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Quality of Life of Adults Who Have Attempted Suicide

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A thesis

presented to

the faculty of the Department of Sociology and Anthropology

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Master of Arts in Sociology

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by

Karen Rhea Hoefler

May 2020

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Dr. Martha Copp, Co-Chair

Dr. Candace Forbes Bright, Co-Chair

Dr. Jon Ellis

Keywords: Quality of Life, Adult Suicide, Reasons for Living, Suicide, Life Course

## ABSTRACT

### Quality of Life of Adults Who Have Attempted Suicide

by

Karen Rhea Hoefler

This study focuses on the quality of life of suicide attempt survivors and the trajectories of their lives after their last attempt in the past two to ten years. Employing both a quantitative and qualitative approach but focusing largely on the qualitative data, I collected demographic data, gathered responses on an abbreviated Reasons for Living Inventory, and conducted open-ended phone interviews with 26 participants. The primary life course finding is that participants' suicide attempts are often built on years of dealing with mental illness. The analysis also dispels many stereotypes associated with people who have attempted suicide. I explore patterns in participants' reports of their experiences surrounding their attempt(s), the stigma they felt (largely internal), and how they tried to alleviate that stigma and speak openly about their experiences with suicide attempts and ideations.

## DEDICATION

I dedicate this thesis to my participants and others who struggle with passive and active suicidal ideations. I also dedicate this to those who struggle and fight with mental illness.

“You can’t preach hell and damnation on someone who has been through this...you know they need love and attention and care. “

--An interviewee

## ACKNOWLEDGEMENTS

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Thank you to the friends that I hold near and dear to my heart for your emotional support through that which is graduate school. I am grateful to my brother Drew, who offered essential emotional support. And lastly, deep thanks go to my parents, especially my dad, as there is literally no way I could have made it through graduate school without him.

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## CHAPTER 1

### INTRODUCTION

In the United States, suicide claims the lives of 47,000 people annually and is the 10<sup>th</sup> leading cause of death (NIMH 2017). In 2017, approximately 10.6 million adults reported having serious suicidal thoughts and 1.4 million people made non-fatal suicide attempts (NIMH 2017). This, of course, does not include all the suicides and suicide attempts that go unreported or are categorized incorrectly. Additionally, it is estimated that roughly one-third of the population have or will have suicidal ideations at some point during their life (Gordon 2005).

Suicide generally brings to mind statistics. Statistics and numbers that get larger every year. But, what about the people behind the statistics? The intimate knowledge and understanding of what happens when people attempt to end their lives helps us understand what we need to do to prevent further attempts and completed suicides.

I took interest in this topic after reading *It's Kind of a Funny Story* by Ned Vizzini many years back. It is loosely based on the author's own hospitalization for depression. Several years after I read it, I saw that Vizzini had killed himself. Being ignorant on all things suicide, I was astounded that it was possible for someone to struggle with suicidal thoughts for such a long period of time and then to finally give in, even when he was so successful in his life, publishing multiple books and working in the film industry. When I told friends that I wanted to look into this, I was surprised by how many in my social network had thought about suicide or had attempted and that is when I knew this is something I had to work on.

Another surprise was that I found little to no research conducted on adult suicide prevention or adult suicide attempt survivors. Research on suicide is predominantly dedicated



to adolescents and suicide survivors--those who have lost someone to suicide. Suicide attempt survivors have to live with the stigma of the attempt, the pain and guilt of what may have been the most horrifying event of their lives, and fight with suicidal thoughts for the rest of their lives regardless of how they are faring after the attempt.

The goal of my thesis is to help readers better understand adults who attempt suicide. I collected and analyzed quantitative and qualitative data on 26 individuals who identified as previously attempting suicide. The participants came from a variety of geographic locations across the United States. Most report following a path of recovery and some continue to struggle. I found many commonalities, such as long-term mental illnesses, having either a major life altering event or a series of problems leading up to “the straw that broke the camel’s back” before the suicide attempt. Other patterns related to how participants experienced dealing with stigma, especially if they were from a small community, and participating in suicide prevention activities once they were in the recovery period. In addition to analyzing similarities in the data, I analyzed the exceptions; taken together, they offer insights about what can best be done to help adult suicide attempt survivors so that we can diminish the stigma and work to reduce suicide attempts.

## CHAPTER 2

### LITERATURE REVIEW

Suicide, by definition, is when an individual dies from an injury where there is proof (implicit or explicit) that the injury was self-inflicted with the intention of a fatal outcome. A suicide attempt is a self-injury where the degree of lethal intent varies (Jamison 1999).

Suicide is at epidemic levels in the United States (Abar et al. 2018), yet this is typically not brought to anyone's attention unless a celebrity dies or someone loses a close acquaintance or loved one to suicide. In 2017, a total of 47,173 individuals died by suicide in the United States, making suicide the 10<sup>th</sup> most frequent cause of death in the U.S. (AAS 2019). On average, a person kills themselves every 11 minutes (AAS 2019). For every completed suicide that occurs, 25 other people attempt suicide. That is a suicide attempt every 27 seconds in the United States (AAS 2019). Prior suicide attempts are among the biggest predictors of a completed suicide. Another predictor of completion is the combined number of suicide attempts. A higher total number of attempts has been a reliable predictor connected with lifetime elevated risk (Paris 2007). About one in 20 individuals in the United States will make a suicide attempt during their life. Three to seven percent of the suicide attempters are estimated to later complete a suicide (Paris 2007).

Most preventive measures and studies of suicide focus on adolescents, yet adults have a higher percentage of deaths attributed to suicide ("Suicide Statistics" 2018). In 2017 the highest suicide rate was among Individuals between 45-64 (35.05%), the second highest was in individuals 25-44 (32.40%). The suicide rate among adolescents was 13.25 percent (AAS 2019). This is evidence that we should expand our focus to adult suicides and attempts. Age is

significant when it comes to suicide. Suicide is a rarity before the age of 12. One percent of all suicides happen in the first fifteen years of life, but 25 percent take place in the second (Paris 2010).

### Motivations for Suicide Attempts

Cultures vary in the most common reasons for suicide. For example, according to the scholar Anton Van Hoof (Jamison 1999), emotions such as shame, grief and despair were the main reasons for suicide for young Romans. For people in present-day western cultures, psychologists and psychiatrists have examined the interconnection between “life events” and the emergence of mental illnesses such as mania, depression, and schizophrenia (Jamison 1999). Though some life events are positive, most researchers focus on disadvantageous events such as mental illness, relationship qualms, death or serious health problems in the family, family dysfunction, and financial or employment problems (Jamison 1999).

Suppressed mental illness or biological predisposition may be serious enough to play a key role in suicide or suicide attempts. Stress may have an overpowering effect not only on the body’s immune system and the creation of stress hormones, but on the sleep cycle which plays a crucial part in the pathophysiology of mania and depression (Jamison 1999).

An unforeseen or sudden heartbreak or catastrophe is often known to have taken place before a suicide or suicide attempt. The eventual impact of the psychological stress is not the same in everyone. People’s responses depend on other life experiences, access to a given suicide method, the extent of hopelessness and helplessness they feel, the type of mental illness, problems and disputes in close relationships, or pending threats of arrest. A criminal prosecution tends to occur more often before the suicides or suicide attempts of alcoholics and

drug abusers than before the suicides or suicide attempts of those with depression (Jamison 1999).

Depression is common in most suicides (Bucik et al. 2007). Next to feeling hopelessness, depressed individuals experience difficulties in problem solving, attentional bias, and reduced positive thinking, which all preserve or enhance suicidal ideations (Bucik et al. 2007).

Neuropsychologists and clinicians have discovered that people who are depressed think slower, distract easily, become more mentally exhausted quicker when it comes to cognitive tasks, and find that they have problems with their memory. Depressed individuals are more likely to recollect negative incidents and failures as well as to remember language with a depressive connotation than a positive meaning (Jamison 1999). In sum, when individuals are suicidal, their reasoning is paralyzed, and their choices appear grim or nonexistent (Jamison 1999).

### History

The history or details about the first individual who killed themselves are unknown. However, it is very probable that once suicide had occurred and others were aware of it, the act was emulated, partly because animals and humans alike learn, to a significant length, through imitation (Jamison 1999). For this reason, suicide can unfortunately have a contagious effect on others.

Media outlets may contribute to suicidal contagion (Stack 2003). When this happens, it is thought of in terms of social learning theory. One sees that troubled individuals are solving their problems by killing themselves and emulate it. Generally, high-profile suicides increase the national suicide rate by 2.51 percent in the month of media coverage (Stack 2003). Celebrities have the most impact on copycat suicides. Also, the greater amount of coverage of suicide in

the media and the medium of coverage has an effect (Stack 2003). The larger amount of media coverage there is, the greater increase in suicide rate. For example, stories on television on suicide typically last around 20 seconds and cannot provide as many details as newspaper stories (Stack 2005). Research findings based on television stories found that they were 79 percent less likely to cause the copycat effect (Stack 2005). If media outlets include “positive definitions,” it makes suicide seem permissible, disinhibiting vulnerable individuals on the verge of suicide (Stack 2005). Positive definitions can include sensational coverage, the glorification of the deceased, focusing on the positive aspects of the victim and rationalizations (Stack 2005).

These copycat suicides fall into two patterns of suicide clusters: point clusters and mass clusters (Mesoudi 2009). A point cluster is what is known as a short-term increase in the number of suicides in a small community in comparison to both the baseline suicide rate before and after the point cluster and the suicide rate in the neighboring areas (Mesoudi 2009). A mass cluster is a short-term increase in the overall frequency of suicides within an overall population in comparison to the period immediately before and after the cluster, with no spatial clustering. Mass clusters are usually correlated with high-profile celebrity suicides that are publicized widely in the mass media (Mesoudi 2009).

Cultures vary in members’ opinions and views of self-inflicted death. Several cultures, such as the Eskimo, Norse, Samoan, and Crow Indian, embraced and even encouraged “altruistic self-sacrifice among the elderly and sick “(Jamison 1999). Among the Yuit Eskimos of St. Lawrence Island, if a person asked for suicide three times, relatives were required to aid in the killing. The person requesting suicide was dressed in a ritual death garb and was then exterminated in a “destroying place” that was set aside specifically for that purpose. To save

resources or to allow a nomadic society to move on without being held back by the physically ill or elderly, some societies gave tacit if not uncensored approval of suicide (Jamison 1999).

No early cultural or religious penalties were connected to the suicides in the Old Testament. However, when described in the New Testament, it was clear that views toward suicide had changed during the early years of Christianity. Most earlier suicides, like ancient Greeks depicted by Homer, were seen as acts of honor, measures taken to avoid falling into the hands of the enemy, to do penance for a wrongful deed, or to defend a religious or philosophical principle. Hannibal, for example, ingested poison rather than be seized or dishonored, as did Demosthenes, Cassius, Brutus, Cato and multiple others. Socrates, instead of renouncing his teachings and beliefs, drank hemlock. Gladiators would plunge wooden sticks or spears into their throats or force their heads into moving carts so that they could choose the method and the time of their death (Jamison 1999).

Beliefs about suicide varied substantially in ancient Greece. The Stoics and Epicureans believed adamantly in a person's right to choose the details surrounding their death. Others were less receiving of the idea. In Thebes and Athens, those who had taken their own lives were not given funeral rites and the hand that had been used for the suicidal act was cut off from the arm. Aristotle viewed those who killed themselves as cowards. Roman law forbade suicide and wouldn't let the possessions and estates of those who killed themselves to be passed down to the heirs. The Catholic Church has always been against suicide; during the sixth and seventh centuries, the church excommunicated and refused funeral rites to people who killed themselves (Jamison 1999).

Jewish customs prohibited funeral orations for anyone who killed themselves; mourners' clothes were discouraged for those who killed themselves and burial was limited to a secluded section of the graveyard so that the "wicked would not be buried with the righteous" (Jamison 1999:14). Over time, a little more compassion was granted to those who had killed themselves while of an unsound mind. In the Jewish tradition, one could comfort and console the people who knew the person but could not "honor" the dead other than burying them. In Islamic law, suicide is viewed as being as bad, if not worse than, homicide.

Over time, both religious and legal sanctions against suicide have become less severe. Researchers all over the world have analyzed how suicide was secularized and medicalized in Europe and North America over time and have studied how suicide went from being a sin to being a mental illness (Weaver and Wright 2009). Most European countries have now decriminalized suicide, although it was still considered a criminal act in England and Wales until 1961 and in Ireland until 1993 (Jamison 1999). Societal understanding of suicide has grown in recent years, but not to the degree equivalent with what the medical and psychological community has learned through research. The views of suicide left by hundreds of years of history still influence the present, both in how people view it collectively and individually. Suicide went from being associated with religious beliefs to being a social phenomenon and being medicalized (Weaver and Wright 2009). This slightly dulled the stigmatization of mental illness and suicide but not enough to where it doesn't greatly affect those who deal with these issues.

## The Differences in Adolescents and Adults

There is an abundance of literature on adolescent suicide attempts in comparison to literature and studies on adults. Because adolescents and adults differ strongly in growth development, they cannot be grouped and studied together; especially in terms of brain development. Adolescents and adults think differently, are going through different stages of life, and they may have different reasons for attempting suicide. The adolescent brain functions differently than that of adults. Adolescents are just developing the capacity for abstract thinking. Adolescence is when individuals become capable of thinking beyond their direct experiences and when they develop the capability to think about hypothetical scenarios (Hazen et al. 2010) Problem solving strategies also improve during adolescence. Young people become more systematic and logical during this growth period. Despite the brain developments that occur during adolescence, adolescents still have limitations relative to adults in their ability to solve problems and to see the consequences of their actions. This aspect of adolescent cognition is why adolescents have a propensity for risk-taking behavior (Hazen et al. 2010). Adolescents, at this point, do not even have a fully developed frontal lobe (Calahan 2012).

Our frontal lobes are mainly responsible for complex decision-making tasks, leading experts to talk about them as the “CEO” of the brain. The frontal lobe doesn’t fully develop until a person is in their twenties, which leads many experts to reason that frontal lobe maturation is what differentiates children from adults (Calahan 2012). Using Random Item Generation Tasks (Gauvrit et al. 2017), researchers evaluated high cognitive skills including inhibition and sustained attention and concluded that human behavior complexity peaks at age 25. Blakemore and Choudhury (2006) found that critical parts of the brain involving decision



making are not fully developed until age 25 or later. The prefrontal cortex is not developed until about this time, and this is the part of the brain that inhibits impulses and helps one plan and organize behavior to arrive at goals (Blakemore and Choudhury 2006).

### Mental Illness and Causes of Suicide

Many things can cause people to attempt suicide. Underlying conditions may predispose an individual to kill themselves, such as genetics, severe mental illnesses, an impulsive or volatile personality, things that happen in life that activate and interact with these other traits (romantic failures, upheavals, economic and job setbacks), confrontations with the law, terminal or debilitating illnesses, situations that cause humiliation, or the inadvisable use of drugs and alcohol are also common (Jamison 1999).

There are several indicators for suicidal behavior. Married and cohabitating individuals are less likely to ever attempt suicide. There is a higher rate of suicide and suicidal tendencies among people with lower educational statuses, those who have been unemployed for extended periods of time, and those having financial difficulties (Norlev et al. 2005). Those with little to no social networks are at risk as well as individuals who have been victims of sexual or physical abuse. Also, suicidal tendencies are two to six times more common for LGBTQ individuals than in heterosexuals (Norlev et al. 2005).

Paris (2010) argues that three psychological issues influence the emotional life of suicidal individuals. First is psychological pain. Psychological pain involves feelings that the suicidal individual tries to cope with that are beyond what most people experience. Suicidal individuals are more than just depressed. They experience serious and ongoing distress, they are seldom happy for more than a few days, and most of the time, their mood is depressed,

anxious and angry (Paris 2010). A second psychological issue is emptiness. This is also not to be confused with depression. Patients who are depressed feel a sense of loss. Individuals who feel empty report feeling a sense of having nothing inside and of being nobody (Paris 2010). The third psychological issue is hopelessness (Schneidman 1996). This happens in depression as well, but what differs is how it is interpreted. If a suicidal individual cannot remember ever feeling happy or content, to them, there is little hope for a return to happiness (Paris 2010).

Schneidman (1996) proposes that 95 out of 100 suicides reflect a deep need to relieve, escape, and end psychological pain. Schneidman notes another common theme: many suicidal individuals either consciously or unconsciously communicate that they are suicidal. For example, they may give off signs of distress, signs of helplessness, or request interventions, which are often indirect (Schneidman 1996).

Mental illness is often the cause or one of the conditions that contributes to suicide attempts. Through “psychological autopsy” studies, in which a researcher interviews people close to or who have provided healthcare for a deceased person, approximately 80-90 percent of all suicides had a diagnosable mental disorder (Goldney 2008). Many mental illnesses start to appear between the ages of 10-22 (Goldney 2008). The average onset of bipolar disorder is 18. The average onset for drug abuse and schizophrenia is 21. However, the average onset for major depressive disorder is 26 (Jamison 1999). The growth in the prevalence of severe mental illnesses is equivalent to the rise in suicide, making an increasing age a notable risk factor (Jamison 1999). Completion has an increased risk with several mental illnesses, particularly melancholic depression, bipolar illness, alcoholism, and schizophrenia, as well as borderline personality disorder (Paris 2007).

## Stigma

Stigma related to mental health, both internal (self-stigmatizing) and external, have been emphasized in literature (Gray 2002). Self-stigmatization refers to the humiliation that prevents individuals from potentially seeking help. Internal consequences are reduced self-esteem, and an increase in shame, fear and avoidance (Gray 2002). External stigma is unjust treatment by others. The result of this is exclusion, discrimination, stereotyping and prejudice from others, and social detachment (Gray 2002).

Some of the stigma that individuals face is still associated with how people in our society deal with mental illness and people who have attempted suicide. People often believe that those who attempted suicide did so to gain attention. This demeans the psychological pain that suicidal individuals endure. When individuals feel suicidal, fear of what other people might think of them if they knew compounds their emotional pain. Elevated amounts of psychological distress were correlated with a significant perceived stigma only in people with a history of past attempted suicide (Scocco et al. 2016). Consequently, it helps to talk about suicide in a way that is direct but also empathetic and sensitive (Dazzi et al. 2014).

Despite its rarity, in most mental health practices, suicide is always a possibility. Surveys have shown that suicide occurs at least once in the careers of 50 percent of psychiatrists as well as 20 percent of psychologists (Paris 2007). Clinicians often have a fear of taking on suicidal patients and avoid treating this portion of the population (Paris 2007). On a professional level, they may only take on a healthier clientele to minimize the risk of having a patient who might kill themselves. Some clinicians may mistakenly avoid discussions of suicide based on the unfounded assumption that it will increase, not decrease, suicide attempts. Treating chronically

suicidal patients requires therapists to accept some degree of risk, but fear of litigation influences the choice on whether to take on a patient. Lawsuits after suicide, almost always initiated by the family, focus on whether the suicidal patients were treated properly while in the clinician's care (Paris 2007).

In a suicide case, the courts determine whether the clinician's management of the patient who attempted or committed suicide was foreseeable (Simon 2011). Foreseeability is a legal term, defined as the expectation that harm is possible to result from acts or omissions. It is not interchangeable with predictability. When previously documented, systematic suicide risk assessments can assist in guiding court cases. When suicide risk assessments are not provided, the court cannot evaluate the clinical uncertainties that exist in the assessment, treatment and administration of patients at risk of suicide. In malpractice litigation, the failure to perform a successful risk assessment is often purported along with claims of negligence (Simon 2011).

Medical examiners may also stigmatize suicide, even if the evidence is unmistakable. They may refrain from labeling a death as a suicide in deference to families' religious concerns, possible stigmatization or blame by the community, or possible financial problems for the heirs. Their own religious beliefs may also affect their assessments of cause of death (Jamison 1999). In Canadian studies for example, fewer cases were determined to be suicides by Catholic medical examiners than by non-Catholics, proposing the likelihood that religious views still play a role in deciding whether some unnatural deaths are determined to be suicides or accidents (Jamison 1999).

### Consumed by Suicide

Once an individual attempts suicide, they are believed to be more at risk for eventual suicide because the previous suicidal experience hypersensitizes them to suicidal thoughts and behaviors (Spirito and Overholser 2003). Suicidal behavior promotes the formation of a “suicidal schema,” which is defined as a kind of obsession with suicide as the only way to solve one’s problem(s); such schema can be triggered in stressful situations (Wenzel and Jager-Hyman 2012). Life is so painful for some individuals that they may feel “half in love” with death (Paris 2007). For the suicidal individual, suicide can become the focal point of their existence. Death, for them, has become a way of life. Although it can be hard to picture, suicidal individuals can be comforted by suicidal ideations. Suicidal individuals suffer at an extremely high level of distress and the only way they can endure that distress is if they know they can escape it. The only way for them to continue to live is to retain the option of dying. They threaten to kill themselves to stay alive (Paris 2007)

### Myths about Suicide

One of the most common myths about suicide is that if you talk about suicide, it will increase suicide rates and ideations. That just mentioning it might embed suicidal thoughts in people who might be suicidal. However, increasingly high rates of suicide are propelling healthcare providers to question this myth (Dazzi et al. 2014) New data suggests that we should be talking about suicide and that it is beneficial to talk about suicide. Nicola Fear, a professor of epidemiology at King’s College in London, finished a review of evidence of whether talking with people about suicide would increase suicidal thoughts. Fear identified thirteen studies where researchers asked questions about suicidal ideation and suicidal behavior and they had

followed up with the people in those studies and asked the same questions to see if there was any increase in those behaviors (Dazzi et al. 2014). None of those 13 studies revealed any association between asking about suicide and then an increase in suicidal behavior. In fact, Fear and her colleagues discovered that acknowledging and talking about suicide may reduce suicidal ideation and lead to improvements in mental health (Dazzi et al. 2014).

Another myth is that by killing oneself, an individual is “taking the easy way out.” But it is important to understand that the self-preservation instinct is hard-wired in every individual when it comes to understanding suicidal behavior. The Jewish historian Flavius Josephus wrote that suicide “is contrary to the instincts shared by all living things” (Joiner 2010:5). One has to fight with one of nature’s strongest forces, that being self-preservation, before one dies by suicide (Joiner 2010).

Thomas Joiner, the author of *Myths about Suicide*, argues that if it were easy to kill oneself, there would be a higher number of fatal suicides and a lower number of attempts given that the ratio is one death for every 20 [now 25] attempts (Joiner 2010). Joiner gives the example of a woman who attempted suicide by cutting her wrists, but due to blood clotting and fainting, she didn’t die. The woman continued to cut herself for over an hour, saying that the battle with her body was unexpected, and then she passed out before being able to complete the act. Meriwether Lewis shot himself twice and neither of the gunshots killed him. Servants and others found him cutting himself all over his body. He finally died a few hours later. These incidents seem to contradict the myth that suicide is an easy escape and an act for cowards (Joiner 2010).

There is also the myth that suicide is selfish (Joiner 2010). But those who die by suicide have often faced a disconnect in their social connections. When they are trying to kill themselves, they are alone in a way that people with strong social connections cannot comprehend. Those who have lost social ties believe that people will be better off without them being alive. Feeling no sense of belonging is the opposite of selfishness. Those who die by suicide consider the effect their deaths will have on others, but they see it differently. They often see their death as being a positive thing rather than a negative one (Joiner 2010). They often think that their death will be a gift to others, worth more than continuing to live (Joiner 2010).

There is also a myth that suicidal individuals don't make plans for the future. Contrary to popular belief, the suicidal individual wants both life and death at the same time (Schneidman 1996). People often make plans for their occupations, vacations, and activities with other people in the days and weeks before their deaths by suicide (Joiner 2010). It would be surprising if they didn't make plans, because that would mean they would have already lost the desire to live. It is difficult to face the fact that people can harbor a dual state of mind where they think about suicide at exactly the same time that they think of weekend plans, going for a run, sitting at a desk or other everyday activities (Joiner 2010).

### Gender

Both suicide attempts and suicide completion reflect gendered patterns. Men take their own lives at roughly four times the number of females and make up around 80 percent of completed suicides; yet female suicide attempt rates are approximately four times higher than men's (Callanan and Davis 2013). Part of the disparity is attributed to the differences in the

rates and types of the mental illnesses linked with suicide and attempted suicide. Women and girls, for example are at least twice as likely as men to suffer from depression, which may account for some of the growth in the rate of suicide attempts. Many studies report higher levels of depression in women; depressive illness is significantly more common in women than men, even internationally (Jamison 1999). This is due to a higher risk of onset, not to different persistence or recurrence (Kessler 2003).

Research shows that genetic, biological as well as environmental influences contribute to the gender differences in depression rates (Sloan and Sandt 2006). Women are more likely to suffer more stressful life events in comparison to men. The overall lifetime prevalence rate of depression for women is 21 percent while it is roughly 12 percent for men (Sloan and Sandt 2006). The rate of depression starts to increase for females around 13, and this rate continues through the lifespan (Sloan and Sandt 2006). Women's increased experiences of both acute and chronic stressful life events have biological repercussions that further increase a woman's risk for depression. Research shows that extremely stressful situations create abnormalities in the hypothalamic-pituitary-adrenal (HPA) activity.

Rates for bipolar disorder, on the other hand, do not differ by gender (Callanan and Davis 2013). Although depression is more common in women, their depressive illnesses are less likely to be impulsive and violent than those of men. This is thought to be what makes women less likely to use violent and lethal methods. There is also proof that men are more likely than women to perceive a stigma attached to a "failed" suicide attempt. Men who may have a more belligerent and volatile aspect to their depression are also less likely to seek professional help (Jamison 1999).



## Methods of Suicide

Historically, sharp weapons have always been the main method of suicide. Firearms, as they have become more readily available, have replaced the use of knives and swords as the weapons of choice (Jamison 1999). In the United States, firearms are accountable for more than 60 percent of all suicides. No other method comes close to that to surpassing that. The most common method used by men is firearms (Callanan and Davis 2013). In 2006, it was reported that 56 percent of men who committed suicide used a firearm. The most common method for women in the same year was poisoning. In reports for 2014, the most common method for men was still firearms and the most common method for women was still poisoning (Curtin, Warner and Hedegaard 2016). Having a gun in the home, regardless of gender, is a risk-factor for gun related suicides of suicidal adults in the United States (Wiebe 2003). A gun, when available, is more likely to be picked over a less lethal method to kill themselves (Wiebe 2003).

Many factors influence people's method for attempting suicide. The availability of the method has the most influence. Suicidal individuals will account for whether a method is lethal or not and that is crucial in deciding what method to use as well. Methods such as jumping, hanging or using guns give the individual virtually no time for discovery, rescue, or time to change one's mind. Other methods, such as drug overdoses or cutting give an individual more time between the act of trying to kill themselves and death. Discovery of the attempt, seeking help oneself, or reconsidering life are usually possible when using these methods (Jamison 1999).

In general, women usually use less violent and final means although women have increasingly been using firearms as they become more familiar with them and as they become

more accessible. Forty years ago, both men and women viewed drugs and poisons as the “most acceptable” way to die by suicide, but men see firearms as more “masculine” (Jamison 1999), effective, and easy to use. Women’s penchant for drugs and poisons is thought to be because of perceived painlessness, accessibility, and ease of use of these methods. Fear of disfigurement has been proposed as well as a reason to explain women’s partiality for nonviolent forms of suicide although the evidence for this is slight (Jamison 1999).

Methods of suicide vary by age. Hanging, jumping from heights, and jumping in front of trains are methods more commonly used by young individuals. Firearms are used by individuals of all ages. The type and seriousness of a mental illness also factor in the method chosen. Severely mentally ill patients are more likely than others to immolate themselves, leap in front of trains, or choose extremely bizarre and self-mutilative methods. Surprisingly, more people kill themselves in mental hospitals than they do in highly publicized places. Five to ten percent of all suicides take place in mental hospitals (Jamison 1999).

### Resilience

Researchers have found that people who have attempted suicide are more likely to have lower resilience levels (Roy, Vladimir, and Sarchiapone 2007). Roy et al. (2007) found that resilience is an important characteristic for people to have, as it protects them from mental illness and suicidal ideations. Perhaps those who have positive trajectories after suicide attempts will be found to have higher resilience levels. This study seeks to find if suicide attempt survivors report any indicators of resilience and any factors that seem favorable in their lives.

### Life Course Questions Used in Other Studies

Life course questions can be very useful in figuring out what led to a person's suicide attempt or what could affect their lives now. One study, the Terman study, used life course questions to predict which participants in their study were more at risk for suicide (Holahan, Sears, and Cronbach 1995). A childhood history of an absent or rejecting father put them more at risk. If individuals had "negative indicators" at an early age (before 20), they were more at risk for suicide. These included variables like alcoholism, suicide threats, homosexuality, failure to achieve goals, mental illness, neurasthenia, marriage, divorce, and difficulty breathing (Shneidman 1996). The behavior of one's spouse may also matter. In the Terman study, participants whose wives were aggressive, not supportive and actively competitive against them, could indirectly play a role in the spouse's death and in some cases did (Shneidman 1996). This shows how life course questions have been utilized in studies concerning attempted vs. completed suicide and turned up fruitful results.

Life course interviews were also done in a study concerning self-harm, suicide, and alcohol use among men. Amy Chandler and Brieger Nugent (2016) tested the effectiveness of using life story methods to obtain qualitative data from a group of men who had experienced self-harm, suicidal thoughts, or actions and explored accounts of alcohol use (Chandler and Nugent 2016). They found that men considered alcohol to be a normal and common-sense response to distress. At the same time, participants of the study were aware that alcohol often had the opposite effect of worsening mental health (Chandler and Nugent 2016).

## CHAPTER 3

### METHODOLOGY

The study is composed of two different sections, an online survey and a phone interview. The invitation to the study explained the project and took interested participants to an informed consent document that specified the criteria for the sample population. Only those participants who met these criteria could participate in the study. I sought participants who were U.S. residents at least 29 years of age, whose last (or only) suicide attempt occurred 2 - 10 years prior to the study. These criteria helped assure me that participants were adults at the time of their last suicide attempt, rather than adolescents.

I used social media outlets to invite people to participate. I originally chose Reddit as the platform for my study invitation, but it was not very accommodating. With an advisor's assistance, I contacted a large number of mental health related social media outlets through Facebook messenger and email. I gained the support of The Tennessee Suicide Prevention Network (TSPN) and eventually the American Foundation for Suicide Prevention (AFSP). I obtained IRB approval to advertise on each new platform.

For the first part of the study, participants responded to a Qualtrics survey that first asked the screener questions. If participants were ineligible, then they were thanked for their interest but could not participate further. Eligible participants were then asked to provide some basic sociodemographic information and answer 24 questions about their reasons for living (see Appendix A). The 24 reasons for living questions were divided up into four sets of six questions and measured on a six-point Likert scale. At the end of the survey, participants could click on a link for a Doodle poll to schedule a time and day to talk with me on the phone for the second

portion of the study. People who responded to the survey but declined to schedule an interview were removed from the study.

The second part of the study aimed to understand participants' quality of life. The semi-structured interview schedule included three life course questions and 19 questions relating directly to the participant's last suicide attempt. Often, I asked further questions and probes to gain more insight and understanding. The interview was estimated to range from 30-45 minutes, but the shortest phone interview was under 20 minutes and the longest interview was one hour and 36 minutes. The shortest interviews seemed to be with participants whose life courses were more negative, despite my efforts to encourage them to speak. With participants' permission, I recorded the interviews on an app called Record by Call, which automatically starts recording once a phone call begins. All participants consented to having their phone interviews recorded.

The ETSU School of Graduate Studies provided research funds that allowed me to give participants a small incentive for their participation in the study. My original plan was to survey and interview 40 participants. After gaining only five completed surveys after the first month of data collection, I obtained IRB permission to drop my sample size to 25 participants in order to increase the amount of the incentive from \$15 to \$30. After TSPN reposted my study on their Facebook page and in their newsletter with the higher incentive, I gained 11 more participants. The rest of the participants joined the study when AFSP got on board and posted the invitation on Facebook, Twitter, and their research study page. I was able to include 26 participants in the study because one person refused their gift card.

This was a non-probability voluntary response sample as not all members of the population had an equal chance of participating due to the rather strict inclusion criteria. The data from the demographic and reasons for living questions were analyzed in terms of simple frequencies and percentages; I aggregated them into tables and figures. The proportion of female participants in the study was 73.98 percent. This is consistent with research findings that women are more likely to attempt suicide, whereas men are more likely to have a completed suicide. The overwhelming majority of participants were white/Caucasian at 88.46 percent. All demographic information from the online survey is presented in Appendix B. The reasons for living inventory data were then compared to what people said in the phone interviews. I tracked how responses differed or were consistent, which is the subject of Chapter 4.

To gain a deeper understanding of the life-course experiences of people who had attempted suicide, I chose to conduct in-depth, open-ended interviews because they capture how participants interpret their experience in their own words (Charmaz 2006). In-depth interviews are an important source of verbal and non-verbal cues. For example, I paid careful attention to how participants sounded, how they said certain things, or how difficult it was for them to elaborate. I went into the interviews with a guide but also asked probing questions—a probe being a gentle way of asking the participant to elaborate more on what they said (Lofland et al. 2005). The interview guide served to remind me of the topics I hoped to learn from each participant, but its purpose is to let participants speak more freely. Sometimes I would not have to ask each individual question because participants would tell me everything when I asked the

first life course question. It was my job to listen and allow the participants to talk as much as they needed in order to establish good rapport.

I transcribed the interviews verbatim. Depending on the length of the interview, transcribing each interview took from three to five hours on average. I used pseudonyms for all participants. I first analyzed the interview transcripts by engaging in line-by-line coding. Line-by-line coding is beneficial because going over the data slowly, attentively, and repeatedly helps researchers discover emergent themes they might have otherwise overlooked (Charmaz 2006). This approach allowed me to establish a wide range of categories for the data and discover key themes and subthemes. I then engaged in focused coding (Lofland et al. 2005) and reviewed the data several times, critically re-examining examples of each theme to ensure that I understood their meanings. I sifted the data carefully for commonalities and for exceptions to each emergent theme in an effort to avoid undue bias in my interpretations (Lofland et al. 2005). This effort gave me an immersive understanding of the information participants shared.

## CHAPTER 4

### REASONS FOR LIVING INVENTORY

The purpose for asking the reasons for living (RFL) questions was to determine what types of adaptive thoughts protect people from taking their lives. Above each set of questions, survey respondents encountered the following instructions:

For the next set of questions, we would like to know how important each of these possible reasons would be to you at this time in your life as a reason to NOT kill yourself. Each reason can be rated Not at All Important (as a reason for not killing myself, or does not apply to me, I don't believe this at all) , Quite Unimportant , Somewhat Unimportant , Somewhat Important , Quite Important , Extremely Important (as a reason for NOT killing myself, I believe this very much, and it is very important) .

This chapter aims to examine the RFL figures and then compare the results with what the interviewees said in the phone interviewees. I will go over the data for each question in the figures individually and then also mention if there was qualitative content that matched each question in the phone interview.

Figure 1 illustrates the first set of reasons for living questions from the abbreviated inventory. The participants' first item asks them to estimate the importance of fear of death as a reason to live/not kill themselves. Seventeen (65.38%) participants answered that this item was somewhat unimportant to not important at all while nine (34.61%) participants chose somewhat important to extremely important. I believe several participants' answers were inconsistent with the phone interview data, as participants often expressed fear when talking



about their suicide attempts and the lengths that they went through to prevent themselves from getting into an active suicidal mind space. More of the participants seemed to fear death than they let on, in other words.

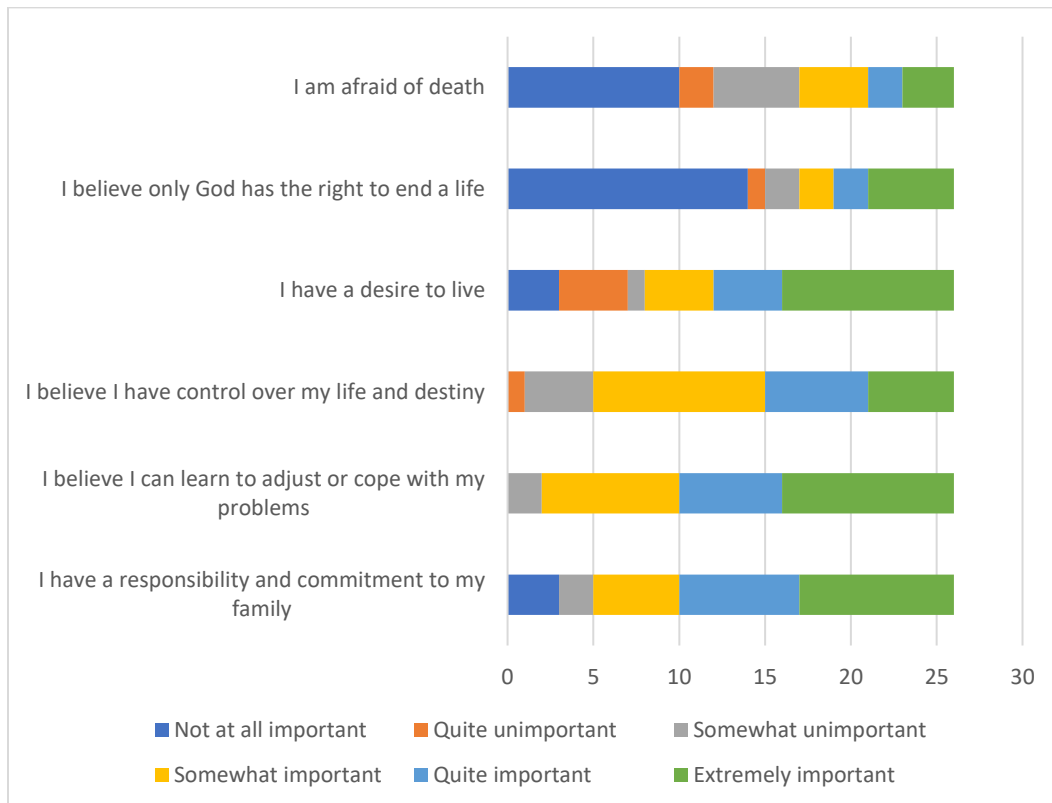


Figure 1. Reasons for Living Inventory: First Set of Questions

The second reason for living item represented in Figure 1 asks participants to rate if they believe only God has a right to end a life. Of the 26 participants, 17 (65.39%) responded that this item was somewhat unimportant to not at all important, and nine (34.61%) indicated somewhat important to extremely important. Religion was not a prominent theme in the phone interviews. Only one participant mentioned that he hoped God would forgive him for his suicide attempt. A couple of people were told by others that they were “going to go to hell” for attempting suicide, but little else pertaining to God or religion came up in conversations with

participants. Third, participants were asked if they had a desire to live. Eight participants (31.27%) selected somewhat unimportant to not at all important, and 18 (69.22%) indicated somewhat important to extremely important. Phone interviews revealed that the majority of participants seemed to be on a positive trajectory, in that they expressed a desire to live and discussed goals or achievements that they looked forward to carrying out now that they were on a path to recovery. In the fourth question, 'I believe I have control over my life and destiny,' five participants (19.23%) responded that this item was somewhat unimportant to not at all important, and 21 (80.77%) marked somewhat important to extremely important. While the issue of control was not directly brought up in the phone interviews, again and again, the interviewees described life-altering events over which they seemed to lack control. The large majority of the interviewees seemed closely attuned to their lives, aware that life could change at the drop of a hat, and what they could or couldn't handle in terms of their mental health.

The fifth question is 'I believe I can learn to adjust or cope with my problems.' Only two participants (7.69%) rated this item as somewhat unimportant to not at all important while 24 (92.31%) indicated somewhat important to extremely important. Responses to this item seemed quite consistent with the interviews. A large majority of the participants mentioned that after their suicide attempts, they learned better coping skills, started therapy, increased therapy if they needed it, even relocated to get away from the environments and people that were toxic to them. For the sixth question, 'I have a responsibility and commitment to my family,' five participants (19.23%) responded that this item was somewhat unimportant to not at all important, and 21 (80.77%) chose somewhat important to extremely important. Responses to this item also seemed consistent with interview data. The interviewees who had

kids mentioned them and the importance of living for them. Other interviewees mentioned how they didn't want to cause undue grief for their close relatives and friends/chosen families.

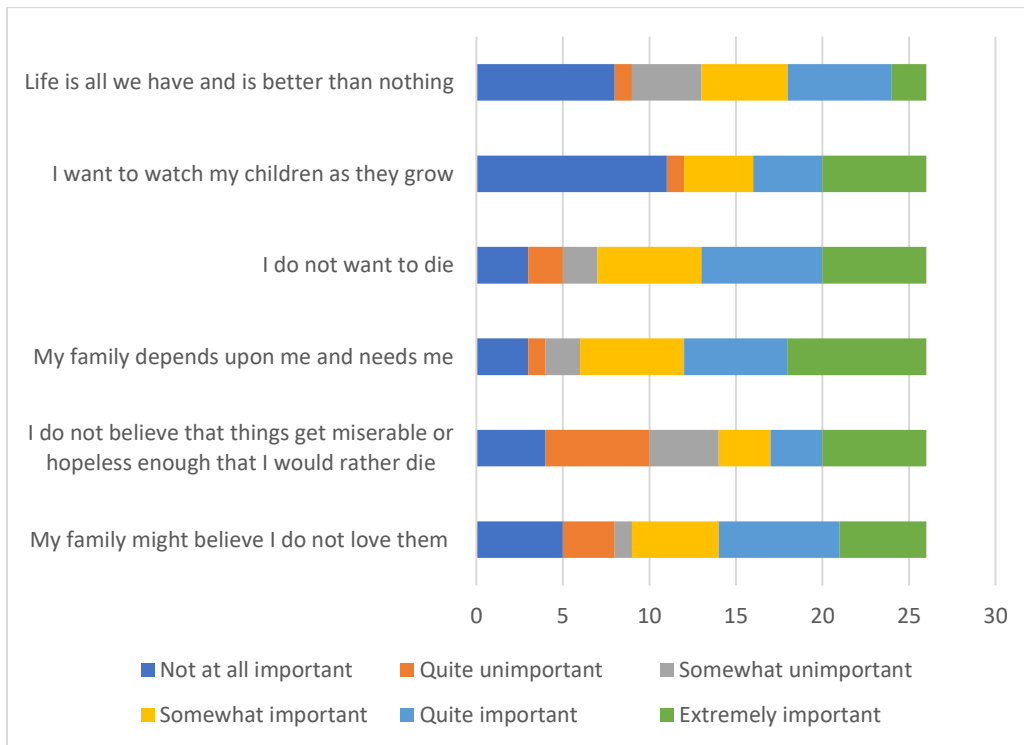


Figure 2. Reasons for Living: Second set of Questions

Figure 2 represents the second set of questions from the abbreviated reasons for living inventory in the online portion of the study. The first question is ‘life is all we have and is better than nothing.’ Participants’ responses were split 50/50 between somewhat important to not at all important, and somewhat important to extremely important, with 13 participants on each side of the item. This topic did not emerge in the phone interviews. The second question is ‘I want to watch my children as they grow.’ Twelve participants (46.16%) marked this item as somewhat unimportant to not at all important while 14 (53.84%) indicated somewhat important to extremely important. This appears consistent as interviewees who had children

often mentioned them as reasons to live, even those who did not have children of their own but who were in contact with them regularly as teachers or nannies.

The third question is 'I do not want to die.' Seven participants (26.92%) responded that this item was somewhat unimportant to not at all, and 19 (73.08%) indicated somewhat important to extremely important. I find this to be consistent with the interviews. Many interviewees pointed out that at certain times in their lives, suicide offered a potential "solution" to overwhelming problems. Interviewees didn't want to die; they just didn't see another way out at the time and often reflected on the suicide attempt as something that they seriously regretted. Next is "My family depends upon me and needs me." Six participants (23.08%) rated this item as somewhat unimportant to not at all, and 20 (76.93%) participants chose somewhat important to extremely important. Family was important for those who were close to their families because they didn't want to hurt them. Otherwise they found other reasons for living.

The fifth item in this set is 'I do not believe that things get miserable or hopeless enough that I would rather die.' Fourteen (53.84%) participants responded that this item was somewhat unimportant to not at all important while 12 (46.16%) marked somewhat to extremely important. All interviewees have been in a place where they would rather die, but in interviews, most related how they know and want others to know that attempting suicide isn't the only option when you "just want it to stop." The last item for this set is 'My family might not believe that I do not love them.' Nine (34.62%) participants rated this item as somewhat unimportant to not at all, and 17 (65.39%) indicated somewhat important to extremely important. This was not a topic broached in the phone interviews.

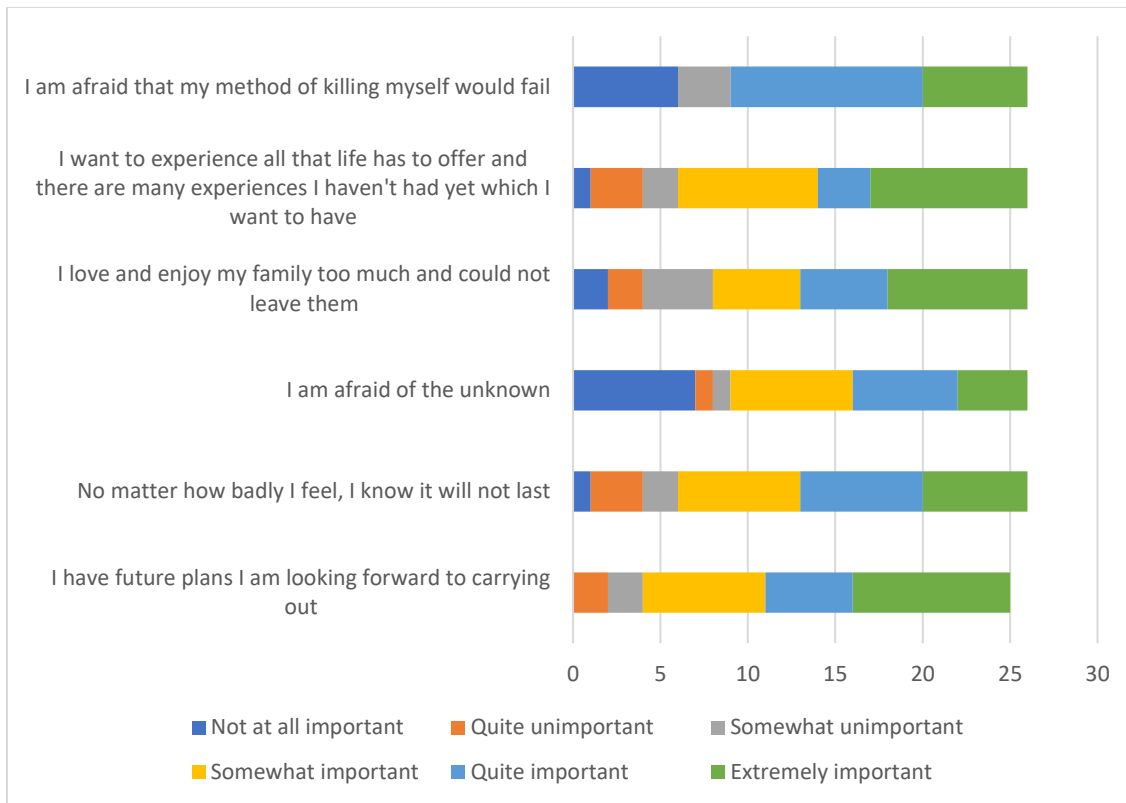


Figure 3. Reasons for Living: Third set of Questions

Figure 3 illustrates the data from the third set of questions from the abbreviated reasons for living inventory from the online portion of the study—as with the previous questions, respondents were asked to select to what extent each item would be a reason *not* to kill themselves at this time. For the first item, ‘I am afraid that my method of killing myself would fail,’ nine (34.62%) participants responded that this item was somewhat unimportant to not at all while 17 (65.39%) indicated somewhat important to extremely important. Even though I asked about their last attempt, several interviewees reported multiple attempts. The importance of this item may come from interviewees fear of being perceived as a failure at even one more thing in their own eyes. One interviewee said one of his first thoughts after his attempt was that it was just another thing he had failed at.

The second question is “I want to experience all that life has to offer and there are many experiences I haven’t had yet which I want to have.’ Six participants (23.08%) marked somewhat was somewhat unimportant to not at all, whereas 20 (76.93%) chose somewhat important to extremely important. After recovery, many interviewees expressed a newfound energy in which they were excited about their future prospects, including just the fact that they even had a future because they survived their suicide attempt. The next question is ‘I love and enjoy my family too much and could not leave them.’ Eight (30.76%) participants indicated that this item was somewhat unimportant to not at all important and 18 (69.23%) responded that this item was somewhat important to extremely important. Those who were close to their families spoke of wanting to live for them and how they regretted their attempts because it caused their families pain.

The fourth item, ‘I am afraid of the unknown,’ was not a topic that was broached during the phone interviews. However, it appears that this item was important to a majority of participants as 17 (65.38%) indicated this item was somewhat important to extremely important while nine (34.62%) participants selected somewhat unimportant to not at all important. Next was ‘no matter how badly I feel, I know it will not last.’ Six participants (23.08%) rated this item as somewhat unimportant to not at all, and 20 (76.92%) indicated somewhat important to extremely important. This sentiment seemed to ring true for those on a positive trajectory, but some participants still saw their futures as bleak. On the last question for this section, ‘I have future plans I am looking forward to carrying out,’ one participant did not answer. Four participants (16%) out of 25 that answered this item responded that this item was somewhat unimportant to not at all, and 21 (84%) indicated somewhat important to

extremely important. A majority of the interviewees had goals they wanted to carry out, including continuing their education, starting families, and achieving stability.

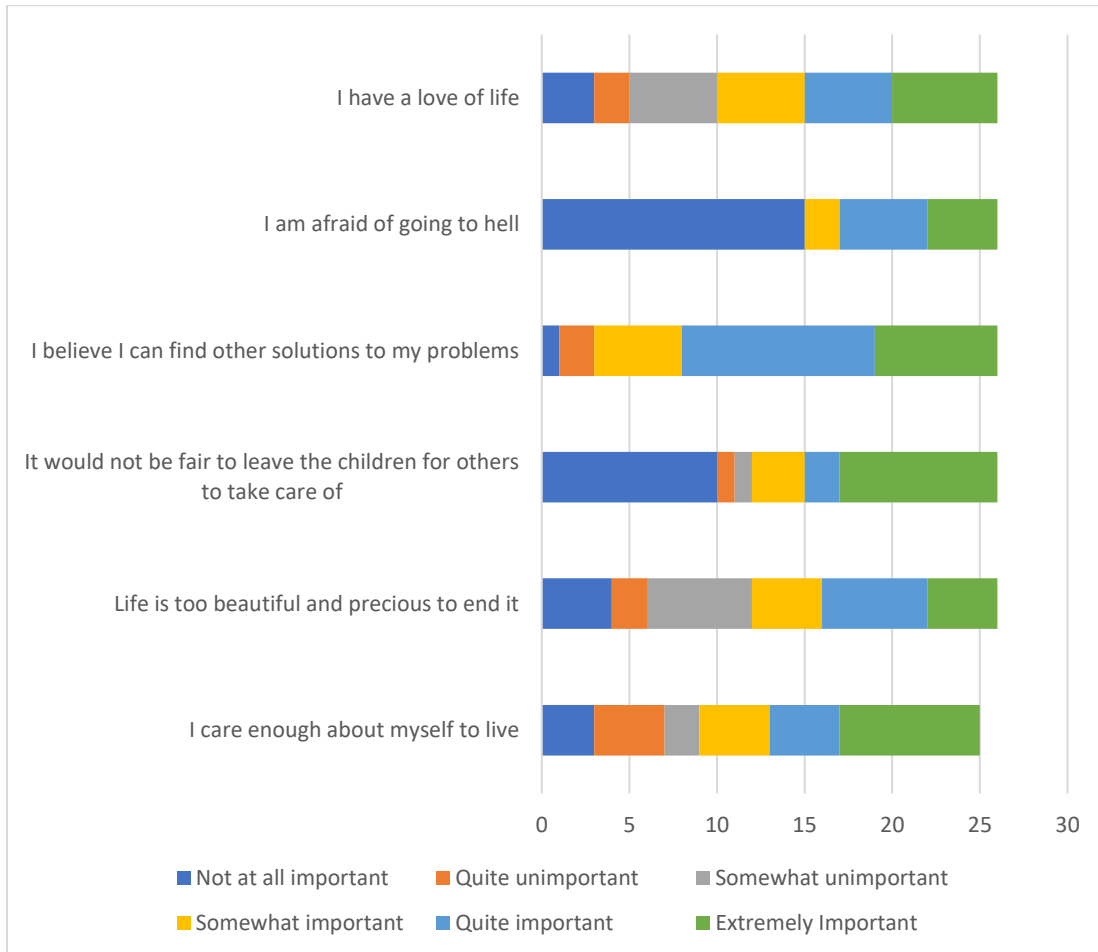


Figure 4. Reasons for living: Fourth set of Questions

Figure 4 illustrates the data from the fourth set of questions from the abbreviated reasons of living inventory from the online portion of the study. The first question is, ‘I have a love of life.’ Ten participants (38.46%) selected somewhat unimportant to not at all important, and 16 (61.54%) indicated somewhat important to extremely important. Some interviewees did express a genuine love for life, one saying that she felt like she was bragging about her life because of how good it was, and others sounded jubilant when talking about their current life

now as opposed to how it used to be. The second question, 'I am afraid of going to hell,' 15 participants (57.69%) responded that this item was somewhat unimportant to not at all important while 11 (42.3%) answered somewhat important to extremely important. As mentioned already, religious themes did not emerge as a pattern in the interviews.

The third question was 'I believe I can find other solutions to my problems.' Only three (11.54%) of the participants responded that this item was somewhat unimportant to not at all important, in contrast to 23 (88.47%) who chose somewhat important to extremely important. This is true for the participants after their attempts. They found other ways to deal with their problems instead of seeing suicide as their only option. Next is, 'it would not be fair to leave the children for others to take care of.' Twelve participants (46.16%) rated this item as somewhat unimportant to not at all important while 14 (53.85%) marked somewhat important to extremely important. Interviewees who were parents affirmed the importance of their role. One participant said that she didn't believe that anyone could take care of her son as well as she could, but otherwise this kind of comment did not come up in the interviews.

The fifth question is, 'life is too beautiful and precious to end it.' Twelve participants (46.16%) responded that this item was somewhat unimportant to not at all, and 14 (53.84%) answered that this item was somewhat important to extremely important. Interviewees did not mention this topic. The last question was, 'I care enough about myself to live.' One participant did not answer this item. Of the rest of the participants, nine (36%) rated this item as somewhat unimportant to not at all important while 16 (64%) selected somewhat important to extremely important. Interviewees said they had to learn to care about themselves after a life altering event and (re)learn that they were worthy of love and of life.



## CHAPTER 5

### QUALITATIVE ANALYSIS

As explained earlier, I gathered qualitative data with the 26 participants through semi-structured interviews over the phone. The interview included life course questions and questions pertaining directly to the participants' last suicide attempt (see Appendix A). Most participants talked about other attempts as well, which gave me a fuller understanding of their lives.

#### Life-Altering Events as Enabling Conditions

Whether in childhood or adulthood, the majority of interviewees shared that life altering events contributed greatly to their eventual suicide attempts. They described events such as divorce (their own or their parents); the end of a relationship/breakup; infidelity; sexual abuse or assault (sometimes repeated); grief following the death of a parent or partner; being orphaned (feeling unloved without a family) or socially isolated; being bullied; feeling sad and depressed; or experiencing poverty or other stigmas such as a chronic physical illness or being on disability. Interviewees' narratives suggested that life altering events were exacerbated when other people around them failed to understand their significance. While life altering events may not be the direct cause of suicidal behavior and suicide attempts, participants' narratives suggests that these events significantly lowered their quality of life in ways they could not manage on their own. They functioned as "enabling conditions" (Schwalbe 2018) for attempting suicide.

## Sexual Assault and Abuse

Narratives revealing sexual assault and abuse as a life altering event were extremely common. Sexual abuse in childhood is known to damage self-esteem, relationships, and the ability to trust. It also causes psychological trauma when the child grows into an adult (Valente 2005). Those who are sexually abused in childhood often have a lower quality of life in adulthood, trouble building social relationships, difficulty in functioning, and self-damaging behavior. Suicide ideations and attempts are a common coping mechanism for victims (Valente 2005). A study on female sexual assault victims found that suicidal thoughts and patterns were more likely in women who were sexually abused as children than as adults, but women sexually abused in adulthood are still at risk (Ullman and Najdowski 2009). It is especially damaging if a woman has experienced sexual abuse in both stages of her life (Ullman and Najdowski 2009). Sexual abuse was the most common life altering event that participants described as sending them into “a downward spiral.” Most of the interviewees who reported having experienced sexual assault said that it occurred either in childhood or adolescence. A few participants said they were assaulted in young adulthood. One participant, Geneva,<sup>1</sup> reported that she was 19 when she was raped by five individuals. Interviewed as an older participant, she said that back then people did not talk about or seek treatment for rape and other forms of sexual assault.

In each of the following excerpts, interviewees reported that other people sexually abused or assaulted them while they were children and/or as adolescents. Their assailants/abusers were family members or acquaintances (who frequently interacted with them) at home, daycare, or their neighborhood.

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<sup>1</sup> No participants are referred to by their actual names. All participant names in this thesis have pseudonyms.

Brittany: I had a lot of trauma in my life from foster brothers. I had sexual abuse from my foster brothers from three years old on up until I was a teenager...Uh... I'm a mother to older kids because of the abuse. You know, I didn't get to keep my two kids because I was so young.

KH: How old were you?

Brittany: I was thirteen and fifteen.

\*\*\*

Seth: Both my mom and dad worked so I was in a daycare center where there was an older boy well much older and I pretty much went through rape five days a week Monday through Friday ..um being in that daycare center while my parents were working and that went on for about two years.

\*\*\*

Chloe: I [had] some sexual abuse from a grandparent.

\*\*\*

Maddie: Um... I grew up with two younger sisters and a stepfather. My real father wasn't in the picture and I was sexually abused when I was younger and when I was around eight years old and I guess I've always dealt with depression from a young age.

\*\*\*

Issac: My childhood was not ideal. My mom and dad divorced at like 3 or 4 and my mom ended up marrying someone she'd been with for three weeks who turned out to be a sexual predator and so he started sexually abusing me and my sister. And that went on

for a little while and I ended up getting into substance abuse around 12 years old too, so not an ideal childhood, I don't think.

\*\*\*

Emma: When I was a teenager, I was sexually assaulted by a...quote unquote friend.

\*\*\*

Regina: When I was seven, I was almost raped by my brother's best friend and that sent me in a downward spiral. There was also a man who was part of the church next door and uh he forced me and other girls to touch him in his private parts well on his dick sorry and that was when I was like nine or ten. He went to jail eventually but uh that definitely took a toll on me because [people would not] believe us that this man of God would do something like that.

Suicide attempts are five to six times more prevalent in individuals with a history of childhood sexual abuse (Brezo, Paris, and Vitaro 2008), which is when most of the interviewees reported the sexual trauma. Repeated abuse is more likely to be associated with suicidal ideations and attempts than if the abuse was an isolated incident. Sexual abuse by a family member, someone who a child is supposed to be able to lean on for support and trust, is more likely to have more severe long-term consequences on the growth of healthy mental health attachment patterns (Brezo et al. 2008). As participants' examples and the literature thus indicate, sexual abuse served as the most common enabling condition for attempting suicide.

### Mental Illness

The contribution of certain psychiatric disorders to suicidal ideation can be potentially lethal. For example, recurrent major depression, severe psychological stress (such as loss,

shame or humiliation) and vulnerabilities (such as a genetic predisposition and early childhood abuse, or both) can enable suicidal thoughts, planning and attempts (McClure 2012). Almost all of the participants in the study told me they struggled with a mental illness or a combination of mental illnesses for an extended period of time with the exception of Andrew, who had acute depression instead of a chronic mental illness. The most common diagnoses were anxiety and depression, PTSD, and bipolar disorder. Individuals with PTSD are at an especially high risk for suicidal thoughts and behaviors (Dixon-Gordon, Tull, and Gratz 2014). A lifetime diagnosis of PTSD is associated with suicide attempts and an increased number of attempts (Dixon-Gordon et al. 2014).

There wasn't one transcript without a diagnosis of mental illness after I asked if the participant had a history of mental illness. For example, Chloe reported a history of depression and had been battling it for a long time before her suicide attempt, June had been diagnosed with anxiety and depression, and Maddie commented:

I still have a lot of chronic illnesses to deal with ...health issues and I'm still fighting with my depression and PTSD and anxiety and all those...and I'm taking my medication and going to therapy to do what I'm supposed to do to deal with my depression and deal with those trains of thoughts and stuff like that.

Some individuals reported dealing with mental illnesses from the time they were children.

Lorena told me that she experienced her first suicidal ideations at the age of six, while Lilly experienced the onset of bipolar disorder when she was eight and now also suffers from PTSD and anxiety:

Lilly: My childhood was not the easiest experience. I was diagnosed with mental illness when I was eight and when I first got diagnosed it was rough situation. I don't remember most of my early years. I just remember around eight years old I started acting out because of my mental illness.

Other interviewees' mental illnesses or combinations of mental illnesses were so severe that they qualified for Social Security disability funding because of it.

KH: What led to you being on Disability?

Seth: PTSD. I was on like 23 medications. Between mood stabilizers , anti-psychotics , just everything, anxiety medication and on top of that ...drinking and using drugs I ended up in rehab and I could not stay awake...even with in rehab with the booze gone and the drugs gone I could not stay awake. I could not perform my duties around the halfway house. I was passing out and they were having to carry me to my bedroom. I finally talked to my doctor and they got it down to three medications and then when I got to Washington, I got rediagnosed with everything with the exception of anxiety. I've just been diagnosed with PTSD from the childhood stuff, the divorces, bad auto accidents, my father's suicide which led to my suicide [attempt]. So as far as the state [of Washington] is concerned, I had PTSD, social anxiety, social anxiety disorder and generalized anxiety disorder whereas in Indiana I had 12 diagnoses and 23 medications.

Two other interviewees, Maddie and Olivia, said they qualified for Disability. Olivia reported feeling ambivalent about her designation: "I would like to not need Disability. I would like to be able to work full-time hours without full-time hours without feeling overwhelmed. I would like normalcy."

Based on interviewees' reports, mental illness was a powerful enabler of suicidal thoughts and ideations; if left untreated, participants began to feel that suicide was their only logical course of action. But suicide is never the answer. It is only a solution to a perceived insoluble problem.

### Grief and Loss

Losing someone or something important, like a job or a relationship, proved catastrophic to many participants. On many occasions, they reported additional pain because other people failed to understand the grief they felt, especially when it came to losing a significant other to suicide. Several interviewees reported being questioned or judged because they were still grieving someone after what others thought to be an appropriate or inappropriate amount of time. Participants also demonstrated how losing a job or an intimate relationship could be just as painful and monumental as the death of a person.

KH: Okay was there anything significant about the time that you attempted suicide? The last time?

Ann: The last time it was because I couldn't handle the fact that my partner had killed himself. Um...I had gotten so depressed that I had stopped functioning even a year and a half after his suicide. Um to this day...it's still...the night I had found out that he had killed himself...I remember screaming at the top of my lungs and my own mother...I was staying at her house at the time and she was like what are you screaming for and I said... you know...Aaron just died. She's like what are you talking about. I said he killed himself and she said you are overreacting and walked out of the room...Um a week passed and um everyone was like it's been a week...it's been two weeks it's been three weeks you

need to move on and the early phases of him dying I think were so poorly supported by the people in my life. Um when I mentioned his name a year later people were like why are you still talking about him. It's been a year. It's now five and a half years later and people are still like why does it still bother you.

\*\*\*

Lorena: My ex passed away from suicide and I was having a really hard time dealing with the grief from that and I didn't have a lot of support from my family. They acted like I should just get over it and they didn't understand the complications of grieving a suicide death. You know, you have grief, but you also have guilt and anger and all kinds of different things that you wouldn't normally have.

Survivors of suicide typically experience acute grief, a response to death that involves deep feelings of intense longing for the deceased, sorrow about the death, preoccupation with memories of the deceased, physiological pain, and not being able to handle normal daily functions due to the grieving process. Acute grief is supposed to eventually dissolve due to a natural healing process (Shear and Mulhare 2008). Research indicates that most people in distress from acute grief eventually come to accept the loss of the loved one and return to their lives as normal (Shear 2008). In these cases where participants lost someone they loved to suicide; it was apparent that they took the losses harder than other people considered normal. It is possible that years of mental illness(es) and their (most likely accurate) perception of inadequate social support exacerbated their non-conforming grief.

A few participants shared how their grief could feel more potent on the anniversary of an important loss and thus contributed to suicidal behavior:



KH: Okay, was there something significant about the time that you attempted?

Seth: Yeah, It was my dad's birthday because my birthday has always been February 19<sup>th</sup> and my dad's was February 20<sup>th</sup> and we always celebrated our birthdays together and we had always celebrated father's day together since my son was born in 2001 so when my dad died on Father's Day [by suicide] it devastated me, and then I made it all the way around to my birthday and I don't really remember celebrating with anybody. I think I got some cards in the mail so the next morning when it rolled around to...his birthday, that's all I could think about was him.

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Brittany: One time I tried to kill myself...it was on the anniversary of my late husband's murder. My late husband was murdered, and I just didn't want to be alone anymore. So, I tried to kill myself and other people didn't understand that I was still grieving the loss of my husband.

At least one interviewee suggested that not only did she grieve the end of a relationship, but also the hopes and dreams that the relationship could have provided in her life:

Olivia: My last attempt was in 2014 and I think I was grieving the loss of a relationship when really what could have been, had things been healthy again, um [I felt] the loss of the plan of having children again, of having a family, of having a healthy long lasting marriage like my parents. So, grief played a factor into that last suicide attempt.

Olivia shared that she had been in that relationship for over a decade. Her loss was magnified by all the time and effort and the things that she had wanted out of it but would not be able to enjoy.

Another interviewee reported that losing his job contributed to his last suicide attempt:

KH: Okay was there anything significant about the time that that you attempted suicide?

Tyler: I had just lost my job and that was everything to me at the time and untreated mental illness. I'd say um... and not taking my own mental health seriously those were all pretty big contributing factors.

KH: What was it about your job that made it a serious loss?

Tyler: It was sudden. I didn't see it coming. It's kind of blindsided me, and with all of the personal issues going on; that was kind of the icing on the cake. That was the last straw.

Researchers have found that increased feelings of depression are common after losing a job. A job loss can be devastating for multiple reasons. It can mean the loss of a person's social network, their means to earn money, and can produce increased anxiety and negative thought patterns (Riumallo-Herl et al. 2014). Whereas work may provide benefits such as structure, self-esteem, status, and a sense that one is being productive and contributing to a collective purpose, losing a job can mean one loses all of those things (Riumallo-Herl et al. 2014). Especially in westernized culture, where people place great emphasis on employment, losing a job is like losing part of one's personal identity (Dirksen 1994).

Taken altogether, feelings of overwhelming grief and a deep sense of loss could come from a variety of sources, not only a bereavement, and consequently serve as an enabling condition for a suicide attempt.

## Cumulative Factors

Often, interviewees reported that a life altering event or series of events brought on feelings of depression, anxiety, substance abuse, suicidal ideation, or a suicide attempt. Several interviewees described feeling overwhelmed by many troubles simultaneously, until one or more thing would “break the camel’s back” and lead them to feel that no other option but suicide existed. The next several excerpts capture how participants attributed their suicide attempt to a series of setbacks and life problems.

Maddie: [I was] at this point in my life where everything was failing, and I didn’t see anything going right. I was working full time and I was in college full time. I guess it was just too much on me and I was also sick, and I was homeless at the same time and I just couldn’t find a way out and that was the only way I could see out.

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June: Well I think the one specifically, there were three, but the survey was asking about the last one and that one was soon after my son was born and I wasn’t...he was born and that was stressful although I was also in a relationship at the time that was really bad so....So I had all the stress of taking care of a new baby and I had to go back to work soon afterward...and I had the person I was in a relationship with [was] really talking down to me, you know, like I’m a horrible mom basically telling me that I’m doing everything wrong. And I think that played a big role in that just because I was already stressed. And then um in our relationship, I pretty much took care of my son completely on my own like cause he had...because after we had been together...he basically quit working and so I was solely supporting the entire household on my own. And, I was the

only person getting up during the night taking care of my son and providing everything for him and them on top...which was stressful... and then lack of sleep didn't help. But then being told you're failing as a mom, why are you even doing this and then sometimes it would turn physical and I was just really unhappy and I really felt that I was a failure and like why am I even doing this. My son would be better off without me.

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Andrew: I think I was depressed before it [the attempt] and didn't realize it and then it got to affecting me in my sleep and I didn't know what was going on. Well, I had just come out of a 25- year marriage ...um not really lost I took over the house we had had and then sold it and took the one I was living in on trade at the time. That house was supposed to be my lifetime home. I hated the fact that I had lost that home. I didn't lose it for bankruptcy. I just had to sell it because I couldn't afford to live in it because I didn't make enough money to pay that kind of house payment and stuff and survive with my income and not being married...uh...and I was telling you both of my parents were sick and in a home in a nursing home. But the sleep deprivation, I can chalk it up to more than anything.

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Chelsea: It was several things stacked up. I was in a relationship in which there was some financial abuse, um enough so that I am still in bankruptcy because of it um I was supporting a family of five on my teacher's salary um for someone who I thought I was in love with and she had married another woman and I thought we were going to be poly and that wasn't how that worked out at all. Um, turned out I was just around for a

good time and by that, I mean my wallet and so I had gotten to a point where I knew I couldn't keep doing this. They had just come back from a three-week vacation in Florida and we had just gotten into a fight over bills being paid. I wasn't invited on the vacation and that was a problem. I paid for it, but I wasn't invited.

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Courtney: It was like I have all this stuff going on. I got financial stuff going on, I got work stuff going on. I had a boss who worked the shit out of me. He didn't care about me he just wanted to make sure I did his job. I had you know family problems. I just had a lot of things. I mean and when that happened. It was like I have nothing to live for, I mean nothing.

As these examples suggest, for some interviewees who experienced compounding problems, suicide offered a means to escape an untenable situation. However, rather than merely categorize suicide attempts as a means to escape their all-consuming problems, some interviewees suggested that attempting suicide paradoxically offered something else: control. For example, I asked one participant, Chelsea, "How have things changed for you?" and she replied:

Chelsea: it is much better. I am not living my life for me, which is a big difference. I have since had a cancer scare which has changed the way I view things. I was fine dying by my hands, not by cancer...It was then that made me realize that it wasn't that I wanted to die it was that I wanted things to stop being the way they were and that I had other options to make them stop being the way that they were. Um, because when I had my cancer scare then and there that I was not okay going out that way. I'm not going to die

due to shitty genetics. This is not how it's going to go down. And again with my therapist, I spent a whole lot of time going 'I don't know why that's different,' and she's like 'why don't you think about that?' and I'm like 'well, I don't have control over it I die by cancer,' and she's like 'so you're doing this for control,' and I'm like 'that's what it sounded like to me.'

Like other self-injurious behavior (such as anorexia, bulimia, cutting, etc.), attempting suicide may paradoxically offer people a means to "control" their life and death at the same time that other deeply troubling factors in their lives are beyond their control.

### Dealing with the Aftermath

#### Experiencing Stigma

Researchers categorize the sources of stigmatizing feelings post-attempt as internal (self-) and external stigmatization (Gray 2002). Internal stigma can be the individual feeling ashamed or embarrassed whereas external stigma is when the stigma is felt from others, such as when friends stop talking to them or family members start treating the individual "with kid gloves," or "walking on eggshells," even years after the attempt had taken place. Participants reported being treated like they were delicate or that they couldn't handle certain things because of their suicide attempts.

Most individuals I spoke with felt both internal and external stigmas after their suicide attempt. They describe varying degrees of stigmatization from self, family, friends and their communities, particularly if they came from a small community. Only those without witnesses to their suicide attempts reported little to no stigmatization.

KH: Did you feel stigmatized after the suicide attempt?

Olivia: Yes, I was ashamed to tell my parents or any of my family members that I had done it again. Their initial reaction last time was...um...hurt...that I didn't tell them that I needed help that I was hurting and then my mom kicked into protective mode.

KH: Okay, who did you feel the most stigmatized from?

Olivia: Uh, Society. I would say there is still a lot of stigma around suicide in society more so in my family they were hurt that I was hurting, and I didn't tell them I was hurting. I feel more stigmatized by society because people talk. People still talk about suicide as in the person is being selfish and really, it's a cloud in our judgement. We're not thinking about others. We are thinking about how we can end our own pain.... Um so society.

Chelsea described feeling stigmatized by well-intentioned co-workers and superiors:

Chelsea: Because it was during the work week the crisis unit sent a work note to my work and then I got pulled into a meeting with the freaking principal and HR and the guidance counselor and everybody and their brother you know so we could discuss what we could do about... Like oh Jesus it was a really bad situation and humiliating. It was very obvious that they had never had that situation happen before at least that they knew of and so they didn't know what to do with it luckily they had written a policy about it now but I got to be their test dummy for that.

Issac described how people's lack of knowledge and unease with suicide contributed to his feeling of stigma:

Um, not as much the last time, definitely some of the times in my twenties. I definitely felt like I couldn't really talk about it because it scared people. And, I knew that there

were some people that they that they were too ignorant on the topic to be able to respond to it or to have a discussion about it.

Lilly reported losing friendships and said that other people “just didn’t look at me the same or they felt more uneasy around me.” Xavier said he worried that word would get out because he was from a small town and everybody would find out about it. His mother evidently had the same worry but handled it badly. He said she was in his hospital room yelling at him about how she felt embarrassed that he had attempted suicide. The nurses removed her from the hospital.

Two interviewees mentioned that they felt some stigmatization because their occupations in counseling and behavioral health. Chloe explained, “I actually work in behavioral health now and it’s still uncomfortable to talk about even though I’m in the field and maybe particularly because I’m in the field. I feel like there is this higher expectation type of thing.”

Courtney said she felt stigmatized

for a while...I think a lot of that had to do with the fact of my profession, you know, that’s kind of like the big thing. It’s my profession and my parent’s profession and I was embarrassed. I’m a crisis counselor, you know, I hospitalize people when they need treatment.

Lorena reported how friends and family treated her “with kid gloves” and avoided the topic of suicide as if it were “taboo,” even though she could talk about it: “I started to work in suicide prevention a lot and I gave speeches and did volunteer stuff.”

One participant described feeling more stigmatized by her mental illness diagnosis and being a suicide loss survivor than by her suicide attempt:

KH: Did you feel stigmatized after your suicide attempt?



Ann: No, that's the weird thing. I felt more stigmatized by the label of diagnoses than ever for being a suicide attempt survivor .Um, I do know that in regards to having lost a boyfriend to suicide I feel like there was a little bit of stigma attached to that, like getting back into the dating world, 'oh well you know her boyfriend killed himself so you know she has baggage.' I felt more of it being a loss survivor than being an attempt survivor.

Like Ann, another interviewee, Seth, said he felt a greater stigma from being on disability for his mental illnesses:

Seth: I felt stigmatized before my suicide attempt. 'Well I'm disabled,' 'well, you don't look disabled you look fine to me why aren't you working?' I have post-traumatic stress disorder. I have generalized anxiety disorder. I have social anxiety. I don't feel it's my place to tell someone I've just met that's why I'm on disability because they just look me at me from head to toe and say 'well, you look fine why aren't you working?'

Despite the many reasons interviewees felt stigmatized, suicide attempts are not inherently stigmatizing. An important condition for experiencing stigma is the presence of witnesses. Two participants explained how they felt no stigma from an attempt:

KH: Did you feel stigmatized after the suicide attempt?

Regina: No...not even my mom knew, it was just me. I mean she knew afterwards after she found the empty bottle of aspirin, but it was easy to cover: "No, this is the one I take to work with me, and it just happened to be empty."

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KH: Did you feel stigmatized after the suicide attempt?

June: No, no because I didn't really tell anyone about it. I did it, it didn't work, so I kind of like bandaged things up and hid it. I think I made up some lie to how it happened like I was playing with the dog or something.

As heavily stigmatized as mental illness and suicide attempts still are among the general public, one can understand why some of the interviewees described hiding suicide attempts or lying about their injuries.

### Undercounting/Mislabeling Suicide Attempts

In this study, eight people shared that they had attempted suicide more often than official hospital or mental health data might reflect. This was almost one third of the participants. For every person who completes suicide, the attempted to completion ratio varies demographically. The rate for a woman being taken to the hospital for a suicide attempt was twice that of men (Daniulaiyte, Carlson, and Siegal 2007) and sexual minorities have higher rates of attempts (and completions) than heterosexuals (Bogaert, Hottes, and Rhodes et al. 2016). My interviewees' references to additional suicide attempts suggests that attempts are likely under-counted. For example, not all suicide attempt survivors go to the hospital, or their suicide attempts may be mislabeled, or they may lie about what happened so that others won't know that they attempted suicide. Data based on confidential self-reports are undoubtedly more accurate and larger than those gathered through other means.

One reason that some interviewees' suicide attempts went unreported is because they were surprised that they had lived after ingesting pills and falling asleep, etc.

KH: What were your thoughts after you attempted suicide?

Regina: Well, my first thought was it didn't work because I woke up after taking a bottle of pain pills...still breathing. I don't remember much after I started taking the pills because I have a really bad pain pill reaction and...uh...I took aspirin and I now can't take aspirin by itself. It makes me sick probably because I took a whole bottle of it. I woke up and just kept moving one step at a time.

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KH: Can you tell me how you survived the attempt?

Beth: No, I literally don't know how I survived it. I took some sleeping pills and did carbon monoxide and this was early in the morning like 8 o'clock when I should have been going to work and I don't know I woke up at 7 o'clock that night and I was on my bed and I was living with my niece at the time who was like 30 something and she said she came upstairs and tried to wake me up and I was just out and she was home and the garage door was like half open and that was weird so I have no idea how that happened throughout that day...I have no recollection.

Another woman's attempt went unreported because she gave up after her method failed:

KH: Did you call 911 or did someone find you?

June: No, I was like in the bathroom and I like tried to cut myself enough to bleed out and it didn't work and eventually I gave up and was like this isn't working.

And at least one interviewee minimized the stigma of "suicide attempt" by opting for a label that, to her, seemed less stigmatizing: "drug overdose. "

Morgan: I enjoyed being around my coworkers, but it was so, so hard for me to talk about that. I would skirt the truth, or I would lie about it a little so that it didn't sound really bad. One of my coworkers started dating an EMT and he was like, "You look really familiar, have I ever met you before?" and I was like, "I don't know, I mean I got taken to the hospital once for a drug overdose," and it wasn't completely a lie because that's what they put on my medical chart in the hospital and they never changed it, so yeah, I didn't want to talk about suicide at all at that point.

Several participants shared that they had suicide attempts in their childhood that were never reported and that were often part of their downward spiral after a life altering event. For instance, Alex said, "There is one suicide attempt in high school and that didn't get reported or anything like that." And Ann explained how this happened in her past:

My first attempt when I was in the eighth grade... the night that it had happened I had said to my dad 'I want to kill myself. Can you please take me to the hospital?' And he said, 'you're fine just go watch TV,' ... just completely dismissed [me]. And so I did I went to my room and I hung myself...um I don't know how the noose broke, I don't know anything for I don't remember being on the floor because the last thing I remember is getting a noose and tightening it and doing my thing... Um and so because it failed...I was like nobody needs to know. I kept it a secret but I did talk to my father about it like shortly after my attempt in 2015 and was like I just want to let you know I tried slitting my wrists and I tried overdosing on pills and I kept it so hidden.

As interviewees explained, if their suicide attempt occurred without involving medical treatment or if that treatment noted only the immediate problem (overdose) rather than its

cause (suicidal behavior), then underreporting and undercounting a suicide attempt offered a path of least resistance. Facing one's mental health problems and suicidal behavior is far more difficult and requires support.

### Getting Help

#### Therapy

Access to therapy differs across states, networks, and income levels. Some participants who received mental illness diagnoses and therapy at early ages were lucky based on their family's higher socioeconomic status. Another hurdle for some interviewees was a reluctance to start therapy, despite knowing that they could benefit from it. It should be noted of course, that people find therapy best when they find the right therapist.

Two participants, Lilly and Ann, fit the class-advantaged model for addressing serious mental health problems. Lilly described her childhood financial status as "stable, strong, my parents were upper middle class." She explained that childhood "was not the easiest experience. I was diagnosed with mental illness when I was eight and when I first got diagnosed, it was a rough situation for about four years, before I was in therapy and boarding school." Ann, from an upper-class family, said, "I have been seeking treatment since I was 12 or 13 years old and I'll be 36 soon, and I'm still in therapy cause yay for therapy." Both Lilly's and Ann's parents were better able to afford therapy, an advantage that lower-income families would not be able to offer their children.

Ann went on to explain how therapy was critical in teaching her mental health survival skills:

I would say therapy has helped me tremendously...throughout the years it was really difficult for me to open up about the suicidal ideation and the attempts until after my boyfriend's suicide in 2014, but it did provide me with coping skills and things to do instead of acting upon the urges. So even though I had a couple of attempts I feel like I probably would have followed through with it had I not had the coping skills and the knowledge of like here is what you should try instead of doing this kind of stuff from the therapy throughout the years. [Cognitive behavioral therapy] was literally the most amazing thing because I needed it and it's something that I...I still apply into my daily stuff like the cognitive restructuring when I have negative thoughts.

Understandably, getting therapy and other mental health care in adulthood presented economic barriers for several participants. In asking Beth about whether there was anything significant about the time she attempted suicide, her answer connected suicidal behavior with the need for affordable care:

Beth: The biggest thing—and working in mental health for so many years and I was working full time—um, I was trying to get help for a couple of years prior to this happening, uh but I had a really high deductible where everything was out of pocket...even meds for the first 4,500 dollars, and I couldn't afford it and I made too much money for any assistance but not enough money to get help because I knew I was in trouble. I mean this didn't just happen overnight and I planned this suicide for months.

A couple of individuals joked about the expenses stemming from attempting suicide. For example, I asked Courtney if she still thought about suicide and she answered:

No. It cost too much. I had to pay for the ambulance. The wings...when they gave you the bill was like 30,000 dollars and the ambulance, I lived five to six miles from the hospital, and it cost me six hundred and something dollars. Yeah it was so damn expensive, I could have gone to the Philippines on first class.

In addition, finding a good therapist can be difficult, and harder still if the individual lacks a decent insurance policy. Ann, a therapist, said:

One difficulty...when I've been trying to find treatment throughout the years, is that people often say that they specialize in something that they have no competency in at all...And then there is always the insurance issue, too: The people...that are actually trained in that competency area [can be] out of your network.

Even the state one lives in can determine whether one qualifies for counseling. Seth moved to another state and the change in health care systems altered his eligibility. I asked Seth if he still receives treatment, and he replied,

No, that's the horrible part. I have been here since November 4, 2013. Washington state has a completely different health care system....Um, I've gone through all kinds of different insurance companies since I've been here to help with copays for medicines, doctors' visits, the normal stuff, but when it comes to counseling, they absolutely cannot .So... it's pretty much I go to my family M.D....This is just a state where no one wants to deal with Medicare/Medicaid paperwork and they are wanting [me] to self-pay....So my doctor in his words [says], "Well, I guess I'm going to have to put on my psychiatrist's hat and what do you think we should do here." "I'm like well I took Prozac x amount of years ago and maybe that might do something." "Okay, I'm prescribing you

a low dosage of Prozac,” and that’s the way it’s been since 2013...[My M.D.] flat out tells me “I am a...medical doctor I only know how this is affecting you if you have follow-up visits and that’s the only way I’m going to know because I’m not even pretending to know what I’m doing in the mental health field. I’m not licensed to be that kind of doctor...”. So, they’re like, “Have you ever thought of moving back to the Midwest? Because it may come to that point because eventually, we are going to run out of drugs that we can throw at you.”

Trying to navigate a state’s patchwork system for mental health care seems to add an extra burden for people who are open and willing to getting therapy.

Other interviewees—June, Morgan, and Courtney—expressed reluctance to start therapy or make an effort to benefit from it. June, who recently started therapy at a fiancé’s urging, first answered my question “is it helping?”:

I’m not sure yet. We’re talking about a whole lot of stuff. I guess for the most part, I’m not feeling good about it, but also, you know , I was told it might take a while before things actually start helping...The relationship I’m in now, my fiancé actually urged me to go to therapy cause he was talking about how he’s been to therapy before and was pointing out to me like you know you have really bad patterns you are doing, and I don’t think you know you have had a lot of bad things happen, and, you know, I really think you should go talk to someone like it would probably be good for you.

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Morgan: Well, I didn’t actually start seeing a psychologist [after my attempt] and looking back on it I definitely needed to, and even to this day. I think I still do. Um, but I’ve been



very stubborn and I haven't seen any therapist probably because when I was at the hospital they put me on antidepressants so I felt like seeing my regular doctor was enough to say hey the medicine's working or the medicine's not working and I just felt like that was pretty much enough.

KH: Do you think you will give in [and get therapy] eventually?

Morgan: I do. I mean even right now, it's kind of nice to talk about it because you are a stranger. Um, I don't talk about it very much with my boyfriend because he gets upset about it. Um, I've only told about two of my current co-workers, because again I don't want their opinions of me to change...um...but I think if I did talk about more, I would probably feel a lot better about myself and try to forgive myself for it, that's the hardest part.

Ironically, one participant suggested that her familiarity with therapeutic approaches through her occupation as a crisis responder made her feel reluctant to take therapy seriously. After her attempt, she did not receive inpatient therapy, but she did attend some Employee Assistance Program (EAP) sessions. She described getting nothing from them:

Courtney: The thing about it is with the EAP is that I was just sitting there. I didn't really grasp anything from the session and the why was because, you know, I'm a therapist. I'm a practiced therapist so everything they were telling me; it was just going through the motions. It was like let me just say yes, yes, yes, yes, I am, and things like that. ...I went through the motions to get my sessions over with. Did I get anything out of it, well, hell no, I didn't get anything out of it that I didn't already know.

## Online Help and Self-Help Groups

Another way that interviewees sought help was through the internet. Social media outlets and platforms can be a means of therapy and a way to terminate negative thoughts for people who lack immediate access to a mental health professional.

Regina: I don't open up easily unless it's over a phone, probably because they can't see me, they don't know me, and they can't judge me for me, they have to get to know me before they "see" me. Um...I have gone and done a few things...I do tiktok videos. I don't know if you know what tiktok is ... so it's an app you record videos and post for other people to like comments they can say if they love it hate it and they can be brutally honest with you but a lot of them are 'this is really amazing keep it up' uh they encourage you to be better um and there are a lot of them that are 'I'm here for you if you need me,' so it's like a network of people that will be there for you. There is always bad there is bad with the good, but those are ever rarely in. And music for me is my therapy it's my greatest strength. It's my greatest weakness. The right song can make me depressed; the right song can make me the happiest person in the world. Music is my outlet and tiktok is my way for me to give myself therapy when I can't go to it.

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Morgan: I guess I really want people to know that there are other options, um that [attempting suicide] isn't something you have to do. Um if I ever knew of anyone, I wish they would be comfortable talking to me about it, um you know, I've had my own life experiences. I get on Facebook a lot and sometimes I see videos where people talk about their experiences and I saw one about this man who jumped off the Golden Gate

Bridge and survived so he told his story and said that as soon as his hands and feet left the bridge that he felt regret immediately. And that was helpful for me, I think, to think about mine and how I regretted it how things do get better and I would want people to know that it does get better.

Tyler described that his strategy to avoid suicidal behavior was to go online:

I will try to distract myself to feed my mind more positive things [such as to] look at some more positive content rather than negativity or nonsense anything that is going to feed that negative thought process.

Getting online help resolved transportation problems for Tyler, as well:

I know there are some mental health groups a few miles out, but I have some issues with transportation so I can't do that, but there are many, many, many support groups online. It helps to talk to people that have been through it themselves or are going through it themselves or in the past [and] it makes you feel a lot less alone.

When I asked interviewees if they had ever been to a self-help group specifically designed for suicide attempt survivors, only three participants said that there was one in their area. Others mentioned that there wasn't, or that other types of groups were available in their area, like groups for suicide loss survivors. I asked participants if they thought a self-help group specifically designed for suicide attempt survivors would be beneficial. Most seemed supportive of the idea.

June: I guess being able to talk to people who actually understand the feeling at the time, because I mean they are pretty intense feelings...I mean just talking to someone in my life, I don't think they would necessarily understand like how intense a feeling that

is. But other people in a group maybe would have more of an understanding...I guess those would also be people who would support you and give you a sense of belonging. I guess like knowing you have people there who would help you out, I guess.

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Issac: Yes, I do....When I come across guys who experienced it um, we...the connection and understanding of the people you come across [can be a] pretty deep connection, and they come across someone who has been through it too and [knows] how intense it is.

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Emma: Absolutely.... We are best equipped to help each other in a lot of ways, like I'm in AA and I think that like nobody helps alcoholics like alcoholics are able to help each other.

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Regina: They help. They give you a bond with someone who is facing the same battle as you, they know where you are coming from and you know where they are coming from. For the most part and you can see what the other person can't always see, and it gives you someone to lean on and they can lean on you too. I would recommend getting more self-help groups because I know [\_\_\_\_] county has one, but it only meets once a month and some of these people need it more than once a month. The person who runs it can only rent the building that one day because it's booked up with other things you know having a place where they could go for those meetings would be amazing.

Just as some interviewees expressed reluctance about getting therapy, some participants were concerned about a possible loss of confidentiality or the need for careful group moderation:

KH: Do you think you and others would benefit from having a self-help group specifically designed for suicide attempt survivors?

Lorena: I think it would help and I don't want to say anything negative about that because I think there should be groups for that, but for me, specifically, the survivors of suicide loss helped me more because it gave me a purpose and a goal and I'm not sure I would go to a group that was just for survivors of attempts because I feel that I would kind of keep me in that zone of thought but that is just me personally. [I] definitely think there should be that option out there, but there would have to be a really good leader to keep the conversation in a healthy place.

### Medication

In the course of discussing suicide attempts, some participants related that sometimes, rather than helping them, medications sometimes made their depression even worse:

Olivia: My first time was in 2006....I didn't understand the importance of staying on my medication and being on my treatment—following my treatment plan. The last time, um...I had been inpatient eight months prior for depression...for a major depressive episode and they had changed my medication to one that I had told them I was resistant to. At that time I was so desperate to find stability again that I was willing to try any medication combination and they added it on to my primary antidepressant and I didn't feel like it helped me during that time, and so my suicide attempt was eight months

after I got out of the hospital, after I was released from inpatient. And at that point I understood the importance of being on my medication and I was completely I was compliant with taking my medication also, but it just did not help me and I had reached the point of despair ....'Well, I've been to the hospital they have changed my meds, nothing is going to get better'.

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Alex: The last time was brought on by...I had gone to a psychiatrist and they had put me on a medication for what they thought my diagnosis was and they had diagnosed me with something that I hadn't been diagnosed with prior and the medication kind of led me down into a spiral, you know, I was having side effects of hearing voices and having visual hallucinations and just a lot of stuff that was interfering with my cognitive ability to kind of rationalize all of it--that stuff that was happening. I talked to the psychiatrist. I talked to her once after she started the medication and you know a couple of weeks afterward and when I began having those symptoms, and she wasn't really supportive and kind of just told me to take more of the medication which I likened not to do and when that happened, that's when the depression kind of took over, so that was a different perspective. That was my fourth or fifth attempt at that point.

Given the difficulty of finding the right medication and therapy approach, one of the interviewees wanted others to know that even though it's hard sometimes going through the recovery process, that it was important not to give up:

Chloe: Uh, honestly the biggest thing was finding the treatment that worked for me and I think it's really hard when you are depressed...When you are depressed, it's you try

something for a while, and it doesn't work and they up your pills or change your medication....Pretty quickly, you get tired of it, [it] makes you feel hopeless....But the best thing was that commitment to 'I'm not going to give up.'...[The trial and error process is] really discouraging because there isn't usually a quick fix. There isn't a first med[ication] or a first therapy appointment or a first whatever you do doesn't usually do the trick and by the third or fourth one you start losing hope that anything will, and it makes you want to stop trying and sometimes it's the twelve or fifteenth thing before something finally works.

Overall, in order to get help, interviewees sought therapy, found help online from various social media outlets, and tried to follow doctor's orders when it came to medication, even when they worried it wasn't successful.

As a side note, the majority of the interviewees, including the men, used overdoses as their method of choice for suicide attempts. This brings up the issue of access to the means for an attempt. Emma, for example, related how she took advantage of an "opportune moment." As she explained, "I got medication in like three-month deliveries and my roommates had them locked up... I had intended on suicide and I was like waiting on a time to do it, and [one time] my meds came [while they were out] and my roommates hadn't locked them up yet." Emma's and the other participants' use of medications to intentionally overdose begs the question of how do we prevent overdoses? In 1988, Britain changed the packaging for an over-the-counter medication similar to acetaminophen to blister packs (Emanuel 2013). There is some support that this packaging change is related to a decrease in that method of suicide. Emanuel noted that pharmaceutical companies aren't likely to want to go along with this change, as they will

lose money on the packaging. But such a simple way to discourage an impulse to attempt suicide matters.

### Passive and Active Suicidal Ideation

I was glad that most of the people I spoke to were on a path to recovery, which I called a “positive trajectory.” However, many individuals, including people who seemed to be doing alright, spoke about feeling suicidal in times when they felt overwhelmed or overly stressed. Suicidal ideation is considered “passive ideation” if the person has suicidal thoughts but there is no planning involved. Suicidal ideation is considered active if the person has the desire to kill themselves and this behavior usually involves preparing a suicide plan, such as hoarding pills or obtaining a gun (McClure 2012).

KH: Do you still think about suicide?

June: Uh...sometimes...like if I’m really stressed or if I feel like things just aren’t going right. I mean not in a ‘I’m going to go do it way’ just like a I guess the idea just pops in my head but I’m not going to make a plan to go do it kind of thing.

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Tyler: Um, not nearly as much as I used to. Sometimes when I’m stressed or overwhelmed those thoughts do creep in, but I’m used to them now I know how to deal with them much better than I used to. I mean they still pop up but um I’m a lot more self-aware these days so I’m able to handle it when it does but as a result it has less of an effect on me now than it used to that is for sure.

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Alex: I think once those thoughts kind of enter your mind, it's something that is always in the back of your mind at some level, but I mean it's not active suicidality or anything. As June, Tyler, and Alex suggest, although suicidal ideation is common, it was possible for many of the interviewees to put it into perspective, along with seeing the connection to stress.

### Making a Life

At some point after an interviewee attempted suicide, they started making life changes. Interviewees worked hard to adjust to and to rise above the challenges they faced in their lives to make a new, better life for themselves. In this section, I explore how interviewees worked towards a better quality of life for themselves, which was easier for some than others. I also discuss the kinds of occupations interviewees had (which were often related to medical or mental health), the goals interviewees were working towards, the things interviewees mentioned as their reasons for living, and the resilience and persistence that got the interviewees where they are today after everything they have been through.

If they were employed, I asked participants to type in their occupation in the sociodemographic part of the online survey. I found that many of the participants worked in the medical or mental health fields. They reported such occupations as therapist, home health aide/certified nursing assistant, mental health crisis therapist, EMT, CPRS, health insurance salesperson, registered nurse, and counselor. Other occupations included supervisor for a textile company, sales, instructional designer, training department, special education teacher, intern, IT technician, and manager. I asked this question originally because there are certain occupations that are more likely to be associated with suicide than others, but I found that

people who had attempted suicide who responded to my study invitation were in or wanted to go into occupations where they could help others because in many ways, it helped them.

As an example of this, Ann, a therapist, described how receiving therapy deepened her ability to help others:

Ann: You know at first, I thought it was going to be incredibly weird....[But] it's nice to talk to someone who I can process and unload what my clients are going through.....So as a therapist knowing how hard it is for my clients to be able to open up and be honest with me has made it so that I have a stronger desire to be honest and its put more drive in me to be more successful with dealing with my own problems. I'm more receptive to learning coping skills and trying newer things and it's kind of a cold test run, because if something is successful with me...[then] I can figure out how to incorporate some of those techniques into working with my own clients. So, it's been amazing pretty much overall. Plus, I finally found a really good therapist so that doesn't hurt.

Many interviewees who talked about going to school spoke of going to school for an occupation that would help others in fields related to the social sciences. One participant, Geneva, said that she was interested in psychology because she wanted to understand why she was the way that she was. The following excerpts are from participants who are either currently working in or are going to go to school for occupations that will help others:

KH: Okay, how do you feel about your life now? How have things changed for you?

Brittany: I'm in college. I'm majoring in social work. I am able to tell people how I feel before it gets bad and then I'm able to talk about my feelings instead of self-harming or

trying to kill myself....I will be finished with college in two years. I will be able to work a full-time job and help others and help myself.

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Issac: I'm very passionate about studying psychology and understanding some of these ideas so that I can help others more. And I'm very passionate about that. I'd say that is one of the main reasons I wake up is to get better at my field and to eventually get a Ph.D. and do research and contribute to the field of psychology and help others.

### What Makes People Want to Live?

The biggest thing I hoped to learn was what helped the people who had attempted suicide want to live. What made the quality of their life better? While not everyone was on a positive trajectory, even those who seemed to be on negative trajectories had something to live for. Many interviewees mentioned having a purpose and having goals, and others spoke of the importance of social support:

KH: What happens in your life to help you want to live?

June : Well, my son does and I guess the big reason is I don't think that anyone else would be able to take care of him...not necessarily as well as I do, and maybe just like now compared to back then like I feel more like I'm making decisions for myself versus things just kind of happen to me I guess.

KH: so, you are more in control?

June: Yeah, and you know I feel like I'm doing more fun things also and it feels back then I never went. I would go out with friends now you know....I also started working out also

and joined a roller derby team like I'm part of a group of people that are really supportive of each other and part of it you know is I have better people around me also. Lilly responded to this same question by saying, "I attribute medicine um for keeping my mood up I attribute a little bit of hope and familial support." Both Emma and Courtney mentioned pets as a source of support in addition to people. Emma said, "I have amazing friends and I have awesome dogs uh and uh just times of just connecting with people." Courtney explained:

I mean this is stupid...real stupid, because in part of my assessment it says do you have anything to live for and that's kind of similar to what you are asking me now. But it might sound silly, but I hear a lot of people say this especially when interviewing them. I mean, I love my cat and my dog. Isn't that crazy? I love my pets. You know they are helpless, and I just can't imagine them...I mean they are like my kids.

Alex and Tyler described that in addition to having social support, they looked forward to the future:

Alex: Um, my job is very important to me, my friends, my family, my immediate support system is very important to me um I do have goals I do want to eventually get married and buy a house and all that stuff and have that experience all that so just thinking about all the possibilities that could be I guess.

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Tyler: a support system, honestly just hope, hope eluded me for such a long time. I never had it. That's always what I was seeking and I trying/finding it get more and more than I did back then, so hope is a big one. Curiosity is a big one. I've always been very

curious so I'm kind of excited about the future too because I don't know what's in store for me but I'm ready for it.

Caring for others was an important reason to live for Xavier, Andrew, and Seth. When Xavier spoke of his attempted suicide, he said the nurse told him that he was as close to dead as she had ever seen in the 20 years that she had worked at that hospital. He explained that coming that close to death and surviving gave him a purpose. He changed his environment, takes care of his father, who was in a home, says it's the little things that make him happy like taking his father out to eat, paying the bills, buying his father a car.

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Andrew: Alright, well I have a loving caring wife that I get up to every day, I have a job where people rely and count on me and friends like I said I love getting up and doing things whether its home things or things for family or things for the neighbors. I'm just constant and I've always been that way of trying to do for others my son has picked up on that and said you always have to have someone who needs you because you want to do for others because you want and I find peace and comfort in helping other people whether if it's some form of labor or if it's some conversation over a cup of coffee about something over something good or something bad or a problem I guess I guess you could say I'm a fixer I like to fix things.

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Seth: Well, just in the attempt process where I came to my senses, I couldn't imagine hurting my family that way um my fiancé lost her husband due to suicide. Her and I have been very proactive in the suicide walks in our area. We talk to people online and in

person who seemed to be near the edge. I just have a lot of positive influences around me that want to see me succeed and accomplish anything that I want to succeed at and they are willing to do anything they can to make sure that I get there so...that's why I don't think about that type of thing anymore. I have a lot of optimism, now I have a lot of goals and a lot of hope and a lot of plans and I've been taking all the plans necessary to move in that direction instead of just kind of sitting on the couch like I did for years just in my head you know with the PTSD and recalling every bad thing that had happened now most days I'm like I need to go to the gym uh the apartment looks like it could use some cleaning. I'll do my best there um I stay active I used to all the time be so bored I haven't been able to say I'm bored for months so things are a lot better.

Like Seth, Ann described volunteering, and participating in suicide prevention efforts as a way to be helpful to others. I asked Ann how active she was in suicide prevention, and her answer was on a scale far beyond most other participants:

Ann: On a scale of 1 to 10 I would say a 25. I do Out of Darkness walks every year, you know Facebook fundraisers for my birthday, and actually starting on Sunday I'm going to be the cohost for something called the social media chat on twitter um so I do have an open dialogue I use my social media very actively to promote awareness for suicide and suicide prevention. I do like live videos and I get a lot of people because I am a working therapist I get a lot of people can you answer this question for me and so I'm like how about I do a live video so people can chime in um but I do try to promote as much attention to it without being overbearing. I try to help professionally in a way but I think the coolest thing I'll be doing with this whole advocacy thing is social media thing on

twitter because that has a social media reach of five to six thousand people across the country um and we get to interview other suicide survivors we get to interview people from AFSP and the American Foundation of Suicidology and so I'm currently trying to network to see how I can help um I was working with NAMI for the past two years and I was part of their ending the silence program so I would go into middle schools and high schools in parts of New York and talk to them about my experiences with depression at their age and my suicide attempts um and we incorporate warning signs and how to tell if you are struggling with a mental illness or how to get help if you are having suicidal thoughts or how to help a friend so it was a really amazing experience to be able to go out and help the youth which is what I think helped parlay me into becoming a child therapist um so yeah like I said on a scale of 1 to 10 I'm like a 29 for advocacy. I want to stay alive I really do it keeps me going all this stuff the advocacy it just keeps me going.

Putting together the different responses in this section, interviewees indicated that more than having a purpose, their connections to others (families, partners, helping others, etc.) mattered and helped them avoid feeling suicidal. As I mentioned earlier in this thesis, the participants in this study received a gift card for their participation, yet no one seemed overly concerned about it. The participants were largely doing this to help me and to give a voice to people who have attempted suicide. A number of the participants in this study were involved in volunteer work, suicide prevention the most, but other organizations as well. Helping others seemed to be very therapeutic for them and created meaning in their lives. Meaningfulness is essentially a personal assessment of if one's own life has a purpose or value (Baumeister, Vohs, and Aaker 2013). Life tends to be defined as meaningful if a person finds that their life is

continually rewarding, and as you can see with a lot of the interviewees, they found purpose and meaningfulness by helping others. Ignoring the need to feel meaningful can lead to depression, anxiety, hopelessness, and suicidal behavior (Glaw, Kable, and Hazelton 2017).

### Resilience and Persistence

Most of the interviewees were on a positive trajectory. I estimate that 21 out of the 26 participants were doing much better than before their attempts. After listening to them speak, I was astounded by their resilience and what they did in order to keep themselves from being on a negative trajectory. In some cases, participants moved, got divorced, basically changed their environments in order to maintain a better quality of life. Others learned better coping skills, got more involved in volunteer activities or took control of their mental health in ways that they hadn't before. Xavier moved across the country to get away from the friends who sold him drugs, got himself into a better environment, a better job in which he was able to provide for himself and his dad. His refusal to stay in an environment that was toxic to him and to start over was a way of saying, 'I'm not giving in.' Below are some interviewees who spoke about resilience:

Issac: I learned to switch from the victim mentality to look at my childhood that little boy didn't deserve, that developed addiction [as a] 12- year-old. I think the turning point was figuring out that I could use all those situations and do something really great with it—like maybe they happened and ideally none of them should have happened but it did happen, like how can I take some of the strength from it and do something good with it and so I switched from out of the victim mentality and I decided I was going to take my experiences and I think I found my purpose which is to take some of the things I learned



moving through it and moving out of it and take some of those things and help those who are still in pain and still suffering.

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Lorena: I have a much better understanding of suicide and have started to use it to help people with the SOS meetings. I figure if something really horrible happens you can at least use it to [be] beneficial to someone else and then it's less horrible so I've done a lot of volunteer stuff and that's something I didn't do before any of this so it definitely changed my life in that way.

Resilience was historically thought to be genetic but is now thought to be mostly a learned characteristic. Resilient people typically possess three characteristics: They try to be realistic, believe that life is meaningful, and be able to improvise if there is the need (Coutu 2002). Resilient people have a very realistic view of what is needed for survival. Resilient people can create meaning for themselves and people around them and they also have the ability to be innovative. I believe that the majority of the interviewees I spoke with were incredibly resilient; they continue to do what they can to remember that life is worth living even when that takes an effort, and do what they can to keep moving in a positive direction.

Of the few participants who seemed to be on a negative trajectory, the word that at least three of them used to describe their outlook of their future was "bleak." Jessica said that she knew she was going to die by suicide, but she did not know when. She lives on disability and said that it sucks because she is poor. Geneva works tirelessly with suicide prevention, exercises and keeps a gratitude journal, but has health problems and several upcoming surgeries and knows that things can change in a minute. A few of the interviewees said they did not have

anything to look forward to when asked about their future. One, Emma, has had several interventions since her last suicide attempt.

When I compared the average length of time since the last suicide for people who seemed on “negative” vs. “positive” trajectories, the average for interviewees with negative outlooks was six years and the average length for those with positive outlooks was five. Even though these individuals did not seem to be doing as well, their interviews revealed persistence in the form of some survival strategies. Emma set smaller goals for herself that she knows are attainable and makes sure that she has a solid support system. Olivia makes sure that her psychologist is aware of her active suicidal ideation, follows a safety plan, and attends a local NAMI support group that has been a big help to her along with her familial support group. This suggests that the interviewees did not necessarily have to be on a positive trajectory to exhibit resilience and persistence.

## CHAPTER 6

### CONCLUSION AND LIMITATIONS

My analysis shows how suicide attempts are often the result of dealing with years of mental illness. They are often the result of people feeling overwhelmed and feeling as if they have no other alternative. The life course questions, in particular, were essential in understanding how life altering events often led to a downward spiral that contributed to participants' developing mental illness(es), engaging in self-harm, abusing substances, or attempting suicide.

Life altering events included overwhelming trauma such as sexual assaults, but also events such as the death of a spouse or parent, harassment, emotional or physical abuse, being an orphan, or getting divorced, among other things. In some cases, interviewees attempted suicide due to a significant event like the anniversary of the loss of a loved one, a job loss, or a missed relationship anniversary, but many times their attempts seemed tied to cumulative factors.

All of the interviewees had been dealing with mental illness. Most had chronic mental illness; only one reported an acute breakdown. After the suicide attempts, interviewees often reported feeling stigmatized, with the exception being those who had no witnesses to their attempts. Those who lived in small communities were worried most about being stigmatized in such a small area saying things like, "things like this just don't happen out here." Interviewees were often treated differently after their suicide attempts as if they were too delicate to handle certain topics, even years later.

Therapy was beneficial to some of the interviewees, but it was not accessible to all because it was not affordable or in-network. Many had to resort to other means such as social media or getting treatment through a primary care physician. In some cases when individuals tried medication to help with their mental illness, it could backfire and worsen how they felt. Even with therapy, most participants still dealt with at least passive suicidal thoughts, thinking of suicide especially in times when they were overwhelmed or stressed. Given the sheer volume of adversity the interviewees reported experiencing over their life course, resilience became a prevalent factor.

My study reflects some limitations, of course. Initially I did not realize the degree to which sexual assault histories would be reported as life-altering events, so I recommend that researchers add resources and hotlines for sexual assault and domestic abuse victimization, not just suicide prevention, when providing a list of helpful resources for participants in future studies of adult suicide attempts.

Because the majority of research on suicide prevention is focused on adolescents, it was extremely difficult to find published research on adults even though they attempt suicide more often than adolescents. There is a great need for more research for adult suicide prevention.

I found it incredibly difficult to find platforms willing to post the study and help me locate participants who would volunteer to take the survey. This made the data collection process more time consuming than expected. Even though the ETSU IRB approved the survey and interview protocol, many gatekeepers to suicide prevention organization websites and special Facebook support groups were still reluctant to post. I did not learn why they were so cautious, but it is possible that they wanted to avoid alienating their respective audiences, or

perhaps they did not want to bring up a stigmatized and uncomfortable topic, which would be ironic from a prevention-oriented perspective. Despite our best efforts, it is difficult to combat the stigma surrounding talking about suicide attempts. It is also a challenge to speak openly about an experience that may still be extremely painful for some to discuss, regardless of the amount of time that has passed.

Additionally, because the study had a modest number of semi-structured interviews, caution should be exercised in generalizing beyond the sample. Life course questions nevertheless give me and other qualitative researchers a better, more intimate understanding of interviewees' feelings so that we can arrive at useful insights (McCombes 2019). A last limitation is that a convenience sample always runs the risk of being somewhat biased as some people are more likely to volunteer to participate in this kind of research than others (McCombes 2019).

In future research, because reaching out to many mental health or suicide prevention-related social media platforms was inefficient (and thus stressful), I recommend concentrating recruitment efforts on research-based mental health platforms such as AFSP. Such organizations have a better understanding of research and are more likely to understand that it can be beneficial to talk about suicide and other difficult life events (Dazzi et al. 2014). I also recommend doing a longitudinal study. Knowing that previous suicide attempts are a risk factor for completed suicide, additional waves of interviews or other data collection strategies would be useful over a 5-10-year time frame.

Future research incorporating the Reasons for Living inventory would be more appropriate for a larger sample size. Although a valuable instrument, it did not prove as useful

in this study as I focused largely on the qualitative data. While 26 is a good sample size for qualitative research, it is insufficient for quantitative research.

Lastly, I would have liked to have more open communication with my participants. I had many questions when coding data; a follow-up phone call could have helped me resolve inconsistencies between interviews. In other cases, I saw an emerging theme, but not enough people brought it up. More open communication with participants could offer opportunities to pursue emergent themes or rule them out. Although interviewees did not mention religion unprompted, it would be helpful to ask about religion in future research.

My study offers two practical applications that can be explored and possibly implemented. First, life course interviews can be used as a method of suicide prevention. In the item 'what makes you want to live,' the participants can list their reasons for choosing to live; if a suicidal individual can think of just one of those items—no matter how small—and work with it, maybe it can save a life. A second practical application relates to how almost all of the participants were in favor of a support group specifically for suicide attempt survivors. Designing a pilot program that offers self-help groups specifically for them would be worthwhile. Helping people with suicidal ideations talk with others who know and can empathize with their struggles will help reduce the damage of shame or silence. It's time to start talking and stop stigmatizing suicide.

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## APPENDICES

### Appendix A

#### Interview Questions

Karen Hoefler

#### **Online portion**

Screenener questions

1. What year were you born?
2. Have you ever attempted suicide?
3. How long ago was your (last) suicide attempt?
4. Are you a resident of the United States?

#### **Part 1: Demographic questions**

1. What is your marital status?
  - single (never been married)
  - living with a partner
  - married
  - divorced
  - widowed
2. What is your employment status?
  - working for pay at a job or business
  - with a job or business, but not at work (off-season)
  - not employed, but looking for work
  - not working, disabled
  - working, but not for pay at a family owned job or business
  - not working at a job or business and not looking for work
  - going to school full time and not working
  - retired
3. If employed, what is your occupation?

4. What is your highest educational level?

- did not complete high school, no GED
- Did not complete high school, GED
- high school diploma, no additional education
- high school diploma, went to college but no degree
- beyond high school, completed a vocational or technical program
- Associate degree from a community college
- Bachelor's degree
- Master's degree
- Professional degree
- Doctoral degree

5. What is your racial identification?

- Asian/Asian American
- African
- Black/African American
- Native American
- Pacific Islander/Native Alaskan
- White/ Caucasian
- Two or more races
- Other/ please specify

6. Are you Hispanic or Latino/Latina?

7. What is your gender identification?

- female
- male
- trans male/transman
- trans female/ transwoman
- genderqueer
- gender nonconforming
- I identify as \_\_\_\_\_



**Abbreviated Reasons for Living Inventory (Source: First 24 questions from <http://depts.washington.edu/uwbrtc/wp-content/uploads/Reasons-for-Living-Scale-short-form-48-items.pdf>)**

The reasons for these questions are reasons people sometimes give for NOT committing suicide. These questions aim to know how important each of these possible reasons would be at his time in your life as a reason to NOT kill yourself. These are measured on Not At All Important, Quite Unimportant, Somewhat Unimportant, Somewhat Important, Quite Important, Extremely Important.

1. I have a responsibility and commitment to my family.
2. I believe I can learn to adjust or cope with my problems.
3. I believe I have control over my life and destiny
4. I have a desire to live.
5. I believe only God has the right to end a life.
6. I am afraid of death
7. My family might believe I did not love them
8. I do not believe that things get miserable or hopeless enough that I would rather be dead
9. My family depends upon me and needs me
10. I do not want to die
11. I want to watch my children as they grow
12. Life is all we have and is better than nothing
13. I have future plans I am looking forward to carrying out
14. No matter how badly I feel, I know that it will not last
15. I am afraid of the unknown
16. I love and enjoy my family too much and could not leave them
17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have
18. I am afraid that my method of killing myself would fail

19. I care enough about myself to live
20. Life is too beautiful and precious to end it
21. It would not be fair to leave the children to others to take care of
22. I believe I can find other solutions to my problems
23. I am afraid of going to hell
24. I have a love of life

## **Part 2: Phone Interview**

Hi, this is Karen Hoefer from East Tennessee State University. Someone at this number scheduled a phone interview for this time. Was that you? Okay, Thank you. Since we aren't using names, how would you like to be addressed during the interview? As you have read in the disclaimer, I'm doing my thesis on the quality of life of adults who have attempted suicide. This part of the study involves answering a few life course questions and questions about your (last) suicide attempt. You are welcome to skip over any questions that make you uncomfortable and you may withdraw from the study at any time without penalty.

Do I have your permission to record this interview? I will use the recording to transcribe our interview and will delete the voice recording once the transcription is complete. The interview will be kept confidential. That confidentiality will only be broken if you appear to be in imminent harm or danger to yourself or others. Okay, Thank you. This interview will take approximately 30-45 minutes. Upon completion you will receive an email with a code for your \$30 Tango gift card incentive. Is it okay if we begin? Thank you so much.

### **Life course questions** (follow-up questions may occasionally be needed)

1. Could you tell me about your childhood?
2. When you were a child, how did you envision your future?
3. How did your life turn out?

Thank you. Now we are moving on to questions pertaining to suicide attempts. Remember that you don't have to answer any questions you are uncomfortable with.

### **After Suicide Attempt Questions**

1. What were your thoughts after you attempted suicide?

2. Was there anything significant about the time that you attempted suicide?
3. What did you think would be the response of those close to you in the event of a completed suicide?
4. Can you tell me how you survived the attempt? Ultimately what saved you in the event?
5. How did you feel after the attempt? (if clarification needed: whether they felt regret or relief)
6. Did you feel stigmatized after the suicide attempt? If so, how?
7. Did you receive treatment after your attempt? If so, what kind? (medical/psychiatric, emergency help, inpatient/outpatient)
8. How do you feel about your life now? How have things changed for you? Do you see your life in the same way or differently?
9. What were the circumstances surrounding your suicide attempt? (for clarification: What happened just before you attempted and what happened after?)
10. What method did you use? Why?
11. Were you influenced by others?
12. Do you have a history of mental illness? How about your family?
13. Has anyone in your family ever attempted or died by suicide?
14. Do you still think about suicide?
15. How do you feel about your future?
16. What happens in your life to help you want to live?
17. If you began to have thoughts of killing yourself again, what would you do to help yourself?

18. Are there any self-help groups specifically for suicide attempt survivors in your area? If so, have you ever been to one? Why do or don't you attend? If you don't go to any self-help groups, what would make attending seem worthwhile?

19. How do you think you and others might benefit from having a self-help group specifically designed for suicide attempt survivors?

Appendix B

Demographic Charts

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|                                    |           |
|------------------------------------|-----------|
| Year of Birth (Mean)               | 1979.5    |
| Year of Birth (Range)              | 1953-1990 |
| Year of Birth (Median)             | 1983.5    |
| Year of Birth (Mode)               | 1987      |
| Year of Birth (Standard Deviation) | 10.19     |
| Percent Female                     | 73.03%    |
| White/Caucasian                    | 88.46%    |

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Table 1: Basic Demographic Information for Survey Respondents

Table 1 illustrates the basic demographic data, mainly from the year of birth, from the survey respondents.

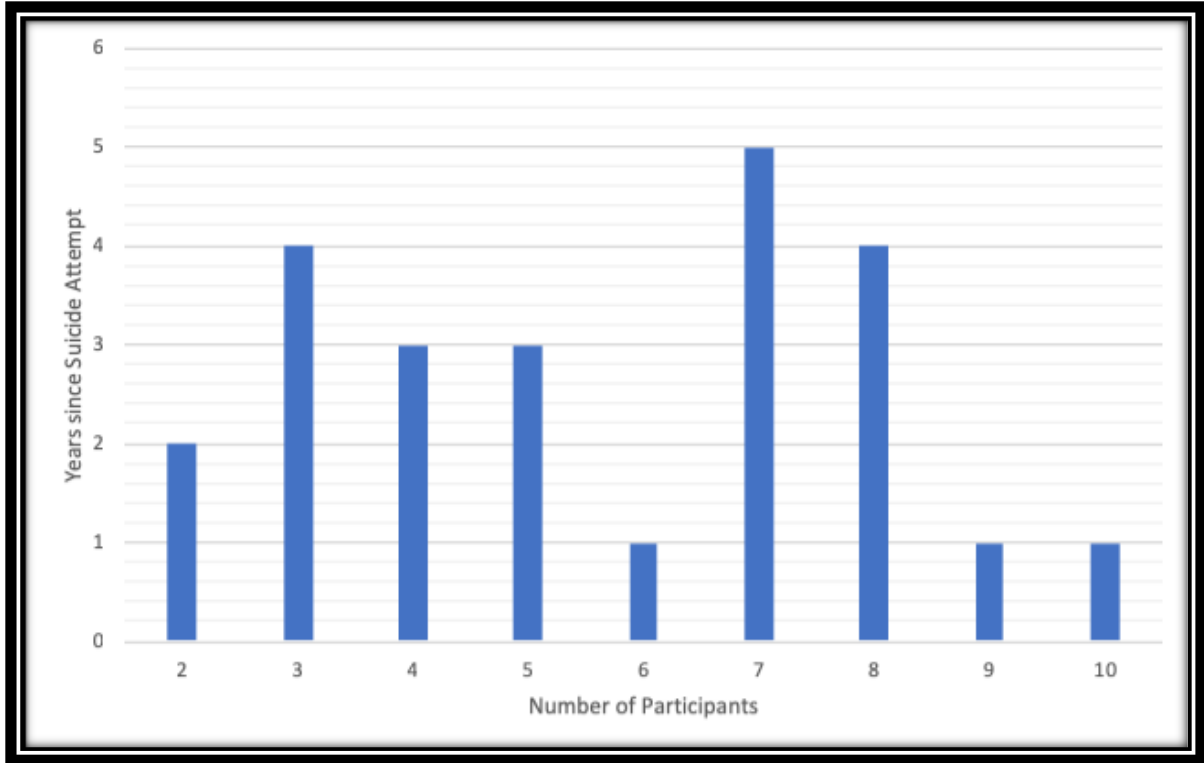


Figure 1. Years Since Suicide Attempt

This chart demonstrates the amount of years since the participants' suicide attempts. The participants were required to have attempted between 2-10 years after being at least 29 years of age. This distance was chosen to ensure it was far enough from the suicide attempt that it would be safe enough to talk about but not too far in the past that the participants wouldn't be able to recall the event.

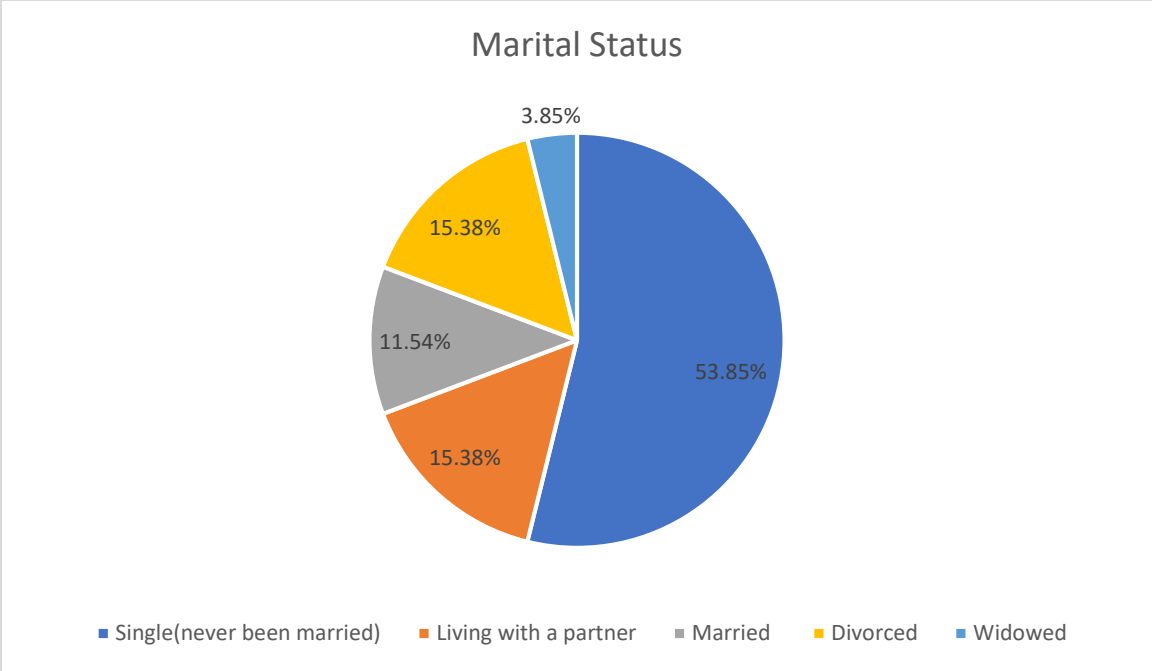


Figure 2. Marital Status

Figure 2 illustrates the percentages of the participants' marital status. As you can see exhibited in the pie chart above, the majority of individuals who participated were single (never been married) at 53.85 percent, followed by living with a partner and divorced, both at 15.38 percent; 11.54 percent of participants were married and 3.85 percent were widowed.

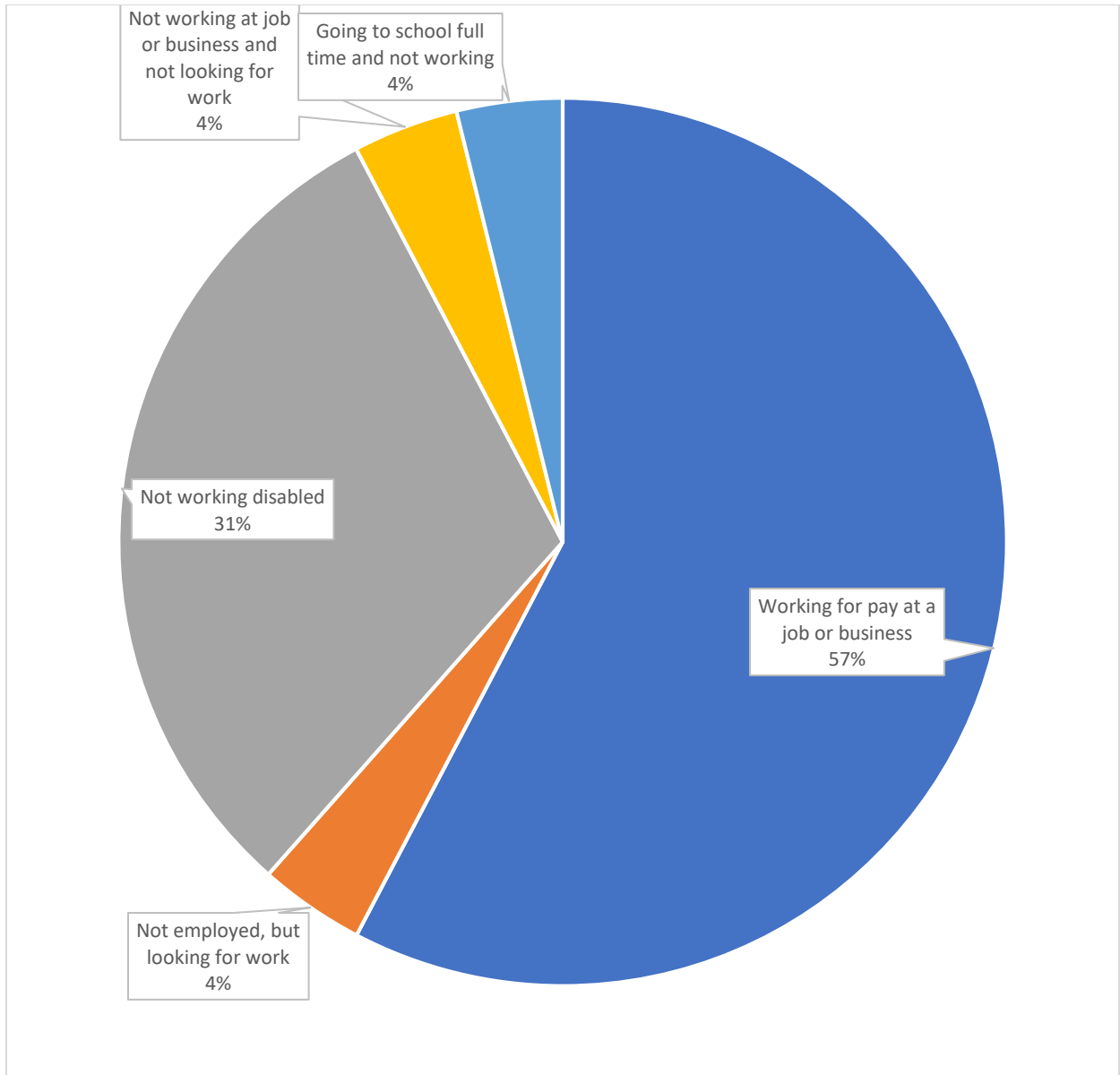


Figure 3. Employment Status

Figure 3 illustrates the employment status of the 26 study participants. The chart above includes the employment statuses that weren't selected by any of the participants. The majority of the participants (15 people, or 57.69%) were working for pay at a job or business, while eight (30.77%) were not working due to disability. One person said they were going to



school full time and not working, another selected not working at job or business and not looking for work, and one other person selected not employed but looking for work.

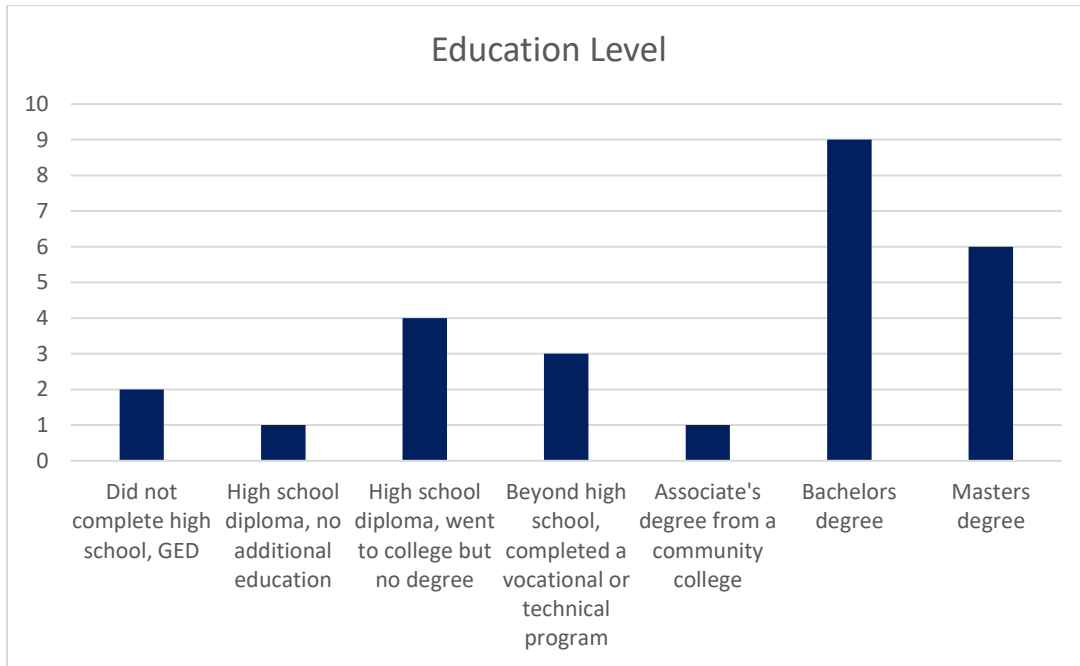


Figure 4. Education Level

Figure 4 illustrates the highest level of education attained by the participants. As you can see from the table above, nine individuals had bachelor's degrees, six individuals had master degrees, one individual had an associate's degree from a community college, three individuals had completed a vocational or technical program after high school, four individuals had a high school diploma and had gone to college but didn't have a degree, one individual had a high school education while two did not complete high school but had GED's.

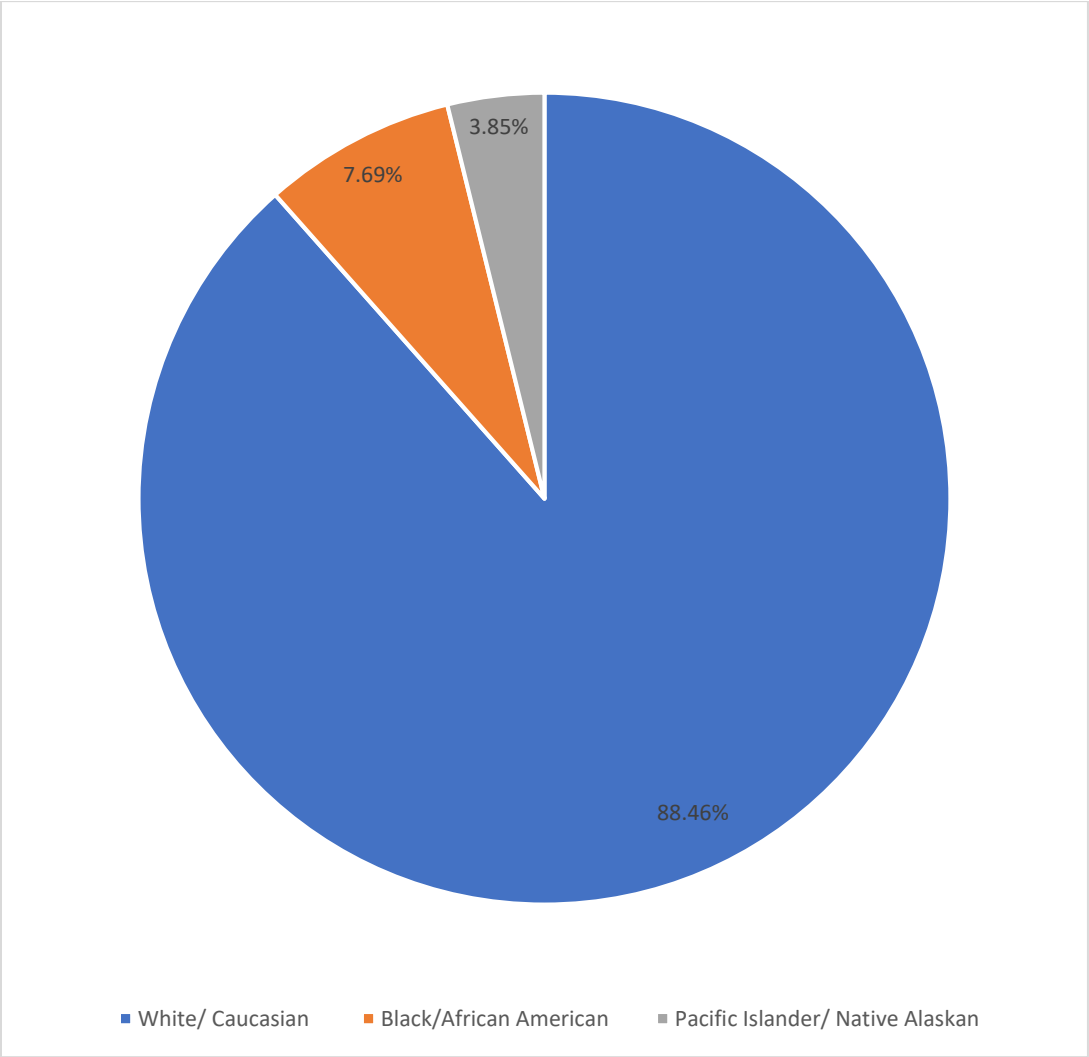


Figure 5. Racial Identification

Figure 5 Illustrates the racial classifications participants selected: 23 participants (88.49%) were White/Caucasian, two (7.69%) identified as Black or African American and one individual (3.85%) identified as Pacific Islander/Native Alaskan. Other racial identifications were available but not represented.

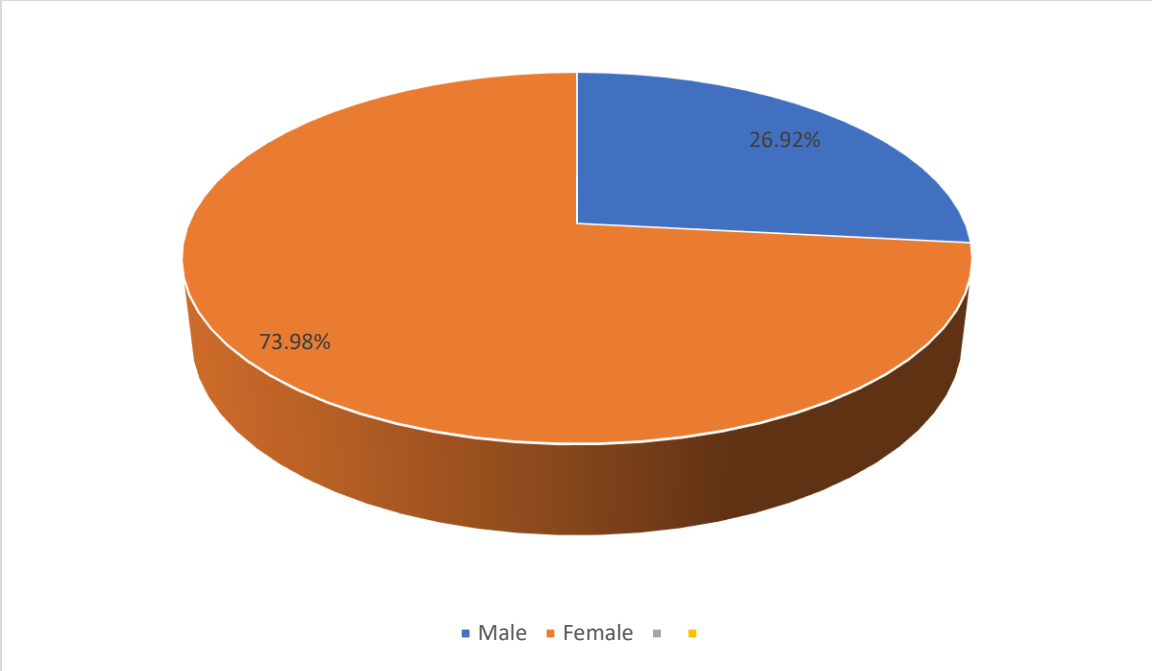


Figure 6. Gender Identification

Figure 6 illustrates the gender identification of those who participated in the survey. The majority of those who participated were female (73.98%) and 23.92 percent were male.

VITA

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