Qualitative Evidence in Suicide Ideation, Attempts, and Suicide Prevention

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20.1 Background

The scholarly study of suicidal behaviors (i.e., ideation, plans, expressions of suicidal intent, attempts) has long been associated with quantitative research. The important contributions that such studies have made to the field of suicidology[1] are beyond dispute. For example, epidemiological studies have informed our understanding of the patterned distribution of nonfatal suicidal behaviors by age and sex, across time periods, and between jurisdictions. Surveys have told us about the number of people who consider suicide, the number who attempt suicide, and the proportion who seek professional help following an attempt within a given catchment area. Suicide prevention programs have also been extensively studied and numerous evidence-based reviews have been completed (Katz et al. 2013; Mann et al. 2005). Several programs and strategies appear to hold promise, including physician education, gatekeeper training, and means restriction (Mann et al. 2005). Without undermining the value of these contributions, it is important to acknowledge that within the field of suicidology, a persistent positivist bias has resulted in an intellectual culture that has historically undervalued qualitative research. This was noted by Range and Leach back in 1998 when they recommended that greater methodological diversity and a more reflexive and humble posture toward knowledge generation (exemplified by many feminist and qualitative research frameworks) are needed to be seriously considered if the field of suicidology was to advance in any meaningful way. Ten years later, Hjelmeland and Knizek (2010) conducted a rigorous review of all of the research articles published in the main suicidology journals over the period 2005–2007 and found that less than 3 % were based on qualitative methodologies. Meanwhile, the editor of a leading suicidology journal recently suggested that an "insistence on the rigorously and quantitatively scientific" (Joiner 2011, p. 471) will provide the necessary conditions for the field to advance.

[1]Suicidology is the study of suicide, suicidal behavior, and suicide prevention. In the United States, suicidology is strongly associated with the work of Edwin Shneidman and Norman Farberow who began publishing research on suicide in the 1950s and 1960s (Spencer-Thomas and Jahn 2012). While the scholarly study of suicide goes back centuries, Laird (2011) notes that suicidology is a distinctly modernist movement that emerged in the 1960s based on the growing prominence of the social sciences, particularly psychology, sociology, anthropology, and statistics.

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Not surprisingly, the overreliance on a narrow range of positivist methodologies exerts a powerful influence over what is to count as knowledge and whose knowledge counts. As others have argued, the rationalist biases, privileging of randomized controlled treatment (RCT) designs, and the largely atheoretical, technical orientation of the evidence-based practice (EBP) paradigm have collectively contributed to an overly scientific understanding of human experience within the broad field of mental health (Brophy and Savy 2011; Kirmayer 2012; Thomas et al. 2012). Many of the relational, contextual, and historical factors which are relevant for understanding human suffering and suicidal despair are not easily amenable to categorization, measurement, or replication (Fitzpatrick 2011; White in press), and, as a consequence, most traditional evidence-based reviews leave readers with an incomplete understanding of suicidal behaviors and a rather limited vocabulary for conceptualizing and representing prevention practices. While there have been a few clear voices advocating for greater methodological diversity (Hjelmeland and Knizek 2010; Kral et al. 2012; Leenaars 2002; White 2012), it is fair to say that the most significant contributions to the qualitative evidence base on suicide ideation, attempts, and suicide prevention have been made from outside mainstream suicidology, with scholars from nursing, counseling, social work, as well as health and social care fields, furnishing the bulk of this material.

All research questions are predicated on particular values and assumptions, and all are driven by specific ontological and epistemological commitments (including the stance of so-called value neutrality), even though they are not always explicated. Instead of viewing qualitative and quantitative methodologies as singular or static entities that are in a hierarchical or opposing relationship to one another (which can lead to polarizing debates such as the "science or paradigm wars"), they should be more properly judged on how well they answer the particular research questions being asked, using criteria that are commensurable with the underlying theoretical and philosophical assumptions (Caeli et al. 2003). Ultimately it is the question at hand that should be driving the choice of methodology (Fitzpatrick 2011; Polkinghorne 2005). In short, if we want to adequately engage with the multiplicities, complexities, and uncertainties that characterize our social worlds, including experiences of suicidal despair and the contexts that surround its emergence, and work toward the development of ethical, effective, and culturally responsive approaches to suicide prevention, then multiple paradigms and diverse research, policy, and practice frameworks will need to be mobilized (Fitzpatrick 2011; Goering et al. 2008; Gould 2006; Rogers 2003).

The main purpose of this chapter is to bring to light the significant contributions that qualitative researchers have made to the evidence base on suicidal behaviors[2] and suicide prevention. The remainder of the chapter has been organized into three main sections. First, the context will be set for understanding the significance of suicidal behaviors as a major health and social problem. Some of the challenges associated with defining suicidal behaviors will also be introduced here. Second, the burgeoning qualitative research literature on suicidal behaviors and suicide prevention practice will be discussed. The majority of this work has been published since 2000, attesting to the relatively recent contributions that qualitative researchers have made in this area. In the final section, the practical implications of this body of evidence for health practitioners, policy makers, and researchers will be discussed.

20.2 Setting the Context

Most countries have clear classification systems in place for defining and tracking deaths by suicide over time (DeLeo et al. 2006). Despite general

[2]Suicidal behavior is an all-encompassing phrase that includes suicidal thoughts, feelings, attempts, and communications.

common sense understandings of suicide (i.e., self-inflicted, intentional death), scholars and researchers continue to revisit and debate existing terminology and definitions (DeLeo et al. 2006; Silverman et al. 2007) suggesting that the matter of what counts as a suicide death is not as self-evident as it might seem. Meanwhile, determining how many individuals think about suicide (suicide ideation) and/or engage in nonfatal suicidal behaviors in any given year is even more challenging given the difficulty of defining terms like suicide ideation or suicide attempt with any precision. Multiple, overlapping categories and conflicting terms have been proposed, including suicide attempt (with or without injuries), deliberate self-harm, and parasuicide, with different regions/countries favoring different terms (DeLeo et al. 2006). Some terms and concepts have been critiqued for their pejorative implications (e.g., suicide gesture) (Heilbrun et al. 2010). This line of critique is especially relevant when studying the lives and identities of girls and women, whose suicidal behaviors have often been construed as "passive," as "not serious," or as "cries for help" (Canetto 2008; Jaworski 2003; Range and Leach 1998).

Ascertaining intention and agency have become central preoccupations in the effort to classify a behavior as a "suicidal act," and this of course relies on human judgment, cultural context, and interpretation. On top of the multitude of challenges associated with trying to establish another person's "true" intentions (which must include an acknowledgment that multiple and contradictory intentions can coexist) (DeLeo et al. 2006), many people attempt suicide without coming to the attention of a formal service provider, which means there is no opportunity for these behaviors to be systematically counted and tracked through existing public health surveillance systems.

As this brief overview shows, far from being timeless, self-evident, universal categories, suicide and suicidal behaviors carry multiple meanings that are historically contingent and contextually specific. For example, throughout human history, suicidal behaviors have been variously conceptualized as a sin, a crime, an honorable action, a philosophical question, and an illness (Canetto 2008; Marsh 2010). Such cultural variations, unstable meanings, and the social processes that bring suicidal behaviors into existence as objects of study are ripe for qualitative investigation and analysis.[3]

While recognizing the unstable and historically contingent character of these terms, for the purposes here *suicide ideation* will refer to thoughts of killing oneself, while *suicide attempt* will refer to "self- inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die" (Silverman et al. 2007, p. 273). *Suicidality/suicidal behaviors* will refer to all aspects of suicidal thoughts, behaviors, and actions (Bridge et al. 2006).

In general, suicide ideation and attempts are far more common than deaths by suicide. Cross-national lifetime and one-year prevalence rates of suicide ideation and attempts have been calculated (Borges et al. 2010; Nock et al. 2008). Average lifetime prevalence rates across 17 countries were 9.2 % for suicide ideation and 2.7 % for suicide attempts (Nock et al. 2008). Among American adolescents (aged 13–17), lifetime prevalence rates were 12.1 % for ideation and 4.1 % for attempts, highlighting the fact that nonfatal suicidal behaviors are typically more common among the young (Nock et al. 2013). Besides being young, a number of other factors have also been correlated with suicide ideation and attempts. These include: being unmarried, female, and less educated and having a history of a mental disorder (Nock et al. 2008).

Interestingly, in these studies, "risk factors" such as gender, age, and marital status are typically treated as discrete and static entities. Very little attention is paid to how existing social arrangements (Scourfield, et al. 2012) might actually produce vulnerability and suicidal despair among those who are the most powerless

[3] As just one example, the social and bureaucratic processes through which coroners and medical examiners come to classify a death as a suicide were the focus of an interesting ethnographic study by Timmerman (2005).

(Canetto 2008). In other words, these large-scale epidemiological studies tell us something important about the magnitude of the problem and the factors that are most strongly associated with suicidal behaviors, but they are clearly limited in their ability to tell us anything about *how* specific factors are linked to suicidal behaviors (Hjelmeland and Knizek 2010). For the most part, standardized clinical interviews that rely on dichotomous (yes/no) variables are used to determine a past history of suicide ideation or attempts. In most cases, this leads to relatively simplistic and decontextualized understandings of suicidal behaviors. Complex, ambiguous, or contradictory narratives are typically overlooked (Kidd 2004). As Hjemeland and Knizek argue,

> The linear cause-and-effect thinking that focuses only on one or a few variables is too simplistic, too reductionist; it does not take the whole individual and his or her surroundings into consideration at the same time, which is necessary if we want to understand why that particular person at that particular time in his or her life is considering to or actually has carried out a suicidal act. (p. 77)

Particularity, context, narratives, and meaning making are the raison d'être of qualitative research. The next section provides an overview of the recently published qualitative research literature.

20.3 Mapping the Landscape

At least two previous reviews of the qualitative research literature addressing suicidality have been undertaken. For example, Lakeman and FitzGerald (2008) conducted a systematic review and thematic analysis of qualitative studies that explored how people live with, or recover from, being suicidal. Meanwhile, Han et al. (2013) reviewed the qualitative research literature addressing suicide and suicidal behaviors among East Asian populations. The current approach will be guided by a much broader question: what is the extent and nature of the qualitative research evidence pertaining to suicide ideation, suicide attempts, and suicide prevention?

Despite its broad focus, the following topics will be *excluded* from consideration: qualitative studies of suicide deaths (which are the focus of another chapter in this volume), qualitative studies of non-suicidal self-injurious behaviors[4] (which are behaviors that are categorically defined by an absence of suicidal intent), and mixed-method designs (unless a subset of qualitative data was analyzed and reported on separately). Only peer-reviewed studies (excluding books) published in English have been included.

The following databases were searched: MEDLINE, CINAHL, PsycINFO, Social Work Abstracts, Web of Science, and Academic Search Complete. Search terms included: "qualitative research," "qualitative evidence," "suicidal behaviors," "suicide attempts," "suicidal ideation," and "suicide prevention." The following journals were also hand searched: *Qualitative Health Research, Archives of Suicide Research*, and *Suicide and Life Threatening Behavior*. After reading all of the abstracts that were generated by the search process, discarding those that were duplicates or irrelevant, and setting a firm end date (December 2013), just over 75 published (English language) articles were identified.

The material has been sorted into three broad, overlapping categories: (a) lived experience of suicidality and healing, (b) practices and perceptions of care and treatment for suicidal individuals, and (c) conceptualizations of suicidal behavior and suicide prevention.

20.3.1 Lived Experience of Suicidality and Healing

The concept of "lived experience" comes from phenomenology where the focus is on studying everyday experiences as lived by particular

[4]Since terms like deliberate self-harm (DSH) are used in multiple and inconsistent ways by researchers (i.e., inclusive of suicidal actions in some cases, but not always), some relevant studies may have been inadvertently excluded.

human beings (Van Manen 1990). Over half [5] of all of the qualitative studies identified through this review addressed the lived experience of suicidality (i.e., suicide ideation and/or attempts) and/or healing, making this by far the most common focus of qualitative investigations. Most of these studies were published in the last 10 years. These studies, which feature the insights and voices of those who have lived through a suicidal crisis, have typically been published within the broad health and social care literature.

20.3.1.1 Survivors of Near-Lethal Suicide Attempts

Rosen (1975) published one of the earliest qualitative studies examining the lived experience of suicidal behavior. He interviewed seven of ten known individuals who all survived near-lethal attempts following a jump from the Golden Gate or Oakland Bridges in San Francisco. The main purpose of his study was to "learn more about the nature of suicidal behavior by jumping and its alleged impulsive and ambivalent qualities" (p. 289). Interestingly, the term "qualitative research" is never used by Rosen to describe his work and the details regarding his approach to analysis are minimal. However, his use of structured interviews, the reading across informant accounts, and the reliance on direct quotes to bring the material to life are emblematic of qualitative research. Rosen's findings suggest that survivors of a near-lethal suicide attempt did not appear to go through a stage of "resistance" or "life review" at the time of their jump. The participants did however all appear to go through a stage of "transcendence," which Rosen characterized as an experience of submission or surrender. Almost all of the attempt survivors reported that the choice of the Golden Gate Bridge as the site of their jump was associated with the special and symbolic significance of the bridge. This led Rosen to recommend that a concerted campaign to "deromanticize" suicide, especially its link to the Golden Gate Bridge, and the building of a barrier be pursued.

Over three decades later, qualitative researchers from the UK investigated the experiences of those who survived near-fatal suicide attempts. Specifically, Biddle et al. (2010) interviewed individuals who survived a suicide attempt by hanging. Participants in their study acknowledged that hanging was their preferred method of suicide due to its expected association with certain death and its overall ease and accessibility. This raises challenges for suicide prevention and means restriction campaigns. Another study explored how individuals who survived a near-fatal attempt came to choose particular suicide methods. Television, news stories, the Internet, and past experiences were cited as the most influential information sources (Biddle et al. 2012).

20.3.1.2 Youth and Young Adults

Young people (ranging in age from 11 to 24) who recently made a suicide attempt, or adults who had experienced a suicidal crisis in their youth, were a common focus of qualitative researchers' attention at the start of the twenty-first century. Through the use of in-depth interviews, researchers explored participants' experiences of suicide ideation and attempts. Researchers also elicited narratives of healing and highlighted processes of recovery. Grounded theory and basic qualitative thematic analyses were the most commonly used methodologies.

The lived experience of suicidal ideation was rarely a singular focus of attention among this group of researchers (see Paproski 1997 for a rare exception). More commonly, those young people who had made one or more previous suicide attempts and those with a history of "suicidal behaviors" (which included thoughts, feelings, and actions) were recruited as research participants. In some cases individuals were asked to reflect back to a time (within the past 3 years) when they had made an attempt or been suicidal in their youth (Bostick and Everall 2006, 2007; Everall 2006a, b). In these studies, participants reported experiencing several, deeply felt, negative emotions as part of becoming suicidal, which

[5] Multiple published articles can emerge from a single study, and different members of a research team can analyze and report on different aspects of a large qualitative dataset.

sometimes left them feeling out of control. For example,

> I was a ticking time bomb really. I could at any moment cry, scream, have explosive anger. It came out at strange times. It was lonely, scary, because you don't trust anyone but you don't trust yourself either. It's isolating. (Bostick and Everall 2006, p. 280)

In other cases, previously suicidal individuals were interviewed after they had received a therapeutic intervention (Bergmans et al. 2009a, b) or within a year following the suicide attempt (Bennett et al. 2002). In one case, adult First Nation women, aged 30–45, reflected back on the experience of living with suicide ideation in their youth, and the subsequent processes of healing (Paproski 1997). Young people who were being treated by a mental health team following a suicide attempt (Anderson et al. 2010) and nonclinical populations (Gair and Camilleri 2003) were interviewed about their experiences.

In another set of studies, young female Latina adolescents (as well as their parents in some cases) were interviewed following the young person's suicide attempts (Hausmann-Stabile et al. 2013; Nolle et al. 2012; Zayas et al. 2010). By situating their study of suicidal behavior within a familial and cultural context, these researchers were able to highlight some of the unique challenges that these youth faced as they attempted to reconcile their own needs with their family's expectations. For example, one 15-year-old girl of Mexican descent attempted suicide following her parents' separation and she blamed herself. When asked to give an account of her suicide attempt, she said,

> Like, I blamed the things on me. Like, if I would've done things differently, what if my father–what if I didn't argue so much with my father? My parents would still be together. If I was different, my father would've been different, and my sisters would've been different, and it would have been a whole different situation. (Nolle et al. 2012, p. 324)

Reading across these studies, a few noteworthy findings are worth highlighting. First, suicidal thoughts and behaviors among young people typically occur in dynamic sociocultural contexts, where individual vulnerabilities, relational identities, cultural and familial expectations, and normative discourses intersect in highly complex and conflicting ways. For example, young people are often faced with managing multiple and competing expectations which can sometimes lead to intense and difficult emotions, and under certain circumstances of escalating stress, this can contribute to negative identity conclusions such as worthlessness (Everall 2006a, b) or burdensomeness (Nolle et al. 2012). This could include, for example, living in the midst of irreconcilable tensions between individual and family aspirations (Hausmann-Stabile et al. 2013) or failing to live up to their own or societal expectations. Navigating such contradictory demands can sometimes lead to a "fractured reality" (Anderson et al. 2010). Latina adolescents, with a strong commitment to "familism," for example, may attempt to resolve this crisis by sacrificing themselves for the benefit of their families (Nolle et al. 2012). Second, the emotional experience of suicidality is fluid, complex, and layered. Experiences of overwhelming despair, self-loathing, alienation (Everall 2006a, b) as well as guilt and remorse following a suicide attempt (Zayas et al. 2010) were commonly reported by participants. Third, turning points, relational connections, and multiple pathways were prominent in the narratives of healing and recovery. Paths to healing were characterized by nonlinear "pockets of recovery" (Bergmans et al. 2009a, b) that were culturally and spiritually meaningful (Paproski 1997), which included feeling cared for and having significant relational connections to others (Bostick and Everall 2006; Everall 2006a, b; Gair and Camilleri 2003) and which enabled young people to feel protected and nurtured while, at the same time, allowing possibilities for self-determination (Bennett et al. 2002).

20.3.1.3 Individuals Living with Mental Health Problems

Adults who had received service from a mental health or crisis response team, who had recently been admitted to hospital for suicidal behavior (frequently referred to as "suicidal patients" or "psychiatric inpatients"), or who were living

with depression or another mental health problem were another commonly studied population. These studies were all published within the past 10 years and were conducted in a diverse range of geographical locations, including: Italy (Ghio et al. 2012), Norway (Vatne and Naden 2012), Iran (Keyvanara and Haghshenas 2010), Poland (Mandal and Zalewska 2010), Brazil (Neto et al. 2012), Canada (Oliffe et al. 2010), Sweden (Pavulans et al. 2012), and Switzerland (Valach et al. 2006). In-depth interviews and focus groups were the most commonly used methods for eliciting first-person narratives.

From these studies we learn that suicide attempts cannot always be rationally explained (Ghio et al. 2012; Pavulans et al. 2012), although in some cases people described their suicidal actions in ways that the researchers characterized as "goal directed" (Valach et al. 2006). There is frequently a paradoxical quality to suicidal ideation. For example, "the thought of being able to put an end to one's suffering if it should become unbearable, is comforting and makes it possible to endure suffering" (Vatne and Naden 2012, p. 308). Holm and Severinsson (2011) put it this way, "finding the meaning of one's desire for death might offer a possibility to escape and gain freedom, while at the same time helping one to hold on to life" (p. 171). Participants in the Swedish study spoke about the double meaning of a suicidal act (Pavulans et al. 2012). Specifically, a suicide attempt was equated with "being in want of control" which suggests being out of control and wanting control simultaneously. Finally, Valach et al. (2006) offer the example of the research participant who, "… described cutting herself without wanting to kill herself and then, in the course of cutting, she suddenly cut herself in a manner that endangered her life" (p. 359). These complex narratives hint at the limits of traditional approaches to understanding suicide ideation and attempts that rely on binary (yes/no) answers to questions about suicidal behavior.

As these studies further attest, qualitative researchers can also bring the sociocultural contexts, the dominant discourses, and the historical and political conditions that contribute to the emergence of suicidal despair into sharp relief (Neto et al. 2012). For example, qualitative studies can illuminate how gendered discourses, including cultural expectations regarding the performance of masculine identities (i.e., stoicism, independence, commitment to action), are relevant for making sense of men's suicidal thoughts and behaviors (Oliffe et al. 2010). Other studies shine the light on women's lives, as they attempt to negotiate their identities as mothers, wives, friends, and productive citizens in the midst of changing social norms, asymmetrical power relations, and competing cultural narratives (Keyvanara and Haghshenas 2010). For many women who engage in suicidal behavior, experiences of victimization, and violence were highly salient in their narrations of suicidality (Holm and Severinsson 2011; Mandal and Zalewska 2010). These qualitative accounts offer richer, more complicated, and deeply contextualized views of men's and women's lives, especially when compared with approaches that seek to isolate particular variables (i.e., depression or history of violence) as risk factors for suicidal behavior. From these studies we also learn that change and recovery from suicidal despair is clearly possible (Holm and Severinsson 2011) and it is evident that involving service users in decisions about heath care is an ethical and useful practice in its own right (Ghio et al. 2012).

20.3.1.4 Other Specific Populations

A number of other studies explored the experience of suicidality among specific populations. These included: older persons (aged 55–98) (Crocker et al. 2006; Haight and Hendrix 1998; Moore 1997; Wu et al. 2012), individuals with substance-use problems (Miller 2006; Spence et al. 2008), immigrant populations (Biong and Ravdnal 2009; Chung 2012), individuals with a history of suicidal behavior who posted to an online community (Benson et al. 2013; Dodemaide and Crisp 2013), sexual minority populations (DiStefano 2008; McAndrew and Warne 2010), female veterans (Gutierrez et al. 2013), and farmers from Manitoba (Sturgeon and Morrissette 2010).

20.3.2 Perspectives on Care and Treatment for Suicidal Persons

Approximately 30 % of the published qualitative literature identified through this review examined individual, family, and professional perspectives on the care and treatment of suicidal individuals. All of these studies are relevant to the prevention of suicide. Three different perspectives could be discerned: (a) professionals' views, (b) suicidal individuals' views, and (c) combined views. Almost all of these qualitative studies were published within the past decade.

20.3.2.1 Professionals' Views

Professional perspectives on care for suicidal persons included the views of psychiatric nurses and mental health clinicians (Aflague and Ferszt 2010; Webster et al. 2012), counselors and youth workers (Popadiuk et al. 2008; Ranahan 2013; Slovak and Singer 2012), physicians (Vannoy et al. 2010), hospital emergency department medical staff (Pallikkathayil and Morgan 1988; Redley 2011; Senarathna et al. 2013), and trained suicide prevention gatekeepers (Evans and Price 2013).

In an early qualitative study, Pallikkathayil and Morgan (1988) interviewed emergency department nurses about their previous encounters with suicidal patients. Findings revealed that caring for a suicidal person was highly stressful and was often associated with a sense of loss of control. Anger toward the suicidal person and frustration over a lack of resources were prominent feelings reported by nurses doing this work. Suicidal behaviors often elicited conflicting feelings from nurses who understood their responsibilities as saving lives. Individuals who presented at hospital having made a suicide attempt appeared to have a destabilizing effect on nurses' professional identities. The authors describe how this constellation of factors can potentially lead to avoidance, distancing, and disengaging practices on the part of nurses.

A later study by Ranahan (2013) also raised important questions about the potential for standard suicide prevention practices to have the unintended effect of creating distance between the professional and the suicidal person. Specifically, using a grounded theory methodology, Ranahan interviewed child and youth care practitioners, supervisors, and educators about working with suicidal youth. A consistent finding was the belief that once suicidality was suspected, a series of action steps would need to be activated, including a practice that Ranahan called "flooding the zone," whereby the professionals "… overpower the likelihood of the adolescent dying by suicide by surrounding the adolescent with services and other helping professionals" (p. 144). This study surfaced important ethical considerations regarding the practice of "flooding" suicidal young people with a barrage of services, often without their input or against their own preferences.

Several other innovative methodologies were used to explore professionals' views and a few are worth highlighting here. One study focused on the vocabulary and narrative context for inquiring about suicide risk among primary care physicians based on an analysis of transcripts from previously recorded patient visits (Vannoy et al. 2010). Researchers found most of the physician responses to potential suicide risk among patients to be appropriate, contextually sensitive, and supportive. A small minority of physicians inquired about suicide in a manner that was found to be inhibitive of patient disclosures. These unhelpful responses included: failing to place the inquiry in context, asking yes/no questions, or using a "no-problems-expected phrasing" (e.g., "you're not feeling suicidal are you?").

Aflague and Ferszt (2010) initially observed nurses conducting suicide risk assessments with adult patients in a psychiatric hospital setting. This was followed by a research interview with the nurse participants. Using a methodology called phenomenography, these researchers sought to better understand how nurses think about and perform suicide risk assessments. They write that, "[u]nlike phenomenology, which searches for the essence of phenomena, phenomenography focuses on the different ways people experience, conceptualize, perceive, and understand various aspects of phenomena in the world around them" (p. 249). When coming to their formulations regarding

suicide risk, the researchers noticed great variability among the nurses. At the same time, nurses relied on a combination of knowledge (e.g., risk factors), process skills or "methods" (e.g., active listening), and a "reference dimension" (e.g., stories, cases, or previous experiences).

In another innovative approach, Popadiuk et al. (2008) used a focus group to engage suicide prevention counselors in a discussion regarding the challenges of working with suicidal individuals. They also introduced the counselors to a "self-confrontation procedure," which is a practice that involves counselors videotaping their counseling sessions and then, at regular intervals, stopping the tape and playing segments back for the client, as a way to invite client reflections and generate new insights. Following the initial focus group, counselors were encouraged to consider how the self-confrontation technique might be useful with their own clients. A follow-up interview was scheduled to discuss their impressions one month later. What made this study unique, apart from the important findings it generated about the unique stressors counselors face when working with suicidal individuals, was the process. Specifically, it began with counselors' experiences and provided them with the opportunity to critically reflect on the strengths and limitations of the self-confrontation technique, using an experiential learning format. This provided a stimulating site for joint learning and knowledge creation.

Two recent studies considered the important role of social dynamics, practice cultures, and organizational influences on suicide prevention practices. First, Senarathna et al. (2013) used the treatment of acute self-poisoning cases as a site for studying the social dynamics among rural hospital staff in Sri Lanka. Focus groups were held with doctors, nurses, and other nonclinical hospital staff. Findings suggested that a self-poisoning episode typically brought hospital staff into extensive contact with family and community members. For example, according to one doctor,

> The whole village rushes in to the hospital, because we do not have a security guard here. Removing those people [from the ward] is a big issue for us. It is quite disturbing to have them around [the patient]. A whole village present here crying and weeping. This is my main issue here. First of all [before I start treatment], I chase them away. (p. 1484)

Such vivid accounts invite a much more complicated understanding of what is at stake in these particular moments than studies that focus more narrowly on identifying risk factors or evaluating standardized interventions. Findings from the study by Senarathna et al. (2013) show how the social and cultural dynamics surrounding episodes of acute self-poisoning place unique demands on rural hospital staff in Sri Lanka. Several implications for future practice were noted, including the need to develop more effective communication mechanisms to support constructive interactions between staff and family members and the need for higher levels of collaboration and cooperation across all members of the healthcare team.

Second, Evans and Price (2013) examined the role of organizational culture on the uptake of suicide prevention gatekeeper skills within specific workplaces. Through a series of interviews and focus groups with individuals who had recently participated in a suicide prevention gatekeeper training workshop, they learned that current training efforts needed to move beyond "…a reductionist approach and the focus on individual competencies" (p. 223). Specifically, an ethos of collective responsibility, enhanced opportunities to intervene, and development of a positive organizational context were identified as key enabling conditions that could make a positive difference in advancing the goals of suicide prevention.

20.3.2.2 Suicidal Individuals' Views

The views and experiences of suicidal individuals who have accessed formal mental health services have been well documented by qualitative researchers in recent years (Paulson and Worth 2002; Samuelsson et al. 2000). As one example of the important contribution that such studies can make to the current evidence base, Cutcliffe et al. (2006) interviewed adults who had received care as a result of a suicide crisis from the emergency psychiatric services. They sought to understand how psychiatric nurses work with suicidal patients and learn what was most mean-

ingful from the patients' perspective. Based on an analysis of patient accounts, the researchers theorized that the caring processes that nurses engaged in to facilitate movement from a "death-orientated position" to a "life-orientated position" could be best captured through the idea of "reconnecting the person with humanity," which included several overlapping processes. Specifically, nurses were able to cultivate and restore trust, facilitate insight, provide a bridge back to humanity, and ultimately support patients to learn to live again. These practices of care, which are predicated on a human, close relationship, were set against some contemporary approaches to treating suicidal persons, which are often based on being "treated mechanically" or placed "under observation" (Cutcliffe et al. 2006, p. 802).

Interestingly, an earlier qualitative study by Cardell and Pitula (1999) suggested that even practices of "constant observation" can embody many of the human, caring qualities recommended by Cutcliffe et al. (2006). Specifically, Cardell and Pitula interviewed "suicidal, psychiatric inpatients" who had received constant observation within the previous 2 weeks. They found that when the "observers" engaged them as persons, participated in conversation and distracting activities, showed friendliness and optimism, and provided emotional support, the benefits to patients were perceived to be extremely positive. On the contrary, when observers lacked empathy, failed to acknowledge the person, provided little to no information about what was happening, and invaded the personal space of the person under observation, the effects were experienced as extremely upsetting and negative.

Another study examined the specific experience of young men who had been actively suicidal at some point in their lives and who had accessed formal or informal (mental) health services for support (Jordan et al. 2012). Aspects of care that were considered the most meaningful were elicited from participants through open-ended interviews. These included: having flexible program mandates to enable wide access to services, more proactive outreach, and increased opportunities for more informal types of support. Participants also spoke about the limiting effects of traditional notions of masculinity on help seeking and envisioning possible futures for themselves. When opportunities were created for these men to explore these issues with others who were facing similar challenges and when they were given the chance to challenge some of the limiting and unhelpful assumptions about "being a man" in an open and trusting environment, participants reported feeling less alone, less stigmatized, and increasingly understood. Finally, having a relational connection with an open-minded, empathic, and caring mental health professional made a meaningful difference in the lives of these men.

One study in this group was unique in that it sought out the views of parents and carers whose children had expressed suicide ideation or engaged in self-harm (Byrne et al. 2008). Through a focus group methodology, the researchers met with parents and carers whose children (16 years and younger) had engaged in self-harm and/or expressed thoughts of suicide within the past 3 years. Findings indicated that parents/carers have a high need for particular kinds of support when dealing with a son or daughter who is thinking about suicide or engaging in self-harm. Specifically, parents expressed a need for emotional support for themselves and their families, parenting information, especially parent-child communication, and general knowledge about managing self-harm.

20.3.2.3 Combined Views

A small number of studies examined the combined views of suicidal persons *and* professionals or caregivers (Cooper et al. 2011; Sun and Long 2012; Sun et al. 2008). This is a research orientation that nicely exemplifies the point made by Cutcliffe et al. (2006) that "[t]he practice of providing care for the suicidal client clearly involves at least two people" (p. 793). As just one example of this approach, Bergmans

et al. (2009a, b) interviewed repeat substance abusing suicidal male clients and hospital emergency department (ED) personnel about their interactions and learned that there were a number of potential "disconnects" between the two groups. The two groups often had different ideas and expectations regarding reasons for seeking care, the role of the emergency department, and the availability of community-based resources. For example, participants said they attended the emergency department to get help with their emotional distress. Once in the ED, however, they faced long waits, had to endure multiple interviews, and felt an overall loss of control. Many participants also said that they expected to encounter negative interactions, as exemplified here:

> Well I notice a big difference if I'm coming in for a medical reason than if I'm coming in for a psychiatric reason… I get the feeling like oh they feel that I'm just a revolving door client… it's just a total different way of treatment. Um, it's almost like they're fed up with me. (p. 424)

Meanwhile, ED staff were often faced with highly agitated and frustrated patients, who would occasionally become aggressive once they learned of the long waits in the ED. One staff member said, "Do people like having them as patients? Not when they're spitting on you and punching you" (Bergmans et al. 2009a, b, p. 425). Several practical recommendations emerged from this study, including the creation of high-functioning, interprofessional teams within the ED. Establishing a clear role for the hospital social worker, who can serve as a patient advocate, provide a reassuring presence, support patients throughout their time in the ED, and liaise with outside resources, was also recommended. Finally, alliance-building efforts, validation strategies, and emotional de-escalation techniques were identified as important skills that could contribute to supporting these clients to feel safer and more grounded while in the ED.

Two studies examined the *interactions* between suicidal persons and trained helpers. In one case, researchers listened to telephone-based crisis response calls with older adults (65 and older) in addition to interviewing the telephone counselors (Deuter et al. 2013). In another study, postings made to an online community for distressed adolescents (Greidanus and Everall 2010) were the focus of qualitative inquiry. What is unique about these two studies is the way they afforded researchers an opportunity to attend to how meanings and identities were negotiated through conversational practices, within real-world helping contexts.

20.3.3 Conceptualizations of Suicidal Behavior and Suicide Prevention

In this final group of studies, local understandings of suicidal behavior and practices of suicide prevention were the primary focus of analysis. Not surprisingly, close attention is paid to language, discourse, cultural contexts, and social processes of identity construction and meaning making. Representing approximately 20 % of the total number of qualitative studies identified in this review, these studies represent a growing area of interest. What sets these studies apart from those reviewed in previous sections is that for the most part, *non-suicidal* individuals and groups are typically engaged to find out how suicide risk, resilience, and practices of prevention are conceptualized within their own particular contexts and cultural communities.[6] It is worth mentioning at this point that the categories of "suicidal persons," "non-suicidal persons," and "professionals" are themselves highly problematic for the ways in which they imply that these identity categories are final, singular, and stable, as opposed to emerging, multiple, fluid, and overlapping. It is this very attention to received under-

[6] An exception is the study by Horne and Wiggins (2009). They used a discursive psychology framework to analyze how individuals worked up an "authentic" suicidal identity in an online forum for those with suicidal thoughts. They also examined how others responded to these particular identity constructions.

standings of the social world that many of the studies included in this section set out to disrupt.

A diverse range of communities and social groups were consulted to better understand how they conceptualized suicidal thoughts and practices of suicide prevention. They included: young people (Bennett et al. 2003; Coggan et al. 1997; Fullagar et al. 2007; Kidd 2004; Molok et al. 2007; Roen et al. 2008; White and Morris 2010; White et al. 2012); sexual minorities (Fenaughty and Harre 2003; Roen et al. 2008); Indigenous community members (Decou et al. 2013; Kral 2013; Strickland et al. 2006; Wexler 2006); key informants from Ghana and Uganda, including students, laypersons, and professionals (Hjelmeland et al. 2014; Knizek et al. 2011; Mugisha et al. 2013; Osafo et al. 2011a, b); and healthcare practitioners working in specific cultural contexts (Anderson et al. 2005; Hagaman et al. 2013).

For example, Anderson et al. (2005) used a social semiotic framework to analyze how doctors and nurses working in a hospital context in England made sense of young people's suicidal behavior. These researchers were able to highlight the complexities, ambiguities, interactive qualities, and unspoken meanings embedded in the nurses' and doctors' accounts of suicidal behavior. They called attention to the broader social environments within which to make sense of youth suicidal behavior as well as the culturally mediated systems of meaning that participants relied on to conceptualize young peoples' suicidal behaviors.

Other researchers focused their analyses on the cultural resources that young people drew upon to make sense of suicide (Bennett et al. 2003; Fullagar et al. 2007; Kidd 2004; Roen et al. 2008; White and Morris 2010; White et al. 2012). For example, Kidd (2004) interviewed street youth living in Vancouver and Toronto and found that the theme of "being trapped" featured prominently in street youths' understandings of why they, or others, might become suicidal. Kidd also pointed to a recurrent narrative of social exclusion and stigmatization in the accounts of street youth and suggested that more socially responsible forms of engagement, including family support, media education, and legal interventions, would be necessary to challenge harmful stereotypes and provide meaningful opportunities for street youth to participate more fully in the life of the community. The findings from Roen et al. (2008) amplify the findings from Kidd's study in important ways by highlighting how "suicidal identities" are often saturated with moral judgments, which construct the suicidal person as other. Working in the context of England and Wales, they traced young peoples' (16–24) understandings of suicidal behavior. These discursive practices

> […] locate suicide as being against the community's religious beliefs, as not happening in 'normal families', but as being something that is more expected from 'druggies' and not in 'nice streets'. In a sense reproducing through suicidal discourses a moral order. (p. 2091)

Other studies focused on conceptualizations of suicide risk among sexual minority populations (Fenaughty and Harre 2003; Roen et al. 2008; Scourfield, Roen & McDermott (2008)). Through focus groups and interviews with young people who self-identified as lesbian, gay, bisexual, or transgendered (LGBT), as well as with youth whose sexual identity was not specified, Roen et al. (2008) explored a range of issues, including how young people negotiate distressing environments and how struggles around issues of sexual and gender identities were potentially implicated in young peoples' understandings of suicidal behavior. They highlighted some of the ways that LGBT youth deal with overt homophobia and more subtle forms of stigma and discrimination. The researchers also highlighted the ways in which young people drew on available cultural discourses to make sense of suicidal behavior among LGBT youth, including seeing it as a response to isolation, homophobia, and the stress of coming out.

Another group of qualitative researchers have recently begun to explore understandings of suicide within African contexts, specifically, Ghana (Hjelmeland et al. 2014; Osafo et al. 2011a, b) and Uganda (Knizek et al. 2011; Mugisha et al. 2013).

What these researchers have helpfully pointed out is that meanings of suicide are culturally specific and any suicide prevention program that is developed must take local understandings into account. Across the continent of Africa, there are many different tribal groupings, religious practices, and cultural norms and thus there is a need to study meanings of suicide within particular community contexts. Given the influential role of religion in many African peoples' lives, Mugisha et al. (2013) utilized focus groups and key informant interviews to learn more about religious views on suicide among the Baganda people of Uganda. A prominent finding was that suicide represents a serious breach of the religious order. While there were some divergent views, the researchers noted that for the most part, "[o]ur informants considered suicide as a breach of God's rules by violating the doctrines of sacred life, by violating the commandment thou shall not kill, and by violating the rule of agape" (p. 351). This dominant view has clear implications for how suicidal persons are treated and points to the need to engage with religious discourses as part of any suicide prevention effort in this particular context.

Others have examined North American Indigenous community members' understandings of distress, suicide, and healing (Decou et al. 2013; Kral 2013; Strickland et al. 2006; Wexler 2006). For example, Wexler used a participatory action research (PAR) methodology to engage Inupiat community members in ongoing and transformative conversations about youth suicide. By trying to better understand how community members made sense of youth suicide and by eliciting dominant cultural narratives of the problem, she set the stage for collective critique and social action. In another participatory research design, young people were taught how to create digital stories as part of a larger youth suicide prevention initiative in Northwest Alaska (Wexler et al. 2013). Drawing on a positive youth development framework, the project was designed to be strengths based, empowering, and transformative. Strickland et al. (2006) utilized focus groups and interviews to better understand parents' and elders' perspectives on colonization and the implications for youth suicide prevention in a Pacific Northwest American Indian community. Meanwhile, Kral (2013) drew on ethnographic fieldwork to better understand the disproportionately high rates of suicide and suicidal behaviors among Inuit male youth. Based on interviews with community members from Igloolik, he learned that suicidal behaviors were very often linked to disruptions in romantic and family relationships and intergenerational segregation. Kral discusses his findings in the context of colonialism and suggests that "[A]mong colonized peoples it [suicide] is viewed in part as stemming from dispossession" (p. 73).

20.4 Implications for Practice

As this comprehensive review has shown, understandings of suicidal behavior which contextualize and historicize the experience of despair and which privilege subjective meanings provide important insights into this complex human experience. At the same time, it is important to note that no matter how careful and well designed the study, it is impossible to arrive at some pure, unmediated, authentic, or final account of suicidal despair. For one thing, human beings cannot always "give voice" to every experience, emotion, impulse, or fleeting understanding they have, and many of the complexities of human existence, including contemplations of suicide, remain elusive, shifting, contradictory, and inarticulable (Polkinghorne 2005; Jackson and Mazzei 2013). Further, the active participation of the researcher in constructing the questions, designing the study, interpreting the material, and representing it on the page means that any knowledge that gets generated is always partial, situated, and strongly influenced by the researchers' theoretical lenses. This is as true for quantitative researchers as it is for those working within a qualitative paradigm. With these caveats in mind, the implications of some of these findings for future practice are discussed.

20.4.1 Lived Experience as a Source of Knowledge

Across a range of health and social care fields, there has been a strong call to include the perspectives of those with lived experience (i.e., consumers, service users, clients, patients) in the design and delivery of healthcare services (Ward et al. 2012). The work reviewed here directly responds to this call and showcases the value of a knowledge base informed by first-person perspectives. To begin, what we have learned from the rich corpus of studies investigating the lived experience of suicidality is that "being suicidal" is not a static or singular identity category. Those who have considered and/or attempted suicide are always multiply constituted and are constantly reconstructing themselves (Rogers 2003). At the same time however, there are some common threads. Specifically, the qualitative evidence has offered a thick description of the lived experience of suicidality, which includes intense suffering and struggle, hopelessness, and a strong desire to escape. Importantly, and in contrast to many other research approaches, these accounts of suffering are generated from those with firsthand knowledge and experience. As Hornstein (2013) writes, "…the categories emerge directly from the data of experience, they are not a preconceived classification system imposed on the data, regardless of how well or how poorly it fits" (p. 31). We have also learned that there is often a paradoxical quality to suicide ideation, where holding onto the idea of suicide (as a possible escape) is the very thing that allows a person to endure and go on living. Further, by situating the understanding of these behaviors within specific social and historical contexts, qualitative researchers have revealed the complex, dynamic, culturally situated, and unstable meanings surrounding suicidality (Hjelmeland 2011). Meanwhile, they have highlighted how the ongoing presence of caring others who remain engaged, communicate empathy, seek to understand, and provide opportunities for rediscovering "hidden pockets of strength" (Holm and Severinsson 2011) or "pockets of recovery" (Bergmans et al. 2009a, b) can go a long way toward reconnecting suicidal persons with the desire to live.

20.4.2 Caring Practices, Healing Contexts, and Reflexivity

This review has also showcased the invaluable contributions that qualitative evidence can make to better understanding the complex challenges involved in constructively responding to expressions of suicidal despair, across a range of health and social care settings. What we can take from these studies is the knowledge that providing a warm, caring, empathic, and respectful response, which recognizes the suicidal person as someone who is suffering, but who may not always be able to articulate what he or she needs, is a useful stance to take when doing suicide prevention work, particularly in Euro-western contexts. Further, by helping suicidal persons to see some of the cultural and social constraints that may be contributing to their despair (e.g., narrow notions of masculinity, patriarchal practices), practitioners can help individuals recognize that the challenges they are facing may not be of their own making, which is in keeping with a social justice orientation to counseling and prevention (Aldarondo 2007; Kenny et al. 2009). We have also learned through the qualitative evidence that providing care to those who have lost the desire to live can often be stressful and anxiety provoking. It seems that suicidal behavior can pose a direct challenge to many professional assumptions, identities, and discourses of expertise. Such unsettling experiences can often be an important catalyst for transformative learning (Clouder 2005), although this was not pursued as a line of investigation in the work reviewed here. We have also learned that individuals who have engaged in suicidal behavior are inevitably members of families, communities, and cultural contexts—each with their own expectations, needs, and values—and these larger relational networks and cultural norms need to be honored and mobilized when responding to, and supporting, suicidal individuals.

Finally, standard suicide prevention practices, including "constant observation" and standardized risk assessment interviews, always contain within them the potential to be dehumanizing or disengaging. Qualitative studies like those reviewed here highlight the importance of bringing a reflexive posture to our expert knowledge and professional practices so we can avoid unwittingly causing harm by adhering too tightly to a "one-size-fits-all" mentality when engaged in suicide prevention work (Rogers and Soyka 2004).

20.4.3 Politicized Research and Practice-Based Evidence

As this review of qualitative evidence has suggested, suicide prevention programs that are designed to address the disproportionately high rates of suicidal behaviors among certain groups (i.e., youth, females, sexual minorities, Indigenous peoples) can be made even more relevant by addressing some of the historical, political, and cultural forces that have contributed to oppression, marginalization, stigma, and experiences of suffering. Action research paradigms and other participatory methodologies, which are explicitly political in their aims and which involve local citizens in the design of solutions, show how social justice-oriented, decolonizing methodologies (Tuhiwai Smith 2012) can become important strategies for doing the work of suicide prevention. Such praxis-oriented research frameworks deliberately blur the distinctions between inquiry and intervention (McNamee and Hosking 2012).

A handful of studies included in this review have closely examined *how* we know about suicidal behaviors and have called attention to the ways in which dominant formulations actively shape the development of potential solutions and responses. All forms of research, knowledge, and evidence are products of particular traditions, cultural contexts, and ways of seeing (McNamee and Hosking 2012; White in press). In the future, if we want to avoid complacency and continue to produce innovative scholarship that is relevant for the times we are living in, we need to keep pushing ourselves to think within and against received assumptions about what counts as good qualitative research.

> The methodological implications of this view is that we as researchers question what we ask of data as told by participants, question what we hear and how we hear (our own privilege and authority in listening and telling), and deconstruct why one story is told and not another. (Jackson and Mazzei 2013, p. 262)

PAR, poststructural research frameworks and critical discourse analyses are generally underrepresented in the overall qualitative evidence base. A few books that draw from poststructural and critical frameworks have recently been published and point to the productive potential of these approaches for rethinking suicide prevention (Cover 2012; Marsh 2010). Such approaches may be more in keeping with what Fox (2003) calls transgressive forms of research which are defined in part by their "capacity to transgress, challenge or subvert existing conceptions" (p. 89).

20.5 Concluding Remarks

In a relatively short period of time, qualitative researchers have made several meaningful contributions to the evidence base on nonfatal suicidal behaviors and suicide prevention. Far from providing a definitive statement about the nature and meaning of suicidality, these studies have shown the complex, dynamic, context-dependent, multiple, and contradictory character of suicide ideation and attempts. Despite this variability, there are a number of very practical implications emerging from this review, which can strengthen professional practice when working with suicidal individuals. First, those with lived experience of suicidality have invaluable insights to contribute to the current evidence base on suicide ideation and suicide attempts. As David Webb recently put it in an interview with Liz Sheean (Sheean & Webb, 2010):

> I argue that you cannot hope to understand any human experience, not just suicidality, if you ignore what it means to those who live those experiences. And for this you need to hear directly from

> those who have the lived experience, there's no other way of getting this important information. (Sheean and Webb 2010, p. 28)

Second, we need to place human dignity, flexibility, and the pursuit of culturally meaningful goals at the center of any professional effort designed to support suicidal persons. To do this work well, professional practitioners will need to be supported with ongoing training opportunities that reflect knowledge generated from multiple sources, including service users, findings from qualitative research, as well as more traditional evidence-based practice guidelines. Organizational cultures that support teamwork, invite a reflexive stance toward professional practices, and promote culturally responsive and sociopolitically informed approaches to healing are strongly recommended. Third, we need to take the broader social and political arrangements into account when attempting to understand the sources of human suffering while at the same time never losing sight of the local and particular context. When research directly engages with the "*politics* of the setting which it explores" (Fox 2003, p. 96, emphasis in original), the potential for research to become a site of social justice and transformed social relations is made visible. In closing, as Van Manen (1990) observed: "We gather other peoples' experiences because they allow us to become more experienced ourselves" (emphasis in original, p. 62). Through engaging with this chapter, it is hoped that readers have not only become more experienced with the topic of suicidal behaviors and suicide prevention but also inspired to think differently about what it means to suffer, to care, and to act in ways that support suicidal people to reengage with the project of living, within a broad context of justice, cultural diversity, and ethical social relations.

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