelfanger et al., (16) found clinicians viewed people with FND as time-consuming and litigious, describing them as 'challenging 'and 'frustrating'. Some clinicians perceived seizures as volitional and deemed functional seizures to be less severe than epileptic seizures (17).

While initial research has suggested that PwNEAD report higher levels of stigma than PwE (18), models of internalised stigma have been under-researched. Awareness of

internalised stigma is vital when considering access to services and highlighting targets for intervention.

Various theoretical approaches seek to explain the aetiology of NEAD. Psychodynamic, cognitive behavioural and neuropsychological (74) theories take different perspectives however, most agree that development is due to the interaction of a combination of biological, psychological and social factors (73). Some key factors have been identified across models however, two factors pertinent to this study are attentional difference and experiences of adverse life events (71, 72).

Attentional differences and misinterpretation of bodily sensation are key elements of both the 'Panic without Panic' (PwP) (72) and Integrative Cognitive Models (ICM) (71) of NEAD. The PwP model suggests that that the cognitive and physical components of a non-epileptic attack mimic that of a panic attack but without the conscious experience of panic. It is theorised that cognitions and physical sensations are consequently experienced in a dissociative manner.

Trauma and adverse life events are reported by a significant proportion of people with NEAD (65) and are represented in models such as ICM as both a vulnerability factor and a potential trigger for onset. The underlying mechanisms are likely multifactorial, with psychological (emotional dysregulation) and physiological elements (hyperarousal and acute stress) contributing to the development of NEAD (75, 76).

Disclosure:

The disclosure of conditions is an important metric for exploring levels of stigma between FND and epilepsy. In Corrigan and Rao's (19) model of stigma, disclosure is presented as challenging internalised stigma and promoting empowerment, whilst others linked disclosure

of MH diagnoses to reduced impact of internalised stigma on quality of life (20). However, the benefits of disclosure also rely on reception and whether disclosure was voluntary or forced (21)(22).

Differences in disclosure have not been explored between PwNEAD and PwE. Young people with epilepsy report lower disclosure of their condition than peers with other chronic health conditions (23), identifying stigma as a barrier to disclosure. A meta-synthesis of the experiences of PwE (24) found stigma often promoted shame and negative self-perception, which was managed through concealment and avoidance. Similarly, people with FND have reported developing coping strategies – concealment and nondisclosure – to deal with stigma, which can lead to isolation and exhaustion (11). While concealment has been found in both populations,. this study's unique contribution is centre the comparison on disclosure.

Self Esteem and Self Efficacy:

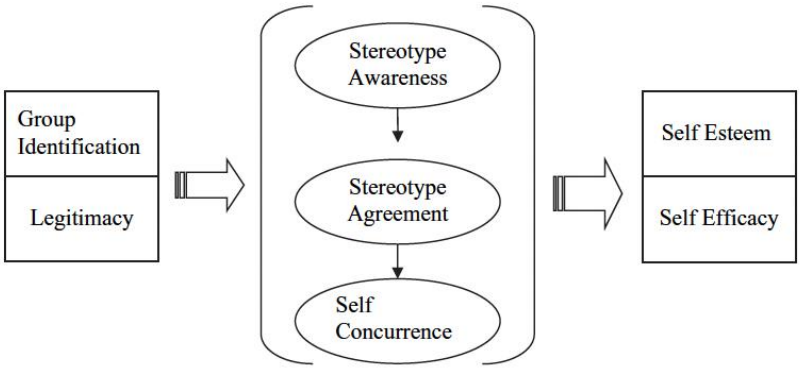
Theoretical models point to the impact of stigma on individuals. Corrigan and Rao (19) refer to impact as 'harm', while Watson et al, (25) define it as lowered self-esteem and self-efficacy (Figure 1). Where self-efficacy describes an individual's confidence in their abilities to enact behaviours required to achieve a goal (26), self-esteem is an individual's self-worth and perceived value. Both have been explored in seizure conditions and have important implications.

Perceived stigma has been associated with lower self-efficacy in seizure management in people with epilepsy (27). Although self-efficacy in NEAD lacks research, unpublished doctoral research found no significant difference in levels of self-efficacy between PwNEAD or PwE (28). Self-esteem research in MH conditions has found low self-esteem to be associated with internalised stigma and with poorer treatment outcomes (28). In PwE, self-esteem was found to mediate the impact of seizure burden on MH outcomes, suggesting self-

esteem is an appropriate target of therapeutic intervention (30). This relationship has not been explored in PwNEAD, but research found explicit self-esteem to be lower in PwNEAD than PwE (31). Meanwhile, anxiety and depression were higher in PwE (32) and in those with NEAD (33), as well as being associated with self-esteem and self-efficacy (34). It was therefore important in this study to control for these covariates.

The present study explores differences in internalised stigma in NEAD and epilepsy alongside disclosure, self-efficacy, and self-esteem. Incorporating these three deepens our understanding of internalised stigma and its impact, as each represent a key psychological factor impacted by the experience of stigma. Establishing the connection between these factors demonstrates how internalised stigma and disclosure of condition may impact self-worth and confidence in abilities. This enables a richer comparison between the existence of stigma in NEAD and epilepsy, since it captures, the internalised impacts of stigma on psychological well-being across multiple domains, presenting targets for intervention.

Figure 1. *Theoretical model of 'Self Stigma' from Watson et al.,* (25)



1.2 Study aims.

Researching internalised stigma in PwNEAD is important for guiding formulation and intervention for work with this population. This study contributes to this goal by exploring internalised stigma in PwNEAD compared to PwE.

It investigates the presence and levels of internalised stigma and disclosure of condition across groups and explore the relationship of internalised stigma with self-esteem and self-efficacy. The findings are applied to Watson's model of self-stigma (with self-concurrence defined as internalised stigma) (25), which provides a framework, offering a foundation for further research, both in NEAD and FND broadly.

1.3 Research questions and hypotheses

1. Do people with a diagnosis of NEAD report higher levels of internalised stigma than PwE?

    Hypothesis 1: PwNEAD will score higher on measures of internalised stigma than people with epilepsy.

2. Do PwNEAD report lower levels of disclosure of their diagnosis compared to PwE?

    Hypothesis 2: PwNEAD will report lower levels of disclosure of their condition than PwE.

3. Do people who experience high levels of internalised stigma around their seizure disorder experience lower levels of self-esteem and self-efficacy?

    Hypothesis 3: There will be an association between high levels of internalised stigma and lower self-esteem and self-efficacy.

2. Method

2.1 Design

An integral part of the ICM model (71) is the 'seizure scaffold'. This refers to cognitive, emotional and physiological processes around seizures and how prior seizure experiences and expectations inform manifestation and development. As such, it was felt that comparison to PwE was an appropriate methodology, so that the presence of seizures was maintained across both groups, while the aetiology of conditions differed.

The study employed a cross-sectional survey design. Participant information sheet, consent form, and online survey were delivered using Qualtrics XM.

2.2 Patient and Public Involvement (PPI)

PwNEAD were recruited from social media groups (see Appendix K for poster) for consultation. Two people advised on study design, recruitment materials, participant information wording, and tested the survey. They considered survey flow, headings, content, and provided a completion time estimate which could be shared on recruitment posts. Consultants were compensated financially for their time.

2.3 Ethics

The study received approval from the Oxford University Central University Research Ethics Committee (reference number; R87156/RE001) (Appendix L). Participants were provided with an information sheet (Appendix M) and gave informed consent.

2.4 Sample size

Sample size was calculated using G*power software (35). A lack of publications around internalised stigma in NEAD, meant research in other populations was used to estimate effect size (36). A medium effect size was anticipated, with an f value set at .30. Power analysis was conducted based on an ANCOVA being used to test the primary hypothesis. A total sample

size of 90 participants was required (45 per group) to detect a significant effect (Cohen's f = .30) with 80% confidence ($\alpha = .05$)

2.5 Participants

Participants were recruited between August and November 2023 via social media platforms, including Facebook and Instagram. Charities, including FND Dimensions, FND Action and Epilepsy Society, were approached via email with information and requested to share a poster (Appendix N). Inclusion criteria for both groups were as follows:

- 18 years or older.
- Self-reported diagnosis of epilepsy or NEAD (or equivalent diagnosis, e.g. PNES,).
- Self-reported level of English which enables the completion of online questionnaires.
- Able to consent to take part.
- Have been diagnosed for >3-months.
- UK resident (to allow for signposting).

2.6 Measures

Demographics were collected from both groups, including gender, age, ethnicity, and education. Despite a range of options offered for ethnicity, data is only reported on those selected. Standardised measures used, their administration and validity are displayed in Table 1.

Table 1: *Overview of Standardised Measures*

Construct	Measure	Validity	Administration	Interpretation
Identification with diagnosis	SISI (37)	Good overall reliability and good convergent, divergent, and test–retest within a range of social groups.	Single item measure of identification. 'I identify with my group (or category)' followed by a 7-point scale.	A higher score indicates greater identification with their group.
Anxiety	GAD-7 (38)	Validated for use in general population and those with psychopathology. Has been used in research into both NEAD	7 items on a scale of 0-3 (not at all – nearly every day. Gives an overall score from 0-21.	A higher score indicates more anxiety symptoms.

		(39) and validated in PwE (Cronbach's alpha = 0.89) (40)		
Depression	NDDI-E (41)	Validated for use in both PwE and NEAD with good internal consistency (Cronbach's alpha = 0.87) (42)	6 items on a scale of 1-4 (never to always), rate statements such as 'everything is a struggle' or 'nothing I do is right'. Gives an overall score from 6-24.	A higher score indicates more depression symptoms.
Internalised Stigma	ISMI-9 (Internalized Stigma of Mental Illness) (Boyd et al., 2014; Hammer & Toland, M, 2017)	A short form version of a well-established scale. Chosen over ISMI-29 or 24 to reduce load on participants, and over ISMI-10 for its stronger reliability (44). The ISMI-9 has good internal consistency (alpha = .86) and correlated highly (r =.95) with ISMI-29 scores.	9 items on a scale of 1-4 (strongly disagree to strongly agree). This was adapted to read 'my diagnoses as opposed to 'mental illness'). Gives a total mean score from 1-4.	A higher score indicates a greater level of internalised stigma.
Disclosure	PaSS-24 (Paradox of Self-Stigma Scale) - Non-disclosure subscale (45)	This subscale has good reliability (alpha = 0.88) and good test-retest reliability (0.83) (45)	8 items on a scale from 1-5 (strongly disagree to strongly agree). Gives a total score from 8-40.	A higher score indicates a lower level of disclosure
Self-Esteem	RSS (Rosenberg Self-Esteem Scale) (46)	Used in both PwE and NEAD (47). High internal consistency (alpha = .88) and test–retest reliability (r = .82). (46)	10 items, rated on a scale of 0-3 from strongly disagree to strongly agree. Gives a total score from 0-30.	A higher score indicates higher self-esteem.
Self-Efficacy	GSE-10 (48)	This measure has good reliability and validity (alpha = .76 - .90) (Schwarzer & Jerusalem, 1995)	10 items from 1-4 'not at all true – exactly true'. Gives a total score from 10-40.	A higher score indicating higher self-efficacy.

Seizure Diagnosis: Participants were asked time elapsed since diagnosis and first seizure (from 6 options ranging from 3 months to 10 years), and their experience of diagnosis (on a scale of 0 (very negative) to 10 (very positive)). Verification of diagnosis was considered via screening tools that aim to differentiate between NEAD and epilepsy e.g. Anxiety, Abuse, and Somatization Questionnaire (AASQ) (49). However, this measure's length and its 'rule out' approach to NEAD diagnosis meant self-report was more appropriate. This was agreed with experts by experience (EbEs).

2.7 Procedure

Recruitment occurred online. While people were encouraged to contact the researcher for further information, no one did. The recruitment poster contained a QR code and link to a participant information sheet, consent form, and the survey. Participants could take breaks and return to the survey for up to two weeks. This was important in allowing for fatigue management, which is reported in high levels by PwNEAD (50) and was highlighted by EbEs. All participants were presented with a debrief page on completion; those who scored above clinical threshold on anxiety or depression measures were shown additional information about support.

3. Data Analysis

All assumptions, such as normality and linearity, were tested and are reported in Appendix P where these were met. Breached assumptions are reported in the main text. Data were normally distributed and did not require transformation.

Group differences: Characteristics between the two groups were examined through Chi square analyses. Fishers exact test was used where cells had expected values of 5 or less. Experience of diagnosis and identification with diagnosis were examined using Mann Whitney U tests.

Covariates: An independent samples t-test showed depression scores were significantly higher in those with NEAD than PwE. Depression was therefore controlled for in analyses.

Further correlational analyses (Appendix P) revealed anxiety and depression were significantly correlated with all outcomes and therefore were controlled for in analyses for hypothesis 2 and 3. In testing hypothesis 1, anxiety and depression were not controlled for, due to their high prevalence in a NEAD population (33). Controlling for anxiety and depression in this analysis was therefore felt to

separate out these components of lived experience, which are also inherently intertwined with the experience of stigma (70), which would remove a key element of what constitutes internalised stigma. Deciding not to control for these factors in this analysis was therefore felt to provide a more accurate representation of the lived experiences of internalised stigma in this population.

Hypothesis 1: An independent samples t-test was conducted using ISMI-9, to explore difference in levels of internalised stigma between groups.

Hypothesis 2: An independent samples t-test was conducted using the PASS-24 self-disclosure subscale to explore differences in levels of disclosure between the two groups. An ANCOVA was conducted to control for the effect of anxiety and depression.

Hypotheses 3a and 3b: A multiple regression was used to investigate whether internalised stigma predicted self-esteem . Depression and anxiety were entered as covariates , as these are known to be related to lower self-esteem (34). To determine whether internalised stigma significantly improved prediction, this was entered in step two. This was repeated with self-efficacy as the dependent variable.

The predictor variables were:

- Step 1: anxiety and depression
- Step 2: internalised stigma

4. Results

4.1 Demographics

In total, 161 people accessed the link to the information sheet and survey. Of these, 133 completed the consent form; however, 21 were removed as they did not complete dependent variable measures and 14 were removed due to comorbid seizure diagnoses. The final analyses included 98 people (PwE=47, NEAD=51). Of these, 4 did not complete all measures

(PwE=2, NEAD=2), but were included for relevant analyses. See Table 2 for demographic characteristics.

Group characteristics:

Participants were predominantly white and female. There was no association between NEAD and PwE groups in respect to gender: $\chi^2(2, N=98) = .75$, $p = .69$; age: $\chi^2(4, N=98) = .5.48$, $p = .24$; ethnicity: $\chi^2(2, N=98) = .4.23$, $p = .12$ or educational level: $\chi^2(4, N=98) = 5.24$, $p = .26$.

There was a significant association between group and time since diagnosis: $\chi^2(5, N=98) = 40.64$, $p = <.001$, with PwE reporting a longer time since diagnosis. PwE also reported a significantly longer time since first seizure: $\chi^2(5, N=98) = 34.69$, $p = <.001$.

Table 2: Frequency table of time since first seizure in PwNEAD and PwE

	NEAD (n=51)		Epilepsy (n=47)	
Time since 1st seizure	Frequency	Percent	Frequency	Percent
3-6 months	3	5.9	0	0.0
6 months – 1 year	1	2.0	0	0.0
1 – 2 years	16	31.4	3	6.4
2 – 5 years	11	21.6	2	4.3
5 – 10 years	12	23.5	9	19.1
10+ years	8	15.7	33	70.2

Table 3: Frequency table of time since diagnosis in PwNEAD and PwE

	NEAD (n=51)		Epilepsy (n=47)	
Time since diagnosis	Frequency	Percent	Frequency	Percent
3-6 months	3	5.9	1	2.1
6 months – 1 year	11	21.6	1	2.1
1 – 2 years	13	25.5	3	6.4
2 – 5 years	13	25.5	5	10.6
5 – 10 years	9	17.6	10	21.3
10+ years	2	3.9	27	57.4

Mann Whitney U test indicated PwNEAD rated their experience of diagnosis more negatively than people with epilepsy (U=754, p=.001) (Table 3).

Mann Whitney U tests indicated no significant difference in group identification between the two groups U=1107.5, p=.507 (Table 2).

Table 4: *Sociodemographic Information*

	NEAD (n=51)		Epilepsy (n=47)	
	n	%	n	%
Gender				
Male	3	5.9	4	8.5
Female	44	86.3	41	87.2
Non-binary/other	4	7.8	2	4.3
Age				
18-24	9	17.6	11	23.4
25-34	17	33.3	21	44.7
35-44	8	15.7	6	12.8
45-54	10	19.6	8	17.0
55-64	7	13.7	1	2.1
Ethnicity				
White British	50	98	44	93.6
White Irish	0	0	0	0
White Asian	1	2	0	0
Any other White background	0	0	3	6.4
Highest educational level				
Degree or equivalent	21	41.2	27	57.4
A level or equivalent	12	23.5	10	21.3
GCSE or equivalent	15	29.4	8	17
No qualification	1	2	2	4.3
Don't know/prefer not to say	2	3.9	0	0

Table 5: *Means and Standard Deviations of Diagnosis Experience and Identification*

	NEAD (n=51)		Epilepsy (n=47)	
	Mean	SD	Mean	SD
Experience of diagnosis	3.18	2.62	5.09	2.87
Identification with diagnosis	4.79	1.58	4.96	1.55

4.2 Anxiety and Depression:

People with a NEAD diagnosis reported higher levels of depression symptoms than PwE; $t(96) = -.2.27, p=.025$. The mean for both groups exceeded the clinical cut-off of 13, indicating a high level of depression symptoms.

No significant difference was found between groups on anxiety symptoms as measured using the GAD-7: $t(96) = -.313$, $p=.755$. Both group means fell in the in the 'moderate anxiety' clinical range (10-14).

Table 6. *Means and Standard Deviations of Anxiety and Depression*

	NEAD (n=51)		Epilepsy (n=47)	
	Mean	SD	Mean	SD
Depression (NDDI-E)	17.98	3.42	16.34	3.73
Anxiety (GAD-7)	11.67	6.58	11.28	5.70

4.3 Primary analysis

Research Question 1: Do people with a diagnosis of NEAD report higher levels of internalised stigma than PwE?

PwNEAD reported significantly higher levels of internalised stigma (M=2.62, SD=.54) than PwE (M=2.30, SD=.60): t(96) =-2.79, p= .006.

Research Question 2: Do PwNEAD report lower levels of disclosure of their diagnosis compared to PwE?

PwNEAD reported lower levels of disclosure of their diagnosis (M=23.89, SD=7.24) than PwE (M=28.53, SD=6.75): t(96) =-3.28, p= .001. An ANCOVA was conducted to control for the effect of anxiety and depression on disclosure. When covariates were controlled for, the effect was maintained, with PwNEAD reporting significantly lower levels of disclosure than PwE: $F(1, 94) = 8.42$, $p = .005$, partial $\eta 2 = .082$.

Research Question 3: Do people who experience high levels of internalised stigma around their seizure disorder experience lower levels of a) self-esteem and b) self-efficacy?

3a) Self-Esteem

A hierarchical multiple regression was run to determine if internalised stigma predicted self-esteem across both groups (Table 5). Model 1 (anxiety and depression) was found to be a significant predictor of self-esteem ($F(2,95) = 4.90$, $p = .009$), with an adjusted R^2 of .074 indicating that model 1 accounted for 7.4% of the variance. The addition of internalised stigma produced a statistically significant increase in R^2 (.155), $F(1,94) = 6.88$, $p = .010$. Model 2 had an adjusted R^2 of .128, indicating this model accounts for 12.8% of the variance in self-esteem, a medium-effect size according to Cohen (51). The R^2 change between models was .062. Looking at the individual contributions of anxiety and depression to model 2, neither anxiety (b =-.05, CI 95% [-.13 - .04], p= .182) nor depression (b = .03, CI 95% [-.13 - .19], p= .707) alone were significant predictors of self-esteem.

Table 7. *Hierarchical Multiple Regression Predicting Self-Esteem from Anxiety, Depression and Internalised Stigma.*

Self Esteem	*b*	*SE b*	⊿ R^2	ß	*t*	*p*
Step 1			.074			
Constant	17.51***	.97			18.07	<.001
Anxiety	-.06	.04		-.18	-1.37	.174
Depression	-.09	.07		-.16	-1.23	.220
Step 2			.128			
Constant	18.19***	.97				<.001
Anxiety	-.05	.04		-.17	-1.34	.182
Depression	.03	.08		.06	.38	.707
Internalised stigma	-1.10**	.42		-.33	-2.62	.010

Note: b = unstandardised regression coefficient; *SE b* = standard error of the coefficient; ⊿ R^2 =adjusted R^2; ß = standardised coefficient
*p<.05, **p<.01, ***p<.001

3b) Self-Efficacy

A further multiple hierarchical regression was run to examine whether internalised stigma was a significant predictor of self-efficacy (Table 6). Four participants were removed due to non-completion of this measure. Depression and anxiety were entered as covariates in step one, and internalised stigma was added in step two. Model 1 was a significant predictor of self-efficacy ($F(2,91) = 21.56$, $p < .001$), with an adjusted R^2 of .307 indicating that Model 1 accounted for 30.7% of the variance in self-efficacy. The addition of internalised stigma produced a statistically significant R^2 change of 0.29, $F(1,90) = 4.05$, $p = .047$. Model 2 had an adjusted R^2 of .329 indicating this model accounts for 32.9% of the variance in self-efficacy, a medium-effect size according to Cohen (51). Looking at individual contributions of anxiety and depression to Model 2, anxiety was a significant predictor of self-efficacy on its own (b =-.26, CI 95% [-.50- -.03], p= .027), however, depression was not (b = .38, CI 95% [-.86 - -.09], p= .111).

Table 8. *Hierarchical Multiple Regression predicting Self-Efficacy from Anxiety, Depression, and Internalised Stigma.*

Self-Efficacy	*b*	*SE b*	⊿ R^2	ß	*t*	*p*
Step 1			.307			
Constant	39.80***	2.91			13.66	<.001
Anxiety	-.28**	.12		-.27	-2.32	.023
Depression	-.63*	.21		-.25	-3.03	.003
Step 2			.329			
Constant	41.67***	3.00			13.86	<.001
Anxiety	-.26*	.12		-.26	-2.24	.027
Depression	-.38	.24		-.21	-1.61	.111
Internalised stigma	-2.50*	1.24		-.23	-2.01	.047

Note: b = unstandardised regression coefficient; *SE b* = standard error of the coefficient; ⊿ R^2 =adjusted R^2; ß = standardised coefficient
*p<.05, **p<.01, ***p<.001

5. Discussion

This study found that PwNEAD reported higher levels of internalised stigma than PwE, but lower levels of disclosure. Internalised stigma was predictive of both lower self-esteem and self-efficacy. A model with internalised stigma accounted for significantly more variance in self-esteem and self-efficacy than a model with anxiety and depression alone.

Finding higher internalised stigma in PwNEAD than in PwE is significant, since this is the first study to demonstrate this difference and is in line with research comparing other functional and organic conditions. This difference may relate to higher levels of perceived stigma in PwNEAD (52) than reported by PwE (53). Perceived stigma was not investigated in this study but may add to understanding of internalised stigma in future research. This study's findings add to the research around perceived stigma in NEAD, and suggest this is not only felt, but internalised and applied to the self, in line with Corrigan's (20) model of stigma. Finally, this reflects qualitative findings of self-blame and negative self-appraisals in people with FND in response to perceived stigma (11,54).

Time since diagnosis and potential impact on self-disclosure has not been investigated in these population or in other physical health conditions. The nuances of disclosure can make this difficult to measure (e.g. to whom and to what level). Based on research around self-disclosure in diabetes, it could be tentatively hypothesised that time since diagnosis may have an impact on disclosure of diagnoses, as motivators to disclose centred around factors which may be more likely to occur in earlier stages of diagnosis (e.g. information seeking and accessing social support (78).

When considering internalised stigma in PwNEAD, factors taken from psychological understandings and theories of the condition can provide insight into potential mechanisms. Maladaptive cognitions around seizure symptoms are positioned in models as seizure maintenance factors (71). Cognitions around the self, such as shame, inferiority and self-blame are features of internalised stigma seen in qualitative research (11). It could be considered whether the differences in

internalised stigma between the two groups is reflect seizure cognitions, and how this may differ to internalised stigma. Further research could consider how negative cognitions relate to level of internalised stigma and whether this may have a maintaining role.

No significant difference in anxiety between groups was found. However, both group means exceeded the clinical threshold, falling in the 'moderate' clinical level. Significantly higher levels of depression were found in the NEAD group than PwE, with both group means exceeding the clinical threshold. Further research may investigate whether the significant difference in depression across groups is maintained when time since diagnosis is controlled for, as depressive symptoms can decrease over time since diagnosis with a chronic health condition (55,56). This is important in ensuring appropriate support and provision post-diagnosis.

PwNEAD were reported lower levels of disclosure of their seizure condition than PwE, which was maintained when controlling for anxiety and depression. These factors were controlled for as research has found depression to be negatively related to disclosure of epilepsy diagnosis (57) and emotional disclosure (58). Higher social anxiety has also been correlated with lower disclosure (56). As this study is the first to investigate disclosure of condition in NEAD, the relationship between disclosure and internalised stigma were not explored in detail. At might be expected however, the higher the internalised stigma, the lower likelihood of disclosure. Research into barriers to disclosure of epilepsy diagnosis suggests that stigma may have a role in concealment (57), with young PwE citing concerns around others' negative perceptions, negative impact on relationships, and worry around differential treatment (23). Research into disclosure of PH conditions found illness severity and knowledge of their illness to decide whether to disclose (59). It may be hypothesised that knowledge of illness may be lower in functional than organic conditions (68). These factors

were not measured in the present study but could be in future research. Further research should examine the relationship between internalised stigma and disclosure of condition in greater depth.

Time elapsed since diagnosis and first seizure were significantly longer in PwE. This may have impacted on level of internalised stigma, as perceived stigma has been found to decrease over time since diagnosis in PwE (70). In this study, time since diagnosis/seizure onset was measured as categorical data of uneven increments, and so could not be controlled for. Future studies should use interval data to allow for analyses controlling this variable to explore whether effects are maintained.

Using the final element of Watson's (25) model higher internalised stigma predicted lower self-esteem and self-efficacy. Internalised stigma was a significant predictor above anxiety and depression, which are known to impact self-esteem (60) and self-efficacy (61). This matches findings that suggest stigma in PwE is related to poor self-esteem (62). The variance accounted for by internalised stigma in self-esteem and self-efficacy differed, accounting for 12.8% and 32.9% respectively. When thinking about self-esteem in a NEAD population, the prevalence of adverse life events and trauma (65) is an important consideration. As trauma experienced in childhood is known to be associated with lower self-esteem in adulthood (77), this may be another mechanism underlying the finding of lower self-esteem in PwNEAD.

In extending Watson's model, it may help to examine potential mediators for each and include the part of the model not addressed by this paper: the relationship between these factors with group identification.

A minimum of 3-months post diagnosis was set as an inclusion criterion, as the newly diagnosed may lack opportunities to disclose to others. This study found a significant association between group and time since diagnosis, with PwE more likely to have been

diagnosed for longer than PwNEAD. This may have impacted findings around stigma and disclosure, as qualitative research has demonstrated a 'journey' over time to epilepsy diagnosis, from 'shame and stigma' to being 'open and comfortable' (62). It could be hypothesised that people more recently diagnosed had not progressed as far in this 'journey'.

Based on qualitative research findings around experiences of stigma from healthcare professionals in FND, experience of diagnosis was considered important to measure. PwNEAD rated their experience of diagnosis as significantly more negative than PwE, mirroring qualitative research (11,54). The difference in time elapsed since diagnosis may also be a confounding factor. Further research could examine the relationship between experience of diagnosis and internalised stigma, since understanding what makes an experience more positive or negative could have important implications for practice.

5.1 Clinical implications

Elevated levels of internalised stigma in PwNEAD indicates clinicians should understand that people may experience shame or other negative cognitions around their condition. It is a crucial element of formulation and presents a target of intervention in therapeutic work. PwNEAD reported lower disclosure of their condition than PwE, which may be a barrier to healthcare and social support and should be considered in service planning and access. Addition targets of intervention should consider that internalised stigma is predictive of lower self-esteem and self-efficacy. Finally, the high levels of anxiety and depression in both groups suggest psychological support is required within both FND and epilepsy multidisciplinary teams.

5.2 Limitations

Participants in this study were predominantly white and female, reducing the findings' generalisability. The means of recruitment is another limitation of this study. Since group

identification has been associated with participation in social support groups (63), recruiting from online groups may have selected for people who identify with their diagnosis and impacted on the level of stigma found. There was no significant difference in group identification between the groups, although this was a single item measure that may not have captured nuance. Further research recruiting from NHS services could provide greater context.

Consideration of questionnaire burden meant certain constructs were not measured in this study. As seizure severity and frequency has been correlated with perceived stigma in epilepsy (64), this could have been controlled for. Measuring these factors would have helped consider the impact of different presentations on internalised stigma and could be hypothesised to impact disclosure. Measuring trauma would have strengthened the study given the higher incidence of early traumatic experiences found in PwNEAD compared to PwE (65). As self-esteem has been found to have a mediating role between childhood trauma and adult MH (66), this may have impacted findings, and should be considered in future research.

5.3 Future Directions

Further research might consider the experience of stigma in PwE and NEAD across cultures. Culturally specific experiences of stigma have been identified in epilepsy, highlighting differences in individual experiences of stigma (24). African and Caribbean Americans with epilepsy have reported high prevalence of anxiety disorders (67), and research suggests levels of epilepsy stigma in Black African immigrants may be exacerbated by a continuation of beliefs from their country of origin (69). Research should consider the impact of 'double stigma' or intersectionality, e.g. having a health condition and coming from a minoritised group. While this has been performed in epilepsy research (69), it is lacking from research into NEAD.

Further longitudinal and experimental research into internalised stigma, disclosure, self-esteem, and self-efficacy is required to establish the directions of this study's findings. It would be beneficial to apply the final element of this model – group identification – and explore whether this is protective against internalised stigma and how it is associated with disclosure.

6. Conclusions

This study found higher internalised stigma in PwNEAD than PwE, but lower reported disclosure of their condition. Internalised stigma was a significant predictor of self-esteem and self-efficacy, above the contribution of anxiety and depression. PwNEAD reported higher levels of depression symptoms than PwE, although both groups exceeded clinical thresholds for anxiety and depression. These findings provide important targets for intervention in therapeutic work with PwNEAD, including work around internalised stigma, low self-esteem, and self-efficacy, and negative cognitions around diagnosis. Furthermore, lower disclosure of condition suggests a potential barrier to social support and healthcare access, which should be considered in service planning. As this study is cross-sectional, future research should pursue experimental and longitudinal approaches to determine the relationship between internalised stigma, disclosure, self-esteem, and self-efficacy.

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Executive Summary

Word count: 883

Why was the study conducted?

The study aimed to explore the existence of internalised stigma experienced by people with non-epileptic attack disorder (NEAD) and people with epilepsy (PwE). Internalised stigma describes when people support negative societal attitudes and beliefs about a condition that they possess. NEAD is a subtype of Functional Neurological Disorder characterised by seizures which occur in the absence of any abnormal electrical activity in the brain. The experience of stigma in people with NEAD has been well established, however internalised stigma has not been extensively researched. Internalised stigma is an important area for research, as it can negatively impact many aspects of life, from health outcomes to quality of life. Understanding internalised stigma in NEAD is particularly important given its functional nature, which can lead to stigmatising experiences from healthcare professionals as well as from society more broadly.

The study also investigated self-disclosure of their seizure condition, as well as self-esteem and self-efficacy. Self-esteem refers to someone's overall sense of self-worth, while self-efficacy refers to someone's confidence in their abilities to carry out the behaviours required to achieve a goal. These factors were included in the project as theories and research suggest they are impacted by internalised stigma. Watson's theoretical model of 'self-stigma' was used to inform predictions about results, and as a framework for understanding how the factors measured may interact with one another.

What was done?

This study used online platforms to deliver a questionnaire to people recruited on social media. Participants had to be UK residents over 18, self-report a diagnosis of epilepsy or

NEAD and have been diagnosed for at least 3 months. The survey was made up of questions around individual characteristics followed by seven measures which assessed internalised stigma (using ISMI-9), self-disclosure (using disclosure subscale from the PaSS-24), self-esteem (Rosenberg Self-Esteem Scale), self-efficacy (General Self-Efficacy Scale), anxiety (GAD-7), and depression (NDDI-E). People with lived experience of NEAD were consulted on recruitment materials and the questionnaire. 98 participants (51 with NEAD and 47 with epilepsy) were included in the analysis.

We found that anxiety and depression were correlated with the constructs we were measuring and so when conducting analyses, the impact of these was accounted for. To explore the differences between internalised stigma and disclosure across people with NEAD and PwE, t-tests were run, followed by an ANCOVA to control for anxiety and depression.

To explore whether internalised stigma predicted self-esteem and self-efficacy hierarchical multiple regression analyses were conducted. This allowed researchers to see if internalised stigma remained a significant predictor of self-esteem and self-efficacy after accounting for the effects of anxiety and depression.

What was found?

The 98 participants who took part were predominantly white (96%) and female (87%). The group of people with NEAD did not differ significantly from the group of PwE in respect to gender, age, ethnicity, or educational level. There was, however, a significant association between group and time since diagnosis, with people with epilepsy reporting a longer time since diagnosis and longer since their first seizure compared to those with NEAD. People with NEAD also rated their experience of the journey to diagnosis as more negative than PwE.

We found that people with NEAD reported significantly higher levels of internalised stigma than PwE, as well as significantly lower levels of self-disclosure of their condition. The

difference in disclosure was still found after controlling for anxiety and depression. Higher levels of internalised stigma significantly predicted both lower self-esteem and lower self-efficacy. Including internalised stigma in prediction models was a significantly better predictor of both, than when anxiety and depression were used as predictors alone.

We also found that people with NEAD reported significantly higher levels of depression than PwE, although mean levels were higher than the clinical threshold in both groups. There was no significant difference in anxiety symptoms between the groups, but again both group means were high, and fell in the 'moderate' clinical range.

What does this mean?

These findings are in line with what we predicted that we would find and are supported by existing literature, especially qualitative findings around self-blame and negative judgements about themselves in people with FND. Disclosure of condition was found to be lower in people with NEAD than PwE. This is an interesting finding, as both are seizure conditions it may be that the cause of the seizures (e.g. functional or organic) and what this means to people impacts how able they feel to share their condition with others. This may be through the mechanism of internalised stigma, but more research is needed to test out whether this is the case.

The finding that internalised stigma is predictive of lower self-esteem and self-efficacy is also important as these factors can have important implications for help seeking, treatment outcomes, quality of life and mental health. They therefore present important targets for clinicians to consider in intervention with people with high internalised stigma. The high levels of anxiety and depression symptoms reported by both groups also suggest these should be thought about in formulation and treatment, as these may increase the impact of internalised stigma and further impair quality of life. The high levels of anxiety and depression also suggest

the importance of providing psychological support within multidisciplinary teams for both NEAD and epilepsy so that people can access help if they need it.

Reflective Narrative

Word count: 994

My relationship to research and my projects

As I had little research experience prior to this course, I was apprehensive about the research requirements of the doctorate and sought support from more involved supervisors. Thankfully, from the course's outset I was encouraged to think broadly about my areas of interest by colleagues and supervisors. During the process of preparing projects for Project Approval Sessions (PAS), I grew confident in determining my own direction of research, in finding answers to my questions independently, and in presenting my research clearly.

For each project, I developed multiple ideas and refined these into feasible projects. This process led to several 'dead ends'. For example, while I intended to complete my SRL on climate change and mental health, I realised there was not sufficient literature to complete this. I also developed a TDRP PAS proposal before recognising challenges around project feasibility and what is possible in the timeframe available. Following these realisations, I moved toward choosing projects which were of interest but also attainable and of appropriate scale for a DClinPsych.

Service Improvement Project (SIP)

The first project I developed and completed was my SIP. As this project was proposed by the service, it provided structure and clear expectations when undertaking my first project. The process of carrying out a project in a team I was not based in brought both benefits and challenges. MDT staff spoke about it being helpful to speak to someone not directly affiliated with the service, which led me to think ahead to the barriers that might occur when

completing my consultancy project in a service I was based in. The challenges of navigating unfamiliar databases, patient record systems and contacting teams I did not know were barriers which I didn't encounter in my consultancy project, however. This project was also the first time that I had been able to benefit from the input of people with lived experience (EbEs). This was key in the development and shaping of the project and resources. This became central to my understanding of the need for EbE involvement in research.

Systematic Review of the Literature (SRL)

My SRL was the next project I developed. Following searches into climate change, I turned to another enduring interest, the experiences of people from sexual and gender minority groups. There was a large amount of recent research in this area, and the questions were refined until became feasible. I was keen to focus on qualitative research and experiences, as I was not able to include this in my TDRP and wanted to ensure I developed both skillsets. I found this project to be emotive and found 'submersion' in the literature to be quite an overwhelming experience at times, as men's narratives reflected on times of great pain and injustice. The presence of quotes centred men's voices and contributed to its emotive nature, something which drew me to using qualitative papers. I drew on a lot of skills from others in this process, finding the librarians to be invaluable in refining search terms and a great source of learning. Since completing this project, I have gained confidence in appraising and synthesising findings of papers.

Theory Driven Research Project (TDRP)

My TDRP was the last project to come together as my original project (in mental imagery and self-harming behaviour) became impractical in terms of scale and ethics. In developing a new

idea, I returned to what I had seen as a need in services. I had been in neuropsychology settings prior to training and had seen that people with FND seemed to fall between neurology, psychology, and psychiatry, with no dedicated service. On reading into stigma around FND I realised there was very little on internalised stigma and its impact in this population and identified a gap in the research. I found this project to be the most challenging, in part, because it was the only original quantitative piece of research I had conducted and so was full of firsts. The analysis and statistics and provided a steep learning curve, but one that I was able to navigate and eventually feel confident in. Recruitment was a real challenge and took more time than I had originally accounted for. In hindsight, applying for NHS ethics would have been helpful rather than relying on social media.

General reflections

I found balancing three projects to be difficult when all three ran concurrently, but once one was complete, I found I enjoyed being able to swap between two, from one topic to another, helped me to remain focussed and engaged in my work. There was more overlap between projects than I expected, and I was able to apply the skills learned during one to another. Balancing projects with demanding placements and other course requirements presented more of a challenge, but manageable and frequent to-do lists helped with this.

Although I initially thought that these would be three very different projects, as they progressed it became evident that they are connected by the theme of stigma. In my SIP, stigma and misunderstandings around the role of psychology acted as a barrier to both patients and staff accessing the psychology team. In my TDRP stigma was internalised and was associated with lower self-esteem and self-efficacy. In my SRL stigma was a key theme which emerged in the experience of suicide in queer men. These experiences of stigma spanned staff

teams, seizure conditions, and people of minoritized identities. Perceived and felt stigma were experienced as well as internalised stigma (in TDRP and SRL). Research into stigma is in line with my interests in equality and inclusivity and a consideration of the impact on people when this has not been the case. I aim to continue research in this area after training.

Completing these projects has also provided me with an appreciation of the value and application of research. I feel that research is key in good psychological practice, and I feel not only more prepared to complete my own, but to apply a more critical eye on the research of others.

Acknowledgements

I would firstly like to acknowledge all those who took part in my research. Without your time and contributions there would have been no findings, so enormous thanks go to you. Thank you also to all those charities and individuals who shared recruitment posters in response to my increasingly desperate pleas.

Acknowledgements also go to my research supervisors for your support and advice. I was fortunate to have five course staff supervise me, and I was able to learn so much from each of you. Particular thanks to Dr Liz Pounds-Cornish for being my only external, and for being such a supportive and present supervisor. You made the prospect of research much less daunting.

Thanks also to other course staff, to my tutor Dr Victoria Roberts and to the eight amazing placement supervisors who have reminded me of the clinical applications of this research and given flexibility with placement/research overlap. It has made a big difference in being able to keep all those plates spinning.

I was very fortunate to be in an incredible and inspiring cohort of people. The last three years really feel like a team effort. Special thanks to Jess, Rachel, Ray, and the 'Crafts' club. Your sharing of knowledge, support, distractions, and laughter have made it not only survivable but enjoyable too. My life vastly improved with having you all in it. To Tiago, you know how invaluable you are in so many ways; thank you.

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To Patrick, who cooked for me often, lifted the load and provided unending support and laughter to get me through. And to my cat Otis, to whom therapy work does not come naturally but stepped into the role as needed.

A final thanks to my parents, Rosemary and Michael. For helping me get through the many *many* years of exams and degrees to get to this submission, for encouraging me all the way through. I hope one day to be the great Clinical Psychologist that you both believe me to be.

Appendices

SRL Appendices

Appendix A: Author Guidelines for Journal of Gay and Lesbian Mental Health

Preparing Your Paper
All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).
Structure
Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).
Word Limits
Please include a word count for your paper.
A typical paper for this journal should be no more than 10,000 words
Format-free Submission
Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), PDF, or LaTeX files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, and references. Further details may be requested upon acceptance.

References can be in any style or format, so long as a consistent scholarly citation format is applied. For manuscripts submitted in LaTeX format a .bib reference file must be included. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
Spelling can be US or UK English so long as usage is consistent.
Note that, regardless of the file format of the original submission, an editable version of the article must be supplied at the revision stage.

Checklist: What to Include
Author details. Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. Please ensure all listed authors meet the Taylor & Francis authorship criteria. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or

LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
Should contain a structured abstract of 100 words.
Your structured abstract should contain the following four headings: introduction, method, result, and conclusion.
Read tips on writing your abstract.
You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
Between 3 and 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:
For single agency grants: This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants: This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
Disclosure statement. This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. Further guidance on what is a conflict of interest and how to disclose it.

Data availability statement. Authors are required to provide a data availability statement, detailing where data associated with a paper can be found and how it can be accessed. If data cannot be made open, authors should state why in the data availability statement. The DAS should include the hyperlink, DOI or other persistent identifier associated with the data set(s), or information on how the data can be requested from the authors. Templates are also available to support authors.

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

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

Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file

formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.

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

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

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

Using Third-Party Material

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

Disclosure Statement

Please include a disclosure statement, using the subheading "Disclosure of interest." If you have no interests to declare, please state this (suggested wording: *The authors report there are no competing interests to declare*). For all NIH/Welcome-funded papers, the grant number(s) must be included in the declaration of interest statement. Read more on declaring conflicts of interest.

Appendix B: Definition of Terms

Sexuality

Cisgender: a person whose personal identity and gender corresponds with sex assigned at birth

Queer: an umbrella term describing individuals who are not heterosexual or cisgender. Used as a slur in the past this has been reclaimed by members of the LGBTQ+ community.

Gay / homosexual: sexual and/or romantic attraction to someone of the same sex. Typically used to describe male-male relationships.

Bisexual: sexual/romantic attraction to both men and women, or to more than one gender.

Asexual: someone who does not experience sexual feelings or desires to people of any gender

Pansexual: sexual/romantic attraction to individuals of all gender identities.

Men who have sex with men (MSM): a term used to describe men who engage in sexual activity with men, regardless of how they self-identify. Initially used in public health discussion and research to avoid excluding men who do not identify as gay or bisexual.

Demisexual: someone who develops a sexual attraction once a close emotional connection has been formed. They may also identify as gay, bi, straight, or any other sexual orientation.

Gender

Transgender: a person whose personal identify and gender does not correspond with their sex assigned at birth

- **Trans men/man**: a transgender person who has transitioned from female to male.
- **FtM**: an acronym denoting 'female to male' transition

Gender non-conforming: a person whose behaviour or appearance doesn't conform to the social/cultural expectations of their gender.

Bigender: someone whose sense of personal identity encompasses two genders

Agender: someone who does not identify as having a particular gender.

Two-Spirit: originally used by indigenous communities such as American Indian and First Nations cultures to describe someone who identifies as having both a masculine and feminine spirit.

Gender-fluid: someone who does not identify themselves as having a fixed gender

Demiboy: someone who may not completely or fully identify with being a boy or man, but feels masculinity reflects some aspects of their identity.

Suicide (definitions taken from (Zortea et al., 2020)

Suicide: intentional fatal self-harmful act undertaken with at least some intent to die.

Attempted suicide: intentional nonfatal self-harmful act undertaken with at least some intent to die.

Suicidal thoughts/ideation: thoughts, considerations, or contemplation of suicide or of killing oneself or ending one's life, which may include the wish or desire to end one's life and may include a suicide plan and/or preparations.

Appendix C: Search Terms

Advice was gained from Bodleian librarian to narrow concept 1, as original searches gave 7500 results, of which many did not capture the concepts examined. Strategies were adapted according to each database (example given below)

Strategy (Scopus)

1. Sexual/gender identity
   - Gay OR homosexual OR GBQ* OR bisexual* W/3 m?n OR queer OR queer* W/3 m?n OR asexual W/3 m?n OR pansexual W/3 m?n OR "gay male*" OR "sexual minority" W/3 m?n OR "men who have sex with men" OR FtM OR transgender W/3 m?n OR transexual W/3 m?n OR "female to male" OR MSM OR "gender non-conform*" W/3 m?n OR "gender minority" W/3 m?n OR "gender variant" W/3 m?n OR "gender queer" W/3 m?n OR "gender diverse" W/3 m?n OR bigender OR agender OR "two spirit" OR "2 spirit" OR "two spirit" OR "gender fluid" OR "gender neutral" OR LGBT* W/3 m?n OR trans* W/3 m?n OR bi W/3 m?n OR "sexual minorit*" W/3 m?n

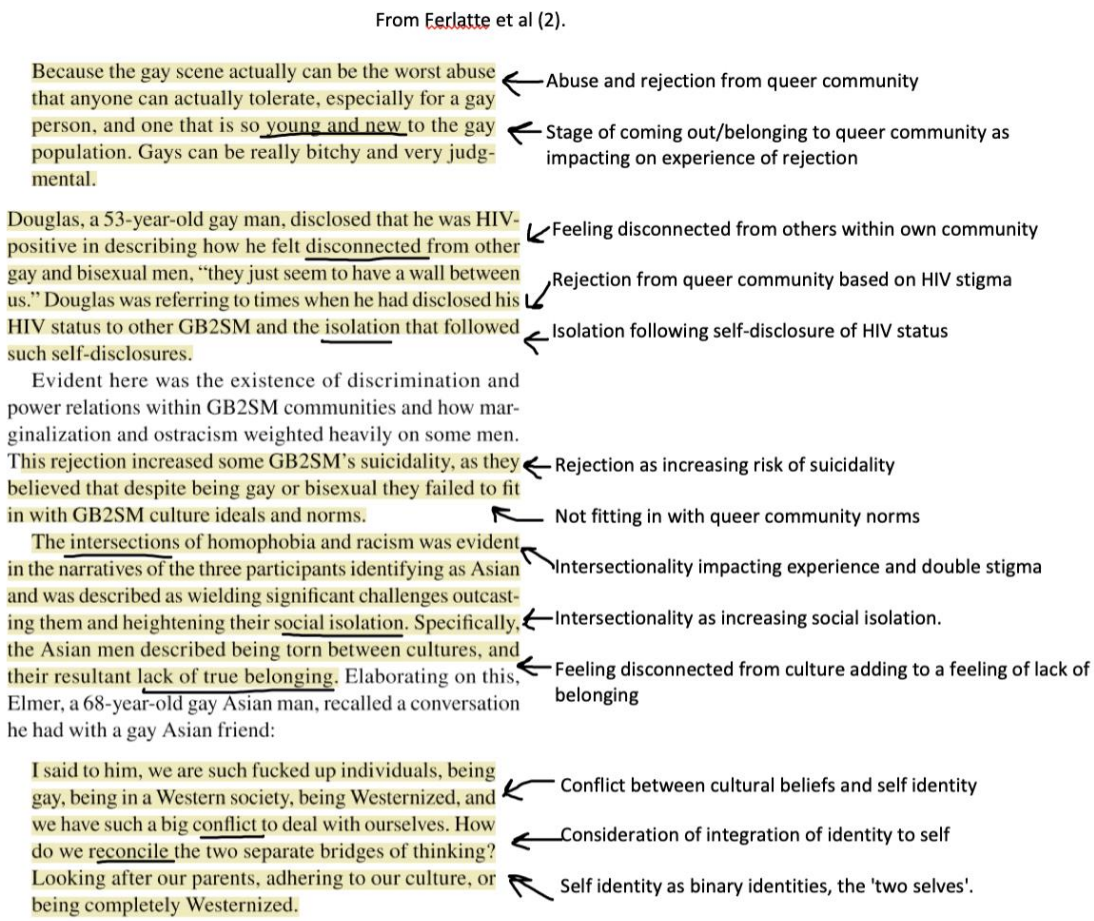
2. Men
   - Male OR masculinity OR men OR "trans men" OR "trans man"

3. Suicide
   - Suicid* OR "suicide ideation" OR "suicidal ideation" OR suicidal OR "suicide plan" OR "suicidal overdose" OR "intentional overdose" OR "suicidal thought*" OR "suicide attempt*"

4. Qualitative
   - Qualitativ* OR "action research" OR "case study" OR "content analysis" OR "Discourse analysis" OR Ethnograph* OR "Focus group" OR "Grounded theory" OR Interview OR Narrative OR Observational OR Phenomenolog* OR fieldwork OR "field work"

Strategy: 1 AND 2 AND 3 AND 4

Appendix D: Excerpts from initial code book and theming to demonstrate audit trail.
NVivo was used for initial coding.



Example:
Codes from Theme 2 – Experiences of rejection and isolation.

ABUSE/REJECTION/NON-BELONGING TO QUEER COMMUNITY
abuse and rejection from queer community
biphobia and feeling of not fitting in to either community.
fear of rejection from queer community
feeling lack of belonging to queer community
Rejection from queer community based on HIV stigma
rejection from queer peers as especially painful
status within the queer community changing with HIV diagnosis

EXPERIENCE OF REJECTION FROM FAMILY/FRIENDS/LOVED ONES
blaming self for difficulties in family relationships
romantic break-up as trigger
centrality of family to individual experience of rejection
confrontation with family as trigger for suicide

Disapproval from family and friends
embarrassed by parent rejection
experience of rejection from family as intensely painful
Desire for paternal approval
Others' responses to coming out as trigger for suicide attempt
rejection from family due to sexuality
rejection from admired person as trigger for suicide
sense of unacceptability of sexuality coming from parents

LACK OF BELONGING TO WIDER COMMUNITY
difficulty in relating to others
feeling a lack of belonging
feeling 'othered'
feeling like 'the odd one out'

SOCIAL ISOLATION
feeling misunderstood and alone
feeling no one would miss me
loneliness and isolation
inability to establish meaningful relationships
insecurity leading to further isolation
isolation as key factor in suicidality
isolation felt to be preferable to disclosing HIV status
lack of social and emotional support from others
not feeling heard or supported
marriage as a means of seeking connection and minimising isolation
stigma around mental health as isolating

SELF ISOLATION
withdrawing from family and friends.
withdrawing as warning sign for suicide
self-isolation as a means of coping with HIV status
self-isolation to feel more secure.

These 5 headings (abuse/rejection/non-belonging to queer community; experiences of rejection from friends/family/loved ones; lack of belonging to wider community, social isolation and self isolation) were grouped as they were felt to be linked by the overarching theme of EXPEREINCES OF REJECTION AND ISOLATION (theme 2). The 5 originally identified subthemes became grouped into three; 2a) rejection and loss of support systems (which consisted of the subthemes experiences of rejection from friends/family/loved ones; lack of belonging to wider community); 2b) rejection and non-belonging within the queer community (which consisted of the subtheme abuse/rejection/non-belonging to queer community) and 2c) 'outsiderness' and self-isolation (which consisted of the subthemes social isolation and self isolation).

Appendix E: The QualSyst quality assessment tool
(Kmet et al., 2004)

Criteria		YES (2)	PARTIAL (1)	NO (0)
1	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			
6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verification procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

SIP Appendices

Appendix F: Author Guidelines for British Journal of Health Psychology

1. SUBMISSION

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

New submissions should be made via the Research Exchange submission portal. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

All papers published in the *British Journal of Health Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The British Journal of Health Psychology publishes original research on all aspects of psychology related to health, health-related behaviour and illness across the lifespan including:

- experimental and clinical research on aetiology
- management of acute and chronic illness

  responses to ill-health

- health-related behaviour changes and maintenance
- screening and medical procedures
- psychosocial mediators and moderators of health-related behaviours
- influence of emotion on health and health-related behaviours
- psychosocial processes relevant to disease outcomes
- psychological interventions in health and disease
- emotional and behavioural responses to ill health, screening and medical procedures
- psychological aspects of prevention

Papers must make a clear potential contribution to health psychology theory, knowledge and/or practice and employ rigorous research design and methodology..

We do not typically publish cross-sectional studies or those using only student populations unless there is a strong rationale for doing so.

Papers describing intervention development (without also presenting an analysis of the outcomes of the intervention) will usually only be considered if they make a contribution to health psychology theory, knowledge and/or practice beyond the specific intervention context.

3. MANUSCRIPT CATEGORIES

The types of paper invited are:

- papers reporting original empirical investigations, using quantitative, qualitative or mixed methods.
- theoretical papers which report analyses of theories in health psychology.
- review papers, which should provide systematic overviews, evaluations and interpretations of research in a given field of health psychology (narrative reviews will only be considered for editorials or important theoretical discourses).
- methodological papers dealing with methodological issues of particular relevance to health psychology.
- we particularly welcome papers reporting effectiveness (for example, Randomised Controlled Trials) and process evaluations of interventions in clinical and non-clinical populations.

Authors who are interested in submitting papers that do not fit into these categories are advised to contact the editors who would be very happy to discuss the potential submission.

Papers describing quantitative research (including reviews with quantitative analyses) should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative or mixed methods research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

Please refer to the separate guidelines for Registered Reports.

4. PREPARING THE SUBMISSION

Open Research initiatives.

Recognizing the importance of research transparency and data sharing to cumulative research, *British Journal of Health Psychology* encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. British Journal of Health Psychology encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (http://www.re3data.org). Personal websites and most departmental websites do not qualify as repositories.

Free Format Submission

British Journal of Health Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author

details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at https://wiley.atyponrex.com/journal/BJHP and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; statement of contribution; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips).
- A short running title of less than 40 characters.
- The full names of the authors.
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted.
- Abstract.
- Keywords.
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. As the abstract is often the most widely visible part of your paper, it is important that it conveys succinctly all the most important features of your study. You can save words by writing short, direct sentences. Helpful hints about writing the conclusions to abstracts can be found here.

Keywords

Please provide appropriate keywords.

Acknowledgements

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

Statement of Contribution

All authors are required to provide a clear summary of 'what is already known on this subject?' and 'what does this study add?'. Authors should identify existing research knowledge relating to the specific research question and give a summary of the new knowledge added by your study. Under each of these headings, please provide 2-3 (maximum) clear outcome statements (not process statements of what the paper does); the statements for 'what does this study add?' should be presented as bullet points of no more than 100 characters each.

Main Text File

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

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.

- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (intro/methods/results/conclusion);
- Up to seven keywords;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below)
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- The main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, we encourage authors to consult Wiley's best practice tips on Writing for Search Engine Optimization.

Article Preparation Support: Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

The Journal receives a large volume of papers to review each year, and in order to make the process as efficient as possible for authors and editors alike, all papers are initially examined by the Editors to ascertain whether the article is suitable for full peer review. In order to qualify for full review, papers must meet the following criteria:

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- the methods and/or sample size are appropriate for the questions being addressed
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Appendix G: Staff Questionnaire

Question	Answer Options
1. How long have you been working at NSIC?	• Less than 6 months • 6 months – 1 year • 1 year – 5 years • 5 years +
2. What discipline do you work in?	• Occupational Therapy • Health Care Assistant • Physiotherapy • Nurse • Medical Team (e.g. consultant, neurologist, junior doctor) • Dietician • Speech and Language Therapy • Pharmacist • Patient Education • I would prefer not to say • Other – please state (text box)
3. As an estimate, how many referrals have you made to the psychology team in the last 12 months?	• None • 1-2 • 2-4 • 6-8 • 10 or more
4. How often do you work jointly with the psychology team?	• I am not sure if the patients I work with are seeing psychology • I work with the same patients as psychology but not jointly • Never • Rarely • Not often • Quite often • Very often
5. How easy is it to access the psychology team for patient discussion/ consultation (helping staff to understand how to support a patient)?	• Very easy • Quite easy • Fairly easy • Not easy • I don't know, I haven't tried to access for client discussion or consultation
6. What do you think psychologists do for *patients* at the NSIC? Please tick all that apply	• Provide emotional support • Provide cognitive assessments • Work with adjustment and acceptance with spinal cord injury

	• Work with those with pre-existing mental ill health • Work with people who are having suicidal thoughts • Work with people who are displaying challenging behaviour • Work with managing pain • Work with families of people with spinal cord injury • Set goals • Provide a point of contact • I don't know • Other (text box)
7. What do you think psychologists do for ***staff*** at the NSIC? Please tick all that apply	• Provide consultation about patients (helping staff to understand how to support a patient) • Provide support to manage patients • Provide emotional support for staff • Provide training and education • Provide a point of contact • I don't know • Other – please describe (text box)
8. Which of the following did you receive to help guide your understanding of the role of psychology? Please tick all that apply	• Information when starting as a new member of staff at NSIC about the psychology service • Training and education in a group e.g. as a CPD (continuing professional development) session. • Training and education 1:1 session with a member of the psychology team • Informal discussion with the psychology team • Information from another staff member (outside of psychology) • Information from a patient • Information from a goal planning meeting • I didn't receive any input • Other (text box)
9. On a scale of 0-10 where 10 is 'very confident' and 0 is 'not at all confident', how confident do you feel in your understanding of the role of psychology within NSIC? (please drag the bar with your mouse below)	0-10 sliding scale

10. On a scale of 0-10 where 10 is 'very confident' and 0 is 'not at all confident', how confident do you feel in explaining the role of psychology to patients? (please drag the bar with your mouse below)	0-10 sliding scale
11. What might prevent you from making a referral to psychology? Please tick all that apply	• Long waiting lists • Not sure if the referral is appropriate • I am too busy to make a referral • Not sure how to refer • I don't feel there are any barriers • Patient declines a referral (concerns around stigma, lack of understanding, confidentiality…) • Other (text box)
12. How has your experience with making referrals to the psychology team been in the past?	• Very negative experience • Negative experience • Neutral experience • Good experience • Very good experience • Excellent experience • I have never made a referral to psychology
13. What are your reasons for your answer to the previous question? Please give quick comment or sentence	Free text box
14. What do you feel is the most important area that the psychology service could improve on / develop at the moment?	• 1:1 therapy sessions • Group work • Staff consultation (helping staff to understand how to support a patient) • Education and training • Promoting the service / getting to know who they are and what they do • Other (text box)
15. For me, the most important contribution that the psychology service makes at the NSIC is…	• Supporting inpatients • Supporting families • Supporting staff • Providing leadership and management • Doing audits and research • Providing patients and families with support, to improve outcomes beyond NSIC (setting up for the future) • Making referrals to community services (social support, mental health support etc,)

	• Facilitating peer support • Leading and managing the goal planning service • Other (text box)
16. If you are happy to be contacted to take part in a focus group to discuss psychology referrals further, please enter your email below. Thank you	Free text box

Appendix H: Focus Group Questions

Focus Group questions for staff and psychology team: clear that this is about referrals for inpatients. It Is recognised that psychology work with outpatients is an unmet need.

1a) What resources would be helpful in guiding staff understanding of the psychology team's role?
1b) A barrier to referral that was flagged in the questionnaire was patients declining a referral. What resources would you like to have when helping patients to make an informed decision?

2. What would make it easier to refer to the psychology team?

3. When we're aiming for a 'good referral process', it is helpful if we can define what that would look like. So, what would a good experience of referring look like?

4. The questionnaire identified that consultation is not currently used as much as it could be. Why do you think this is, and what could we put in place to overcome it?

5. When asked about where people had gained an understanding of the psychology team and what they do, people shared that 'informal discussion' with the team was an important method. What would this look like and how could these opportunities be made more accessible and frequent?

6. Of everything discussed today, what do you feel is the most important thing to take forward in removing barriers to MDT staff accessing the psychology team (through referrals, consultation etc).

Appendix I: Lay Summary

This project is based in the National Spinal Injuries Service and looked at how staff made referrals to the psychology team. There are 'gold standard' guidelines that recommend all new patients have a specialist psychological assessment within 10 days of admission, however the psychology team have limited staff, time and money and so aren't able to assess everyone. Although the team cannot meet the 'gold standard', they are keen to improve the current process to make it work as well as possible for both staff and patients.

The project aims were to understand who is currently being referred to psychology; how staff view and understand the team; to explore the barriers staff experience in accessing the team and finally to give recommendations to reduce these barriers.

The study had 4 phases:

1. An audit
2. A questionnaire to all staff (except psychology)
3. 2 focus groups (1 psychology team only, 1 other team members)
4. Recommendations and feedback

The findings from the audit showed that the people referred to psychology were more likely to have a complete spinal cord injury and have higher levels of anxiety and depression. There were no differences in age, gender, ethnicity or civil status found between the groups of those referred and those not referred.

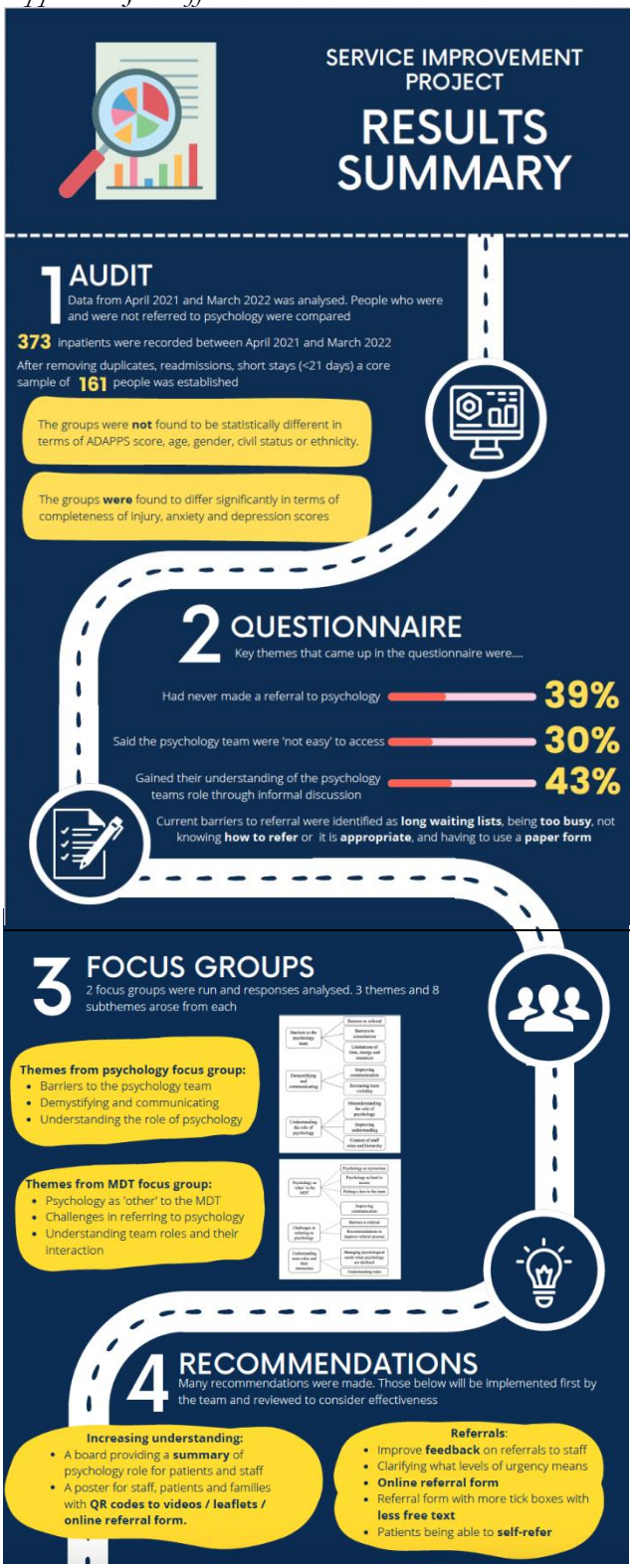
The questionnaire found that 39% of staff had never made a referral to psychology. 30% said the psychology team were 'not easy' to access. Barriers to making referrals were identified as long waiting lists, being too busy, not knowing how to refer or whether a referral is appropriate and having to use a paper form. 43% of staff said they developed their understanding of the psychology team through informal discussion.

Thematic analysis was used to examine the findings from the focus groups. The psychology group themes were around barriers to the team, demystifying the role of psychology and improving communication and improving understanding of the role of psychology. Similar themes came up in the staff group, with psychology being seen as separate or 'other' to the other staff members, identifying challenges in referring to psychology and understanding roles and how they interact with each other.

The recommendations were based on improving understanding and improving referral pathway.

- To improve understanding it was suggested that there be a board providing a summary of the psychology tole for patients and staff, with a poster with QR codes and links to videos, leaflets and an online referral form.
- To improve referrals, it was suggested that feedback to staff be improved, that levels of urgency be made clearer, that an online referral form is used which uses more tick boxes and less free text. Patients should also be able to use this to self-refer.

Appendix J: Staff Feedback Poster



TDRP Appendices:

Appendix K: Author Guidelines for Journal of Epilepsy and Behaviour

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[1] Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific article. J Sci Commun 2010;163:51–9. https://doi.org/10.1016/j.Sc.2010.00372.

Reference to a journal publication with an article number:

[2] Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific article. Heliyon. 2018;19:e00205. https://doi.org/10.1016/j.heliyon.2018.e00205

Reference to a book:

[3] Strunk Jr W, White EB. The elements of style. 4th ed. New York: Longman; 2000.

Reference to a chapter in an edited book:

[4] Mettam GR, Adams LB. How to prepare an electronic version of your article. In: Jones BS, Smith RZ, editors. Introduction to the electronic age, New York: E-Publishing Inc; 2009, p. 281–304.

Reference to a website:

[5] Cancer Research UK. Cancer statistics reports for the UK, http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/; 2003 [accessed 13 March 2003].

Journal abbreviations source

Journal names should be abbreviated according to the List of Title Word Abbreviations.

Supplementary material
Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files as these will appear in the published version.

Research data
This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings, which may also include software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking
If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

Research Elements
This journal enables you to publish research objects related to your original research – such as data, methods, protocols, software and hardware – as an additional paper in a Research Elements journal.

Data statement
To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

Appendix L: PPI Recruitment Poster

Oxford Institute of Clinical Psychology Training and Research
Emily.Townsend@hmc.ox.ac.uk

UNIVERSITY OF OXFORD

LOOKING FOR PEOPLE WITH EXPERIENCE OF FUCNTIONAL SEIZURES TO HELP SHAPE RESEARCH



WHAT ARE WE RESEARCHING?

We are looking at levels of internalised stigma in people with epileptic and non-epileptic seizure disorders, and the impact on self-esteem and self-efficacy.

WHAT WOULD I BE ASKED TO DO?

We would like people with lived experience of functional seizures to help design and shape the project before it is launched.

This will involve: :

- Reading over materials
- Reading over the questionnaires
- Meeting with the researcher over video call to share your feedback and ideas.
- We are keen to know your thoughts on the language used, the appropriateness of questions and how this is delivered.

WHAT NEXT?

You will be compensated £15 for 1 hour of your time, reading material and feeding back in a video meeting.

If you are interested please contact:
Email **Emily.Townsend@hmc.ox.ac.uk**



Appendix M: CUREC Ethics Approval Letter

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Lorna Hogg & Emily Townsend
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre
Warneford Hospital
Oxford

28 July 2023

Dear Lorna and Emily,

Research Ethics Approval - CUREC 2

Ethics Approval Reference: R87156/RE001

Study title: Internalised Stigma in Individuals with Psychogenic Non-Epileptic Seizures: The role of disclosure and impact on self-esteem and self-efficacy

Short title: Internalised Stigma in people with seizure conditions

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **28th July 2023** until **27th January 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

You will be required to submit an annual progress report on each anniversary of study approval, until the study is completed, and your study may be selected for review during an annual audit.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix N: Participant Information Sheet

Project: Internalised Stigma in people with seizure conditions
Contact: Emily.Townsend@hmc.ox.ac.uk
Document: Participant Information Sheet

Participant Information Sheet
Central University Research Ethics Committee (CUREC) Approval Reference: R87156/RE001

Thank you for your interest in our research study. To help you decide whether you would like to take part, please read the information below explaining why the research is being done, and what taking part would entail. If you would like any more information or to discuss the content, please contact us on Emily.townsend@hmc.ox.ac.uk.

What is the purpose of the study?

We are researching internalised stigma in people who experience functional seizures, compared to people with epilepsy. Internalised stigma is a term that refers to negative thoughts and feelings, such as shame, that people have about their condition. Research has found that some healthcare professionals have been found to have stigmatising views of functional seizures. We are interested in the similarities and differences in people with functional seizures and those with epilepsy in relation to internalised stigma. We are also interested in the impact that this might have.

Why have I been invited?

You have kindly shown interest from one of our online posts. We are looking for people to take part who are:

1. 18 years or over
2. Live in the UK
3. Have a diagnosis of either:
    a. Psychogenic Non-Epileptic Seizures (PNES) /Non-Epileptic Seizure Disorder (NEAD)/ Functional Neurological Disorder and experience seizures (FND)
    b. Epilepsy
    c. Both a and b
4. Have had this diagnosis for 3 months or more

Do I have to take part?
No. You do not have to take part in the study and can contact the researcher to ask questions if you would like more information. You can withdraw from the study at any time without any negative consequences by simply exiting the page. As all data is collected and stored anonymously, we cannot remove your data after you have submitted your responses.

What will happen if I decide to take part?

You will be taken to a webpage asking you to give your consent to take part in the study, followed by a series of questionnaires. You can complete this at a time that is convenient for you. This will involve questions about your diagnosis, your mental health, stigma, disclosure of your diagnosis, self-esteem and self-efficacy. This is expected to take between 10 and 20 minutes.

What are the possible benefits of taking part?

Although there is no direct benefit to taking part, we hope that these findings will help to add the experiences of people with functional seizures to the research. It will be the first to consider how theories which explain the psychological processes by which stigma might become internalised could be used to explain the experiences of people who experience functional seizures. We hope that this will lead to further research which will help to improve treatments and outcomes for people with this diagnosis.

Are there any possible disadvantages or risks of taking part?

The questionnaires are estimated to take 10 – 20 minutes

All the questionnaires are measures which are commonly used in research. Some of the questionnaires will ask about your mental health and experience of difficult events. This is because we know people with seizure disorders may have higher levels of anxiety or low mood than other groups. You may find some of these questions emotional or upsetting. Details of support services will be provided before the study and throughout, and you can withdraw from the study at any time.

Will my taking part be kept confidential? What will happen to my data?

You will not be asked to provide any data that could directly identify you (e.g. name or contact details) at any point.

The University of Oxford will store consent forms and questionnaire responses for 3 years after publication. These will be saved securely on Oxford Nexus365 OneDrive. After 3 years the information with be permanently deleted.
The research team will have access to the data collected, and other responsible members of the University of Oxford may be given access for auditing or monitoring.

What happens at the end of the study?

This study is part of a doctoral research thesis (Doctorate in Clinical Psychology), and we aim to publish the findings in an academic journal. As we do not have any way of identifying participants we cannot feedback findings to you directly, however we will create a poster summarising key findings and post this on the same pages and with the same charities that we recruit from.

How have patients and the public been involved in the study?

People with a diagnosis of Functional Neurological Disorder who experience have been involved in study design, questionnaire selection and development of resources (such as this information sheet and poster). Once we have collected the data, experts by experience will also help to produce and develop a poster that can be distributed to share findings.

Who to contact if you have a concern or want to make a complaint?

If you have a concern about any aspect of this research, please contact Emily Townsend (Emily.Townsend@hmc.ox.ac.uk/01865 226431) or Dr Lorna Hogg (Lorna.Hogg@hmc.ox.ac.uk), and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at the University of Oxford who will seek to resolve the matter as soon as possible:

The Chair, Medical Sciences Interdivisional Research Ethics Committee; Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, Oxford OX3 7GB

Who has reviewed the study?

This research has received ethics approval from a subcommittee of the University of Oxford Central University Research Ethics Committee. (Ethics reference: R87156/RE001).

Further information and contact details:

If you have any questions about this information, or questions arise during or after the study, please feel free to get in touch by email and I would be happy to arrange a time to call:
Emily.Townsend@hmc.ox.ac.uk
You can also get in touch with research supervisor Lorna Hogg on
Lorna.Hogg@hmc.ox.ac.uk

Thank you for taking the time to read this information

Appendix O: Recruitment Poster



Appendix P: Pearson Correlations for covariates (1 and 2)

	1	2	3	4	5	6
1. GAD-7	-					
2. NDDI-E	.666**	-				
3. ISMI-9	.465**	.649**	-			
4. PASS-ND	.258*	.264*	.410**	-		
5. RSS	-.280**	-.271**	-.377**	-.104	-	
6. GSE	-.503**	-.530**	-.483**	-.333**	.267**	-

Appendix Q: Normality checks and assumptions

Research Question 1

ANCOVA: There was a linear relationship between ISMI level and both covariates (GAD-7 and NDDI-E scores) across both groups, as assessed by visual inspection of a scatterplot. There was homogeneity of regression slopes as the interaction term was not statistically significant, for both GAD-7 ($F(2, 92) = .496$ $p = .611$) and NDDI-E ($F(1, 92) = .049$, $p = .825$).

Research Question 2

ANCOVA: Linearity assumption not met according to visual inspection. Homogeneity of regression slopes assumption met, as interaction term not statistically significant, for both GAD-7 ($F(1, 92) = .665$ $p = .417$) and NDDI-E ($F(1, 92) = .793$, $p = .376$).

Research Question 3

A) Hierarchical Regression: There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.194. There was homoscedasticity and normality of the residuals as assessed by visual inspection of a normal probability plot. No evidence found of multicollinearity, with tolerance values exceeding 0.1. No significant outliers. Leverage values all fell below 0.2, and no highly influential points (as determined by Cook's distance of more than 1).
B) Hierarchical Regression: There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.850. There was homoscedasticity and normality of the residuals as assessed by visual inspection of a normal probability plot. No evidence found of multicollinearity, with tolerance values exceeding 0.1. 4 participants did not complete the measure and so were removed from the analysis. Leverage values all fell below 0.2, and no highly influential points (as determined by Cook's distance of more than 1) were identified.

Appendix R: ISMI-9 adaptation example

ISMI-9 (Hammer & Toland (2017) is not produced in full due to copyright limitations, however an example of how the language of items were adapted are below:

Item 1:
Original – "Stereotypes about the mentally ill apply to me."
Adapted – "Stereotypes about my seizure diagnosis apply to me."

Item 9:
Original – "I can have a good, fulfilling life, despite my mental illness"
Adapted - "I can have a good, fulfilling life, despite my seizure diagnosis"