An Interpretative Phenomenological Analysis of the Lived Experience of Suicidal Behaviour

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ABSTRACT

Introduction

Suicide is a significant social and public health problem. Considerable research has focused on the epidemiology of suicide and the identification of risk and protective factors. Research that explores the subjective experience of suicidal individuals is embryonic but growing. This review synthesises research that has examined how individuals who have attempted suicide make sense of the suicidal process.

Methods

A systematic search of CINAHL, EMBASE, Medline, PsycINFO and Google Scholar was conducted, and the reference lists of related reviews were examined, identifying 18 articles describing 17 relevant studies. The findings were extracted and then synthesised using content analysis.

Results

The analysis of studies identified four central, interrelated themes: 1) The interpersonal landscape of attempted suicide, 2) Heavy psychological burdens, 3) Resolving difficulties through suicide, and 4) Suicide as oblivion. These themes highlight the role of interpersonal factors and psychological suffering in the development and progression of suicidal behaviour. They also represent efforts to resolve distress through suicide, and the comforting qualities of suicidality.

Conclusions

Collectively, the studies examined by this review provide rich accounts of the suicidal process, locating our understanding within the specific intrapersonal, relational, social and cultural experiences of individuals who have directly experienced it. The findings are broadly consistent with existing research and provide further empirical support for explanatory accounts of the suicidal process, including the integrated motivational-volitional model of suicide (O'Connor 2011). The review has also highlighted a number of significant gaps in the evidence base that require attention.

INTRODUCTION

The World Health Organization (WHO) estimates that approximately 1.53 million people will die by suicide by the year 2020 (Bertolote and Fleischman 2002). Suicide prevention is an international public health priority and the WHO has set a global target of reducing suicide by 10%. Efforts to prevent suicide should be aided by research and the existing literature is vast and growing exponentially (Lakeman and Fitzgerald 2008). The overwhelming majority of suicide research is dominated by a quantitative agenda that has focused on providing explanatory accounts of suicidal phenomena (Hjelmeland and Knizek 2010). Much of this research has adopted an atheoretical stance and sought to elucidate predisposing factors or underlying pathologies for suicidality, as well as risk factors pertinent to the aetiology of suicide (Beautrais et al. 2005).

This body of research has advanced our understanding of suicide and informed suicide prevention initiatives directly by highlighting factors that can increase vulnerability to suicide. However, one outstanding challenge relates to our understanding of *how* these factors are linked to suicidal behaviour and, indeed, *why* people try to end their lives (Hjelmeland and Knizek 2010; O'Connor and Nock 2014). Fitzpatrick (2011) argued that the many historical, relational and wider contextual factors that help us understand suicidal despair may not be readily quantified, and made the case for diversifying existing methods to include methodologies capable of providing more contextualised accounts of suicidality, and informing our understanding of the suicidal process in particular (O'Connor, 2011).

Qualitative Research on Suicide

This focus on understanding suicidal despair has led to increased recognition of the potential value in harnessing qualitative methods to contextualise existing findings (Hjelmeland and Knizek 2010). This research remains embryonic but has recently been described as 'burgeoning' (White 2016). In recognition of the increased use of qualitative methods to inform our understanding of suicide, efforts have been made to begin to synthesise the characteristics of this research and to distil key findings. Lakeman and Fitzgerald (2008) conducted the first published systematic review of qualitative research on suicide. Their review examined research published within a ten year period from 1997 to 2007, and examined studies that explored how individuals live with suicidality or recover from being suicidal. They explicitly identified research that was undertaken with participants who had experienced suicidal *ideation,* and provided personal accounts of their experiences, including the factors that assist in recovery from suicidal ideation. Their search yielded 12 relevant studies, typically based on semi-structured, individual interviews. These studies

employed a range of analytic methods including grounded theory, thematic analysis and interpretative phenomenology. The authors synthesised the findings using content analysis and identified five interconnected themes: 1) the experience of suffering, 2) struggle, 3) connection, 4) turning points, and 5) coping. In their review, they concluded that living with or overcoming suicidality involves different struggles, often of an existential nature, and that while suicide can be perceived of as failure it often provides a means of coping. The Lakeman and Fitzgerald (2008) review provides a helpful account of research published within a specific ten-year period and includes the accounts of individuals who have experienced different aspects of suicidality, though focusing principally on suicidal ideation.

In a related review, Han and colleagues (2013) systematically identified qualitative research undertaken with individuals from East Asian countries (i.e. China, Korea, Japan and Taiwan). They examined published research from January 2002 to December 2011 and identified 11 qualitative studies that 'addressed suicide' among this population. Given the limited number of relevant articles and diversity of methods used, the authors were unable to undertake a fully systematic analysis of findings. However, interestingly, the importance of the cultural and social contexts of suicidality was highlighted in all of the included studies and the authors identified three common themes: 1) the influence of cultural beliefs, 2) the role of caregivers and 3) specific sociological contexts. It was the authors' view that these findings may be generalisable to other non-East Asian cultures but this has yet to be determined.

More recently, in a book chapter, White (2016) reviewed all of the existing published qualitative literature on suicidal behaviours and prevention in an effort to highlight the contributions that qualitative researchers have made to suicidological research. Her approach was largely descriptive however, and sought to map out the extent and nature of this research. Although the review describes its methods as systematic, the search methods were not described in sufficient detail to render them replicable, and there is no formal synthesis of findings. The quality of the included studies is not appraised, so it is not possible to arrive at an assessment of the methodological strengths and limitations of the research.

These limitations notwithstanding, White's (2016) review provides a descriptive account of the qualitative research that was undertaken prior to December 2013. The review identified 'over 75' published articles that were grouped into three overlapping categories including studies that explored: 1) the lived experience of suicidality and healing, 2) practices and perceptions of care and treatment for suicidal individuals, and 3) conceptualisations of suicidal behaviour and suicide prevention. Of particular interest are the studies that feature the insights and voices of individuals who have lived through a suicidal crisis, as it is this research that may provide the missing context with respect to our limited understanding of the suicidal mind as noted previously (Rogers 2001). White (2016) stated that 'over half' of

the studies identified by the review (exact number not specified) contributed to research in this area; by exploring either the lived experience of some aspect of suicidality (e.g. ideation, attempts) and/or accounts of recovery and healing from suicidality. Interestingly, the majority of these studies were published within the last decade, highlighting the recency of research in this area.

Rationale for the Current Review

These existing reviews conclude that, in a relatively short period of time, qualitative researchers have made important contributions to the evidence base. Findings from the reviews suggest that, far from providing a definitive statement about the nature and meaning of suicidality, studies that directly explore personal accounts of suicidality expose the highly complex, dynamic and context-dependent characteristics of these phenomena. These reviews also highlight where further, more detailed examination and appraisal of the evidence may be helpful.

From the preceding discussion, the potential to specifically interrogate the accounts of those who have attempted suicide as means of unpacking the complexity of the suicidal process emerges as an area worthy of investigation. Indeed, it is clear that a focused, systematic and rigorous examination of this research is warranted.

Review Aims

To extend the extant literature, this review targeted studies that had explored the accounts of individuals who have attempted suicide, focusing specifically on research that has examined their experiences of the suicidal process. The main aims of the review were to:

- Identify and describe the key characteristics of this research.
- Formally synthesise and distil key findings and reflect on how this contextualises and informs our understanding of the suicidal process.
- Appraise the quality of this research, highlighting methodological strengths and limitations.
- Make recommendations for future research, based on a comprehensive assessment of this evidence.

REVIEW METHODS

The review methods were developed in accordance with accepted standards for qualitative systematic reviews (Popay et al. 1998) and under the advice of a Library Support Supervisor (with technical expertise in constructing electronic searches) and College Librarian (with expertise relating to the topic of suicide).

Literature Scoping Exercise

A literature scoping exercise was undertaken to provide an early indication of the evidence base, and to ascertain the feasibility and utility of undertaking a review in this area. Initially, scoping searches were undertaken on four relevant databases: CINAHL, Embase, MEDLINE and PsychINFO. Potentially relevant search terms (identified from the literature) were searched for as subject headings (MeSH or thesaurus terms) in these databases to identify related indexing terms used by each system. Filtered searches were then undertaken on each database to identify original research and literature reviews that helped to characterise research in this area. A small sample of studies, identified through this process, was entered into the Web of Science Core Collection system in order to link to further related research. The scoping exercise indicated that there was a relatively small but growing body of research in this area. It identified three existing related reviews; however, these reviews had different aims and none offered a systematic and rigorous examination of the accounts of the suicidal process from those who have attempted suicide, therefore confirming the viability of the current review.

Search Strategy

Electronic Databases

The main source of original studies was electronic databases. On advice, a decision was taken not to hand-search journals given that the most relevant titles (e.g. *Archives of Suicide Research; Crisis: The Journal of Crisis Intervention & Suicide Prevention; and Suicide & Life Threatening Behavior*) were indexed on the electronic databases that were searched. Instead, the strategy was designed to maximise the potential from electronic sources.

Systematic searches were undertaken on: CINAHL, Embase, MEDLINE and PsycINFO using the search terms identified in the scoping exercise. Details of every search were documented to provide a transparent and replicable record of the review process (see Table 1). The 1233 records generated through the database searches were exported to EndNote and, after removing duplicates, 880 records were systematically evaluated according to the inclusion criteria for the review.

Table 1: Electronic Search Strategy and Results

Database	Search Terms/Fields	Results	Interface	Date Searched
CINAHL	[MH suicide OR MH suicide attempt OR MH suicide attempted OR MH suicidal behavio*] AND [MH research OR MH research study OR MH qualitative OR MH qualitative study OR MH interview*]	451	EBSCO	15th April 2016
EMBASE	[SH Suicide OR SH suicide attempt] AND [SH research or SH qualitative research]* [Limits: Human, English Language]	359	OVID	15th April 2016
MEDLINE	[SH Suicide OR SH suicide attempted] AND [SH research OR qualitative research]* [Limits: Human, English Language]	326	OVID	15th April 2016
PsycINFO	[DE suicide OR DE suicide attempt OR DE suicide attempted OR DE suicidal behavio*] AND [DE research OR DE study OR DE qualitative OR DE qualitative research OR DE interview*]	87	EBSCO	15th April 2016

Reference Chasing

The reference lists of three related systematic reviews (Han et al. 2013; Lakeman and Fitzgerald 2008; White 2016) were systematically examined to identify further relevant research and to serve as a useful 'quality check' in terms of the coverage of the database searches. Two additional studies were identified this way.

Google Scholar

A search was also undertaken on Google Scholar using the terms: suicid* AND attempt* AND qualitative. Due to time constraints, the first 100 results from this search were screened but this did not identify any additional studies not already identified by the main searches.

Inclusion Criteria

The inclusion criteria were as follows:

- Study reporting primary data.
- Published in English Language in a peer reviewed journal.

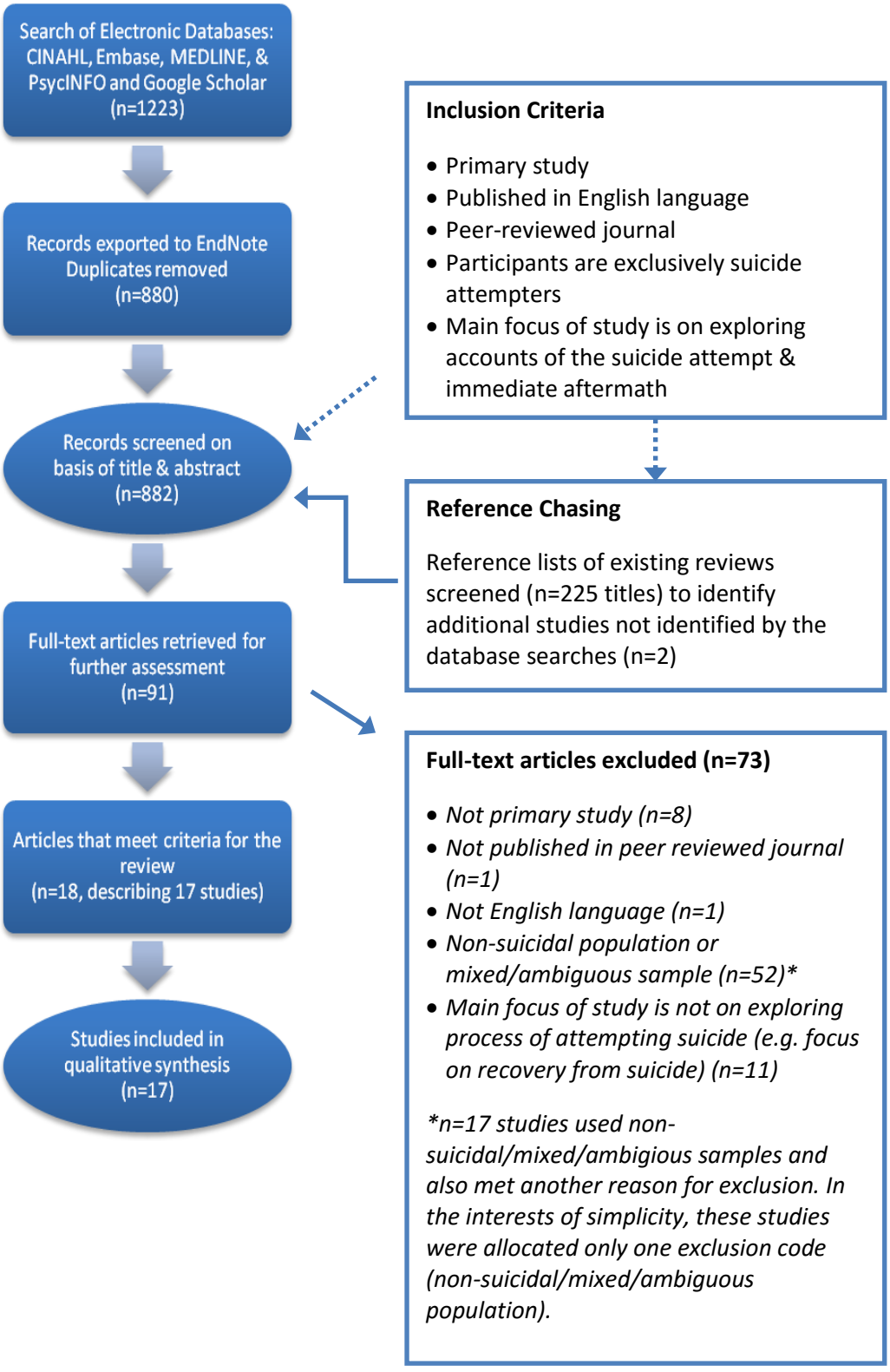
- Participants are exclusively suicide attempters.
- Main focus is on exploring the participants' accounts of their suicide attempt(s).

Studies undertaken with non-suicidal populations, suicidal ideators or individuals whose suicidal histories were not made clear were excluded. Studies with 'mixed' samples (e.g. ideators and attempters) were also excluded to ensure that the review included only data from individuals with direct experience of *attempted suicide*. As noted above, the main focus of the study had to be on exploring participants' experience of the attempt(s). Studies that principally focused on other aspects of suicidal experiences, for example, recovery from suicide or experiences of care and treatment, were also excluded.

Screening Process

An overview of the screening process is provided in Figure 1 (overleaf). As shown, a total of 91 full text articles were retrieved and assessed according to the review's inclusion criteria. Of these, 18 articles describing 17 studies were identified as meeting the criteria for the review and were subject to data extraction and quality appraisal.

Figure 1: Overview of Screening Process



Data Extraction

A data extraction table was compiled for the 17 included studies (see Table 2 in Results). This table standardised the extraction of information across studies and provided a full but concise description of each study in terms of authorship, year of publication and country; study aims; design; sample characteristics; method of analysis; themes; and quality rating. The author extracted the findings and these were sample checked by an independent researcher. There were only minor differences and these were resolved through discussion.

Quality Appraisal

Walsh and Downe (2006) developed a framework for the appraisal of qualitative research comprising 12 essential criteria. This framework was used as the basis for assessing studies in this review. Appendix 2 provides a summary of these criteria; full details can be found in the original article. The authors advocate that each study is read and considered thoroughly before applying this framework 'imaginatively rather than prescriptively' to facilitate the identification of methodological strengths and limitations (p.117). The approach employed by Craig (2015) was applied using Walsh and Downe's (2006) criteria in order to arrive at an overall categorisation of study quality - good, acceptable and poor - (see Appendix 2 for further details). The author rated all papers initially. A second researcher, independent to the study, rated a sample of included studies (25%) and any discrepancies were resolved through discussion, resulting in full agreement.

Data Synthesis

This review employed a content analysis approach, using guidance provided by Hsieh and Shannon (2005). In summary, the key findings from the included studies were extracted to form a long list of statements that represented initial coding categories. These coding categories were examined to explore the relationships between them, allowing the formation of broader thematic categories. Similar to the approach used by Lakeman and Fitzgerald (2008), the emphasis was on understanding and interpreting findings, rather than quantifying themes.

RESULTS

The characteristics and key themes identified by the included studies are summarised in Table 2 (overleaf) and briefly below. The four central themes identified by the content analysis are then described.

Characteristics of Included Studies

The studies were published within the last 13 years, with one exception (Rosen 1975). The majority were from developed countries, although there were studies from Ghana (Akiota et al. 2014) and Iran (Keyvanara and Haghshenas 2010). Only three studies were from the UK (Biddle et al., 2010, 2012; Crocker et al. 2006; Rivlin et al. 2013).In each study, individuals' accounts of attempted suicide were addressed differently. Four studies focused on the experiences of adolescents and young adults (Bennett et al. 2003; Gair and Camilleri 2003; Orri et al. 2014; Zayas et al. 2010); one explored attempted suicide among older adults (Crocker et al. 2006); and one examined the experiences of male prisoners (Rivlin et al. 2013). Three studies were interested in the sociocultural contexts of suicidal behaviour: Biong and Ravndal (2009) explored the experiences of North African male migrants in Norway; Akiota et al. (2014) explored the role of religion in attempted suicide among Ghanaian adults; and Keyvanara and Haghshenas (2010) explored the experiences of Iranian females. Two studies focused on method choice in relation to near-fatal attempts (Biddle 2010, 2012; Rosen 1975). The remaining studies recruited participants through mental health services. Four conducted research with psychiatric inpatients (Ghio et al. 2011; Mandal and Zalewska 2012; Pavulans et al. 2012; Talseth et al. 2003) and two were undertaken with community mental health samples (Adler et al. 2016; Vatne and Naden 2014).

All of the studies utilised qualitative designs to explore experience of attempted suicide; in two cases this qualitative component was part of a mixed methods approach (Adler et al. 2016; Zayas et al. 2010). The majority of studies used semi-structured, individual interviews. Talseth et al.'s (2003) research was based on a secondary analysis of interviews undertaken as part of an earlier study (Talseth et al. 1999, 2001). Adler et al. (2016) examined the transcripts of individuals' cognitive therapy sessions following their attempts and Ghio and colleagues (2011) used focus groups. The studies employed a range of analytic methods including grounded theory, thematic analysis and interpretative phenomenological analysis.

Quality Appraisal of Included Studies

The quality of studies was appraised using Walsh and Downe's (2006) criteria. Appendix 3 summaries the allocated scores for each study in relation to the 12 criteria and Appendix 4 provides a narrative summary of this quality appraisal of the evidence. With respect to overall classification of study quality, ten studies were of 'good' quality, four of 'acceptable' quality, and three were 'poor' (see Table 2).

Table 2: Characteristics and Key Findings from Included Studies

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
1. Adler et al. (2016) **USA**	To identifying cognitive warning signs that occurred within one day of a suicide attempt, to distinguish factors that signify imminent risk for suicide.	Mixed methods study comprising the analysis of transcripts of cognitive therapy sessions following a suicide attempt. Individuals were evaluated in an emergency room within 48 hours of an attempt and randomised to receive CT & case management or case management only. Clinicians trained to elicit thoughts, images, feelings and behaviours leading to the attempt.	35 individuals (21f, 14m) aged 19-66 who had attempted suicide.	Grounded Theory	• State hopelessness • Focus on escape • Suicide as a solution • Fixation on suicide • Aloneness	Acceptable

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
2. Akiota et al. (2014) **Ghana**	To examine the role played by religion in the experiences of persons who attempted suicide in Ghana.	Qualitative study involving individual interviews. Participants asked to describe what led to the attempt; the act itself; the reaction of those around them; and how religion featured in their experiences.	Individuals (12m, 18f) aged 18-46 years who were hospitalised for a suicide attempt in Accra, Ghana.	Interpretative phenomenological analysis	• God's superiority & ownership of life • Failure to fulfil religious obligations • Guilty feelings • Condemnation of oneself • Seeking forgiveness • Blaming God for not helping • Anger & disappointment in God	Acceptable
3. Bennett et al. (2003) **New Zealand**	To explore the ways young people engage with discourses of depression to justify and explain their suicidal behaviours.	Qualitative study involving individual interviews. Participants asked to consider aspects that had contributed to their attempt and events leading up to/immediately following it.	30 young people (23f, 7m) aged under 25 years, invited to interview within two weeks of presenting to an Emergency Department following a suicide attempt.	Discourse analysis	• Depression as disease • Personal failure • Fear of stigma	Acceptable

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
4. Biddle et al. (2010, 2012) **UK**	To explore (i) factors influencing the decision to use hanging among individuals who had survived a near-fatal suicide attempt and (ii) information sources used to inform choice of method.	Qualitative study comprising semi-structured interviews. Interviews focused on decision-making surrounding choice of method; views and decision-making about other methods; sources of information; and preparation involved in the attempt.	22 individuals (12m, 10f) aged 19-60 years who had survived a suicide attempt.	Thematic/constant comparison	• Anticipated nature of death (Certainty; Experience of dying; A 'clean' method) • Accessibility (Access to means; Ease of implementation)	Good
5. Biong and Ravndal (2009) **Norway**	To illuminate and interpret the lived experiences of emigration, substance abuse and suicidal behaviour in young non-western men in Scandinavia.	Qualitative study comprising open-ended, in-depth interviews. Interviews adopted an open approach to inquiry regarding participants' experiences of moving to a new country and allowed for exploration of their experiences of suicidal behaviour.	4 North African men aged 30-40 years with a history of suicidal behaviour (including attempts).	Phenomenological-hermeneutic approach	• Getting in a tight spot • Being in a fog • Being in a burning bed	Good

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
6. Crocker et al. (2006) **UK**	To capture the subjective experience of older people who had made a suicide attempt.	Qualitative study comprising individual interviews. Interviews focused on the psychological pathway to the attempt; how suicidal thoughts evolved over time; how risk factors came together and contributed to the attempt; and participants thoughts and feelings in the aftermath.	15 individuals (9f, 6m) aged 65-91 years recommended by a mental health service in London and diagnosed as depressed at the time of the suicide attempt within the past 20-weeks.	Interpretative phenomenological analysis	• Struggle • Control • Visibility	Acceptable
7. Gair and Camilleri (2003) **Australia**	To offer a window into young people's lives concerning their suicide attempts and help-seeking.	Qualitative study comprising in-depth interviews. Participants were asked about events leading to their suicide attempt; help-seeking; and suggestions for intervention.	9 young people (5f, 4m) aged 16-24 years with a history of attempted suicide.	Thematic analysis	• Path of events • Means & intent of attempt • Getting help	Poor

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
8. Ghio et al. (2011) **Italy**	To gain insight into the individual experiences of patients who attempt suicide to better understand the reasons for and emotions behind and attempt, as well as insight into risk and protective factors, and attitudes towards assistance.	Qualitative study comprising two focus groups. Participants were asked about the reasons and emotions contributing to their attempt; risk and protective factors regarding repeat attempts; and levels of satisfaction with quality of care.	17 individuals (10f, 7m) with a mean age of 45 years who were hospitalised for attempting suicide.	Thematic analysis	• Causes of suicide attempt • Communication of suicidal ideas • Risk and protective factors in repeat attempts • Satisfaction with received care	Acceptable
9. Keyvanara and Haghshenas (2010) **Iran**	To explore the sociocultural context for suicide attempts among Iranian women.	Qualitative study involving semi-structured, in-depth interviews. Interviews explored meanings of suicide and sociocultural context of the attempts.	50 Iranian women aged 15-56 years who were admitted to a toxicology or burns unit in two Isfahan hospitals following a suicide attempt.	Thematic content analysis	• Family problems • Marriage & love • Social stigma • Pressure of high expectations • Poverty	Acceptable

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
10. Mandal and Zalewska (2012) **Poland**	To explore the risk of suicide attempts by females undergoing psychiatric treatment.	Qualitative study comprising individual interviews. Participants were asked about close relations in childhood; difficult experiences in adult life; choice of method; and emotional state during attempts.	35 adult females, with a mean age of 36, who had undertaken a suicide attempt within two years of the study.	'Qualitative' analysis	• Violence within the family • Negative relations with mother • Negative relations with father • Correct relations with parents • Separation from parents • Childhood sexual abuse • Parents as negative figures • Death of close relative/friend • Marital violence • Conflict with partners • Feelings of loneliness and helplessness	Acceptable

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
11. Orri et al. (2014) **Italy**	To explore the perspective of adolescents who have directly engaged in suicidal acts.	Qualitative study comprising semi-structured interviews with adolescents. Interviews designed to elicit in-depth accounts of participants' feelings before and after the attempt, and expectations and meanings connected to this action.	16 adolescents aged 17-25 years who had directly engaged in suicidal acts. Half of the group had only one prior attempt; and the other half had more than one attempt.	Interpretative phenomenological analysis	• Negative emotions towards the self • Individual impasse • Need for control • Perceived impasse in interpersonal relationships • Communication • Revenge	Good
12. Pavulans et al. (2012) **Sweden**	To explore lived experience of being suicidal and having made a suicide attempt.	Qualitative study comprising semi-structured, individual interviews. Interviews discussed participants' experiences during the day of the attempt; experiences and thoughts about causes, triggers, motives/intentions and reasoning throughout the decision-making process; what might have prevented the attempt; experiences of care; and thoughts/feelings about the future.	Ten individuals (5f,5m) aged 20-61 years (mean age 41 years) who had made a suicide attempt.	Qualitative content analysis	• Being in want of control • Being on the road towards suicidal action • Making sense of the suicide attempt • Opening the door to possible life lines	Good

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
13. Rivlin et al. (2013) **UK**	To study survivors of near-lethal suicide attempts to understand more about their suicidal process.	Qualitative study comprising semi-structured interviews. Participants were asked to tell the 'story' of their attempt in detail, including contributory factors; triggers; state of mind at the time; purpose of the attempt; planning and preparation; process of carrying out the act; emotions and consequences following the attempt.	60 male prisoners aged over 18 years who had made near-lethal suicide attempts.	Thematic analysis	• Adverse life events • Criminal justice issues • Psychiatric factors • Psychological factors • Impulsivity • Visual images • Access to means	Good
14. Rosen (1975) **USA**	Explores experiences of survivors of attempted suicide.	Interviews were undertaken with 7 of 10 known survivors of jumps from the Golden Gay and San Francisco-Oakland Bay Bridges. Participants were asked why they chose to jump from a bridge and to describe the experience of falling; injuries sustained; spiritual aspects; and ongoing suicidality.	8 individuals (1f, 7m) who had jumped from either of these bridges in a suicide attempt.	Descriptive	• Choice of bridge • Reason for jumping • Description of fall • Death-rebirth experiences • Spiritual transcendence • Medical injuries • Subsequent suicidality	Poor

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
15. Talseth et al. (2003) **Norway**	To explore process of consolation in suicide.	Secondary analysis of two narrative interviews with patients (from previous study). Interviews focused on the expressed meaning of care.	Two middle-aged Norwegian suicidal patients who were hospitalised for patient care. (Full details in Talseth 1999, excluded study).	Phenomenological-hermeneutic approach	• Struggling to become ready for consolation • Longing for closeness • Desiring connectedness • Struggling to open up • Inner dialogue • Breaking into outer dialogue • Liberating inner and outer dialogue	Acceptable
16. Vatne and Naden (2014) **Norway**	To develop a deeper understanding of suicidal patients in the aftermath of suicidal attempts.	Qualitative study comprising semi-structured interviews with individuals Interviews took place two weeks following the attempt. Participants were asked about the things that made their lives difficult; their views about treatment; and thoughts about recovery.	10 individuals (4f, 6m) aged 21-52 years with a history of attempted suicide.	Hermeneutics	• Becoming aware of the desire to live • An experience of connectedness • Someone who cares	Acceptable

Author, Year & Country	Study Aims	Design	Sample Characteristics	Method of Analysis	Themes	Quality Rating
17. Zayas et al. (2010) **USA**	To explore the circumstances and internal experiences of suicide attempts among young Latinas.	Mixed methods study comprising individual interviews. Questionnaires were also used to gather information about the number and nature of attempts. The interviews sought meanings, motivations, sensations, perceived causes, and internal experiences in the attempt.	27 teenaged Latinas aged 11-19 living in New York city who had attempted suicide.	Thematic analysis	• Ranges of intent • Patterns of distress • Reactions, regrets & insights	Acceptable

Content Analysis of Themes

The content analysis led to the development of four central, interrelated themes relevant to experience of attempting suicide. These were 1) The interpersonal landscape of attempted suicide, 2) Heavy psychological burdens 3) Resolving difficulties through suicide, and 4) Suicide as oblivion. These themes are now described in more detail.

The Interpersonal Landscape of Attempted Suicide

The interpersonal context to individuals' accounts of attempted suicide was evident in all 17 studies and the main interpersonal features included: experience of loneliness; stigma and marginalisation; and external conflict. Collectively, these features contributed to a challenging interpersonal landscape from which suicide attempts emerged.

Participants' accounts were often characterised by a sense of loneliness. In Adler et al.'s (2014) study, feelings of loneliness emerged as a key motivation for suicide. These feelings were often accompanied by perceived low social support and a belief that they were uncared for by others. Similarly, in Rosen's (1975) pioneering research with individuals who survived jumping from the Golden Gate and San Francisco-Oakland Bay Bridges, 'problems relating to people' (p.290) were among participants' reasons for attempting suicide, including experience of loneliness and alienation. Loneliness was also identified as a powerful affective context for attempted suicide among the Polish females who participated in Mandal and Zalewska's (2012) study.

Crocker et al.'s (2006) research with older adults found that they felt less visible to other people prior to their suicide attempts and their accounts were generally characterised by feelings of loneliness and isolation. Some participants stated that they felt lonely, even in the presence of other people. Participants also described experience of diminishing social networks in the context of growing older, and all of these experiences were conceptualised as providing an important context for their suicide attempts.

Research undertaken with adolescents and young adults identified similar experiences. For example, Orri et al.'s (2014) research with Italian adolescents observed a dominant feeling among participants that they were not accepted by other people. Similarly, Zayas et al. (2010) reported that, within the solitude and sadness experienced by young Latina females, suicide emerged as the 'only option' (p.6) and was cited among the reasons for their suicide attempts.

Extending beyond feelings of loneliness, participants' accounts revealed that they often felt stigmatised and marginalised by others. Bennett et al. (2003) interviewed young people in New Zealand. Their accounts conveyed how they felt stigmatised by their experiences of mental health difficulties and suicidality; participants stated that their behaviours were

often perceived as a consequence of being 'crazy or mental' (p.296). Similarly, adolescent Latinas described how they were called 'loony,' 'psycho' and 'crazy' by their peers (Zayas et al. 2010, p.9). The accounts offered by North African migrants in Biong and Ravndal's (2009) research powerfully conveyed how marginalised they felt. The authors conceptualised these experiences as a 'social death' (p.8) and described how this developed into the pursuit of a physical death. Suicidal behaviour was described as 'one step further on the path of dehumanisation' (p.8).

In many studies, interpersonal conflict emerged as a main trigger for attempted suicide. In an Italian study, participants reported that the main triggers for their suicide attempts were relational conflicts, typically within their marital or romantic relationships, or with family members (Ghio et al. 2011). Vatne and Naden's (2014) participants described family relations as part of their painful experiences, to varying extents, and these, again, were implicated in their attempts.

Studies that examined the sociocultural contexts of attempted suicide highlighted the characteristics of interpersonal conflicts. Biong and Ravndal (2009) conducted research with North African male migrants in Norway and found that they experienced external conflict with respect to feeling rejected by others on account of their cultural identity. The authors conceptualised these experiences, together with a lack of belongingness, as an escalating 'interpersonal insecurity' (p.8) that led to them contemplate alternatives to their current situation, including suicide. The Iranian females in Keyvanara and Haghshenas's (2010) study described significant familial problems, often characterised by difficulty integrating with their husbands' families and living within the social constraints and restrictions placed upon them. These conflicts emerged as a prominent theme in reasons for attempting suicide.

Interpersonal conflict was also a feature of the accounts of younger people. The Australian adolescents in Gair and Camilleri's (2003) study described relational difficulties as the primary circumstances that preceded their suicide attempts. These difficulties often arose when important relationships broke down, or young people felt unable to meet the expectations of others. The familial dynamics in Orri et al.'s (2014) research were described as 'overwhelming' (p.5) and characterised by rigidity, which young people found difficult to tolerate. These experiences were directly linked with the choice to attempt suicide among participants. Zayas et al. (2010) contextualised experiences of interpersonal conflict as triggering incidents within 'an ongoing pattern of instability' (p.7) that usually preceded a suicide attempt.

Heavy Psychological Burdens

The majority of studies contextualised individuals' suicide attempts in relation to their experiences of adversity and the psychological legacy of these experiences. 'Heavy psychological burdens' (Vatne and Naden 2014, p.6) were a strong feature of participants' accounts in ten studies (Adler et al. 2016; Biong and Ravndal 2009; Bennett et al. 2003; Ghio et al. 2011; Mandal and Zalewska 2012; Pavulans et al. 2012; Rivlin et al. 2013; Talseth et al. 2003; Vatne and Naden 2014; Zayas et al. 2010). Across studies, participants made powerful links between their psychological distress and their suicide attempts.

Participants in Vante and Naden's (2014) study were tormented by thoughts about whether or not they would be able to live and they described increasing periods of depression prior to their suicide attempts. Powerful feelings of hopelessness, accompanied by the belief that their circumstances could not change, were important features of participants' accounts in Adler et al.'s (2014) research. Talseth et al. (2003) reported one participant's account of suicidal ideation as a 'heavy experience and a heavy feeling to go around with' (p.618). This individual described feeling trapped by their own agony.

Experience of unending suffering emerged as a prominent explanation for attempted suicide in Pavulans et al.'s (2012) study. This suffering was variably characterised by participants as feelings of anxiety, sadness, emptiness, rejection, worthlessness, disappointment and hopelessness (p.7). Efforts to endure these feelings rendered them exhausted and unable to resist suicidal impulses. When asked about their state of mind during their attempt, participants said that they experienced chaos, panic and despair. At these times, suicide was all they could think of and they could not contemplate the potential distress of significant others. Similarly, the emotional context of participants' attempts in Ghio et al.'s (2011) research included feelings of anger, mental anguish, confusion, and desperation. The affective context of adolescents' suicide attempts was similar and this emotional despair was seen to justify individuals' desire to end their lives (Zayas et al. 2010).

The majority of studies that described these psychological burdens acknowledged the contexts of significant personal adversity from which they were likely to have emerged. Mandal and Zalewska's (2012) research identified childhood trauma, including experience of domestic violence, childhood sexual abuse and negative parental relationships, as an important contextual factor for attempted suicide. In this study, participants' adulthoods were also characterised by significant adversity including the deaths of children, marital violence and alcohol. The male prisoners in Rivlin et al.'s (2013) research similarly identified their suicide attempts as, at least partly, a product of their adversity. Participants in this study described experience of culminating adversity and recent, difficult life events (e.g. a relationship break-up) as the 'last straw' (p.311), triggering an attempt on their lives.

Resolving Difficulties through Suicide

Participants viewed suicide as a means of resolving their difficulties in ten studies (Adler et al.2014; Akiota et al. 2014; Biddle et al. 2010, 2012; Crocker et al. 2006; Ghio et al. 2011; Orri et al. 2014; Pavulans et al. 2012; Rivlin et al. 2013; Rosen 1975; Zayas et al. 2010). This was often conceptualised as the underlying motivation for their attempts.

The problems that participants were seeking to solve included their immediate psychological distress, as well as problematic life circumstances more generally. This was identified as a theme in Adler et al.'s (2014) study; suicide attempts emerged quickly when individuals were confronted with problematic circumstances, and choosing death was perceived to provide a way of solving these difficulties. Biddle et al.'s (2010, 2012) research focused on the decision to use hanging. In this study, the decision to hang themselves was seen as providing 'rapid conclusion' to participants' despair. Pavulans et al.'s (2012) research in Sweden observed that participants' difficulties in directing and regulating their thoughts and emotions were cyclic in nature. In the absence of more adaptive coping strategies, suicide provided the means to address chaotic and overwhelming thoughts and feelings. The accounts of participants in two studies (Rivlin et al. 2013; Rosen 1975) described the silencing quality of suicide with respect to their despair.

Suicide's capacity to offer control prevailed in individuals' accounts in several studies. For example, in Crocker et al.'s (2006) research with older adults, suicide attempts provided a way of taking control of a helpless situation. Research with adolescents in Italy also highlighted participants' suicide attempts as a way to achieve control in their lives. In this study, participants perceived their circumstances as beyond their control during the period immediately preceding their attempt. Control also emerged as a theme in Pavulans et al.'s (2012) research in Sweden. Participants in this study frequently expressed their desire to control different aspects of their experiences, including their thoughts, emotions and life circumstances. Participants commonly described their life circumstances in chaotic terms and experienced this lack of control as 'painful' and 'scary' (p.5), stating that this contributed to their reasons for attempting suicide. This perceived lack of control detrimentally influenced their expectations of the future and, over time, participants felt worn down by a vicious circle of unsolvable difficulties. Resultantly, the focus of their attention shifted increasingly towards their own suffering, providing the context for their suicide attempt.

Suicide as Oblivion

The perception that suicide could provide individuals with the means to be released from their burdens emerged as a dominant theme and was evident in nine studies (Adler et al. 2016; Bing and Ravndal 2009; Gair and Camilleri 2003; Ghio et al. 2011; Orri et al.2014; Pavulans et al. 2012; Rivlin et al. 2013; Rosen 1975; Vatne and Naden 2014)

Attempted suicide was often experienced as having positive and comforting qualities. The accounts of Italian adolescents in Orri et al.'s (2001) research described their experiences of being trapped in an agonising present with a strong sense of hopelessness about their future. The authors describe how suicidal attempts provided participants with the means to free themselves from their unbearable suffering, describing this experience as 'salvational' (p.4). Ghio et al. (2011) described how suicide attempts liberated individuals from their distress. They observed that suicide could be experienced in a magical way by their participants, similarly highlighting its 'salvational' and 'omnipotent' qualities (p.514). The adolescent participants in Orri et al.'s (2014) study often used positive adjectives to describe what they were seeking through their suicide attempts, making references to 'light' and 'freedom,' for example (p.4).

Male prisoners in Rivlin et al.'s (2013) research identified suicide as a peaceful end to their difficulties. They described their state of mind during the process of attempting suicide in positive terms, expressing relief and describing experience of calm and pleasant feelings in response to having made the decision to end their lives. In Adler et al.'s (2014) study, one participant described feeling happy rather than scared about dying following their decision to proceed with their suicide attempt. Similarly, in Vatne and Naden's (2014) study, one participant described feelings of calmness, happiness and comfort when he felt the medication and alcohol he had taken to end his life begin to work. Notably, all of the participants who survived near-fatal suicide attempts that involved jumping from the Golden Gate and San Francisco-Oakland Bay bridges, described the process of falling as 'tranquil' and 'peaceful' (Rosen 1975, p.261). Rosen noted that many reported a feeling of submission or surrender and that they described feelings of extreme calm, peace or ecstasy.

Using suicide to escape emerged as a theme in Adler et al.'s (2016) study. Participants described feeling 'tired' and 'overwhelmed' by their suicidal thoughts or feelings of depression, stating that they wanted to 'get away' from these experiences, with suicide providing them with the means to do so. The male participants in Biong and Ravndal's (2009) study described suicide as 'a window one could approach, open and jump out of' (p.8). This functioned as an 'escape route' when they felt overwhelmed by their experiences.

DISCUSSION

This review targeted studies that explored the accounts of individuals who have attempted suicide, focusing specifically on research that has examined their experiences of the suicidal process. The review described the key characteristics of this research and synthesised the findings using content analysis. The quality of this research was also appraised. A discussion of the key findings of the review is now provided, with reference to the extant literature. The methodological strengths and limitations of the evidence base, and the review itself, are discussed before the implications for future research and clinical practice.

Key Findings

A content analysis of this literature elicited four interrelated themes, 1) The interpersonal landscape of attempted suicide, 2) Heavy psychological burdens, 3) Resolving difficulties through suicide, and 4) Suicide as oblivion. The first and second themes illuminate the contextual features of attempted suicide, while the latter two themes reflect suicide's capacity to offer some form of resolution in relation to these contextual experiences.

Interpersonal Landscape of Attempted Suicide

The interpersonal context of attempted suicide was evident across studies and emerged as a key aspect of individuals' experiences. Participants commonly felt lonely, marginalised and stigmatised by others, and experienced interpersonal insecurity and conflict within their close relationships. These features were all implicated in their suicide attempts. Loneliness emerged as an explicit suicidal motive as well as a dominant affective context for suicidal behaviour. Experience of marginalisation and stigma may have compounded feelings of alienation and worthlessness and provided further context for suicide attempts. This was particularly evident in cases where individuals already felt disenfranchised, including the male migrants in Biong and Ravndal's (2009) study, and the Iranian females in Keyvanara and Haghshenas's (2010) research. This is in keeping with existing research that has identified experience of loneliness, rejection and alienation (e.g. Linehan et al. 1986; Brown et al. 2002) as important features of suicidality. Moreover, social isolation and the absence of social support are established correlates of suicidal behaviour (O'Connor 2003; Appleby et al. 1999).

Interpersonal conflicts emerged as common triggers for suicide among adult, adolescent and young adult populations. Existing research has identified difficulties in relationships with close relatives, friends and romantic partners, as among the primary triggers for attempted suicide (e.g. Bennett at al. 2002; Milnes et al. 2002). Ghio et al. (2011) proposed conceptualising attempted suicide as a 'relational disorder,' suggesting that interpersonal conflict may reactivate particular interpersonal vulnerabilities, including abandonment

anxiety. Within this context, loss or separation become 'unbearable' and can contribute to 'inexorable feelings of loneliness and emptiness' (p.516).

These findings are broadly consistent with the wider literature that has identified the significance of individuals' interpersonal contexts in relation to the emergence and progression of suicidal ideation and behaviour (O'Connor and Nock 2014). The significance of the interpersonal context in attempted suicide is recognised in existing explanatory accounts of the suicidal process, including the integrated motivational-volitional (IVM) model of suicidal behaviour(O'Connor 2011). This model illustrates how relational experiences influence the progression of suicidal thoughts and behaviours, proposing that subjective experience of 'thwarted' belongingness and the absence of social support can increase suicidal motivation. Similarly, Joiner's (2005) interpersonal theory of suicide highlights the role of lack of belongingness in contributing to suicidal desire. The findings of this review provide further empirical support for these explanations of suicidal behaviour.

Heavy Psychological Burdens

Participants' accounts were characterised by significant adversity and intense suffering and struggle. Many studies have evidenced a strong association between experience of childhood adversity - including physical, sexual and emotional abuse, and domestic violence, for example – and suicidal behaviour (e.g. Dube et al. 2001; Bruffarets et al. 2010). Additional studies that have examined the internal world of suicidal individuals have found significant evidence of negative emotional experiences, including psychological pain, anger, rejection, and worthlessness (e.g. Bergmans et al. 2009; Everall 2000).The findings of this review further corroborate these contextual features of attempted suicide. The experience of psychological turmoil is consistent with Shneidman's (1985) concept of 'psychache:' a term coined to encapsulate the 'hurt, anguish, soreness, aching, and psychological pain' experienced within the suicidal mind (p.145). Many of the studies examined by this review provided rich accounts of this 'psychache' and efforts to seek its resolution through suicide. This supports Shneidman's (1985) assertion that suicide occurs when experience of psychache becomes intolerable.

Resolution through Suicide

The review found evidence that suicide provides a conscious means of resolving both inner psychological suffering and external problems. Individuals' use of suicide to establish control, typically within chaotic circumstances or dynamic emotional contexts, was also evidenced by this review. These findings are consistent with Shneidman's (1993) assertion that suicide represents both an internal response and action to internal and external events. Similarly, Maris et al. (2000) stated that suicide is available to individuals as resolution when their threshold to cope with suffering and despair is repeatedly breached. This links to the

concept of entrapment, a focus of significant empirical investigation within the suicide literature. According to the IMV model of suicidal behaviour, impairments in coping and problem-solving in relation to defeating or stressful circumstances, can contribute to feelings of entrapment and build motivation for suicide (O'Connor 2011). These circumstances include the psychological torment and adversity featured in the accounts examined by studies included in this review.

The need for control played an important role in individuals' decisions to end their lives, and this need for control is supported by the wider literature (e.g. Everall 2000). In research undertaken by Pollock and Williams (2004), individuals who had attempted suicide demonstrated deficits in problem-solving, compared with non-suicidal controls. The evidence in this review is suggestive that individuals may actively and consciously seek to solve their problems through suicide, and may reflect experience of impaired problem solving.

Suicide as Oblivion

The 'salvational' quality of suicide also emerged as a theme. Individuals utilised suicide as a means of escaping their own torment; a motivational concept highlighted within the existing literature. For example, Baumeister (1990) describes suicide as a means of escaping from 'aversive self-awareness,' and there was evidence of this in the current review. Both Williams' (1997) and O'Connor's (2011) models of suicidal behaviour identify this possibility of escape as a motivational moderator than can intensify suicidal ideation and develop the progression of suicidal behaviour.

The extent to which individuals derive comfort or relief from their suicidal experiences has received relatively little empirical attention. Crane et al. (2013) recently published research that explored the clinical variables that were associated with suicidal thoughts and beliefs. The study found that only a minority of participants (15%) experienced comfort from suicidal thoughts. This was associated with more severe experience of depression and suicidality. The authors suggest that comforting appraisals may be present for a significant minority of suicidal individuals. Given the emergence of positive and comforting appraisals of suicidality in the current review, this warrants further empirical examination.

Strengths and Limitations

Evidence Base

The review identified only 17 relevant studies, suggesting that research into the suicidal process, based on the accounts of those who have attempted suicide, may be growing but remains in its infancy. It may also be limited in its ability to account for the heterogeneity of those who attempt suicide. More than half of the studies included in this review (n=11)

explored individuals' experiences from a particular perspective, for example in relation to: the role of religion among Ghanaians (Akiota et al. 2014); experience of emigration and substance misuse among North African men (Biong and Ravndal 2009); and experience of depression among young people (Bennett et al. 2003). These studies have provided helpful insights into the wider sociocultural and mental health contexts of attempted suicide; however, their approaches may preclude a more organic exploration of the suicidal process that allowed individuals to identify the experiences they deemed to be most meaningful.

In some cases, the specific focus of individual studies limited their contribution to the review's aim of broadly exploring the suicidal process. For example, Biddle et al. (2010, 2012) produced research of a high quality but it was specifically focused on method choice. Importantly, it was also undertaken with individuals who survived a near-fatal attempt (i.e. used more lethal methods) and therefore sought to compensate, as far as is possible, for the fact that we cannot interview those who die by suicide. Some studies were rich both in detail and interpretation, while others provided a more descriptive account of the characteristics of individuals' suicide attempts, again limiting the potential for insight into underlying psychological processes. Many studies lacked researcher reflexivity or did not report this. Several studies provided helpful insights in relation to the transition from suicidal thought to action specifically; however, this was limited overall within the full set of studies examined by the review.

Systematic Review

The small number of identified studies reduces the power of this review, and the emphasis on qualitative approaches limits the generalisability of findings. However, as argued previously, qualitative methods can address the questions that quantitative approaches cannot; and they can do much to complement the existing, positivist-leaning body of research.

Dixon-Woods et al. (2006) highlight the contention in including qualitative research in reviews and synthesising disparate findings. Integrating the findings for this review invariably involved a degree of subjectivity and interpretation, particularly with respect to applying the inclusion criteria and appraising the quality of research. There are no recognised or firmly established methods for appraising and synthesising qualitative research, and the richness of findings may be diminished by the inevitable process of reduction. As such, readers are encouraged to consult the original publications.

The review excluded research based on mixed suicidal samples (e.g. ideators and individuals with a history of attempts) to protect the integrity of its explicit focus on the experience of attempted suicide; however, it is possible that the accounts of individuals with a wide range

of suicidal experiences may contribute to a more holistic understanding of the suicidal process.

Recommendations for Clinical Practice

The findings of this review have important implications for clinical practice. The strong interpersonal context of attempted suicide highlights the value in providing educational support for individuals capable of contributing to a more predictable and stable interpersonal context, including family, friends and health professionals. The findings also convey the importance of responding sensitively to individuals' distress. Expressing an understanding of their anguish and assisting in containing it are likely to contribute to the development of effective therapeutic relationships. In addition, helping individuals regain a sense of control and mastery over their difficulties is also indicated. This might involve efforts to promote emotional identification, expression and regulation, as well as practical problem solving techniques.

Recommendations for Future Research

Further research is needed with individuals who have attempted suicide, specifically exploring the detail of attempts from a general perspective, including the transition from suicidal thinking to action in particular. This can help with the crucial challenge of identifying not only who will develop suicidal thoughts or not, but who will act on these thoughts and when (O'Connor 2011). Research that is dependent on more interpretative and reflexive approaches may also help to match the complex, individual and nuanced nature of suicidal behaviour.

Conclusions

Collectively, the studies examined by this review provide rich accounts of the suicidal process. This research locates our understanding within the specific intrapersonal, relational, social and cultural experiences of individuals, and supports the view that individuals with lived experience of suicidality have invaluable insights to contribute to our understanding of the suicidal mind. The findings are broadly consistent with existing research and provide further empirical support for explanatory accounts of the suicidal process, including the integrated motivational-volitional model of suicide (O'Connor 2011). The review has also highlighted a number of significant gaps in the evidence base that require attention.

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Chapter 2: Major Research Project
"It Feels Utterly Terrifying and Utterly Safe": An Interpretative Phenomenological Analysis of the Lived Experience of Suicidal Behaviour

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PLAIN ENGLISH SUMMARY
A Qualitative Study of the Experience of Being Suicidal

Background

In Scotland, on average, two people die by suicide every day (Choose Life 2015). Research is needed to develop interventions that can help people who may feel suicidal. Talking to people who have attempted suicide can provide useful information about their experiences, including the factors that led them to feel suicidal, what made them act on their suicidal thoughts and what was helpful in their recovery. This information can help others who may be at risk of suicide.

Aims

This study aimed to better understand people's experiences of being suicidal. The researcher interviewed individuals who had attempted suicide to ask them about their experiences. This included questions about what led them to being suicidal, thoughts and feelings about suicide, and how they felt now about these experiences.

Methods

Individuals (n=7) who had attempted suicide within the last twelve months were interviewed about their experiences. The semi-structured interviews were audio recorded and then transcribed verbatim and analysed using interpretative phenomenological analysis.

Results

Three main themes emerged from the interviews: 1) "Intentions": This theme explored different motives for suicide, including providing relief from upsetting feelings; a way of establishing control; and a means of communicating with others; 2) "The Suicidal Journey": This theme explored how individuals' thinking can change when they are suicidal, including feeling overwhelmed by a build-up of distress and a narrowing of their perspective; 3) "Suicidal Dissonance": This theme explored how people can feel conflicted about suicide and can be fearful of the consequences of their suicidal behaviour.

Conclusions

Participants described a range of experiences and it is hoped that these findings can inform developments in suicide prevention initiatives.

ABSTRACT

Background

In Scotland, suicide prevention is a major public health challenge, with two people, on average, dying every day due to suicide. Any efforts to prevent suicide should be aided by research. Existing research on suicide is dominated by quantitative research that has largely focused on providing explanatory accounts of suicidal phenomena. Research providing rich and detailed accounts of suicidal behaviour among individuals who have directly experienced it is growing but remains relatively embryonic. This study sought to supplement existing understanding of attempted suicide specifically by exploring the processes, meaning and context of suicidal experiences among individuals with a history of attempted suicide.

Methods

The study used a retrospective qualitative design with semi-structured in-depth interviews. Participants were patients (n=7) from a community mental health service in Glasgow, Scotland who had attempted suicide within the previous 12-month period. The interviews were transcribed verbatim and were analysed for recurrent themes using interpretative phenomenological analysis (IPA).

Results

Three super-ordinate themes, each with inter-related sub-themes, emerged from the analysis. 1) “Intentions”: This theme explored different motives for suicide, including providing relief from upsetting feelings; a way of establishing control; and a means of communicating with others. 2) “The Suicidal Journey”: This theme explored how individuals’ thinking can change when they are suicidal, including feeling overwhelmed by a build-up of distress and a narrowing of their perspective. 3) “Suicidal Dissonance”: This theme explored how people can feel conflicted about suicide and can be fearful of the consequences of their suicidal behaviour.

Conclusion

Participants’ accounts were dominated by experience of significant adversity and psychological suffering. These accounts provided valuable insights into the suicidal process, highlighting implications for clinical practice and future research.

INTRODUCTION

Based on current trends, the World Health Organization (WHO) estimates that approximately 1.53 million people will die by suicide by the year 2020 (Bertolote and Fleischman 2002). Furthermore, between 10- 20 times more people will attempt suicide worldwide (World Health Organization 1999). Specifically, within Scotland, suicide prevention is a major public health challenge with two people dying by suicide every day, on average. The Scottish Government has made suicide prevention a national priority and is working towards the World Health Organization's global target of reducing suicide by 10% by 2020 (Scottish Government 2013). Reports suggest that suicide rates fell by 19% between 2011 and 2013 in Scotland, highlighting the potential value of suicide prevention interventions (Choose Life 2015).

Suicidological Research

Efforts to prevent suicide should be aided by research and the existing literature on suicide is vast and growing exponentially (Lakeman and Fitzgerald 2008). The overwhelming majority of suicide research is dominated by a quantitative agenda that has largely focused on providing explanatory accounts of suicidal phenomena (Hjelmeland and Knizek 2010). Maris et al. (2000) highlighted the positivist empirical 'building blocks' of suicide research, including surveys, formal experiments, and 'psychological autopsy' studies that seek to explain completed suicides by gathering information from official records, interviews with key informants including family and friends, and by conducting research into a person's state of mind prior to their death (Rivlin et al. 2013). Much of this research has adopted an atheoretical stance and sought to elucidate predisposing factors or underlying pathologies for suicidality, as well as risk factors pertinent to the aetiology of suicide (Beautrais et al. 2005).

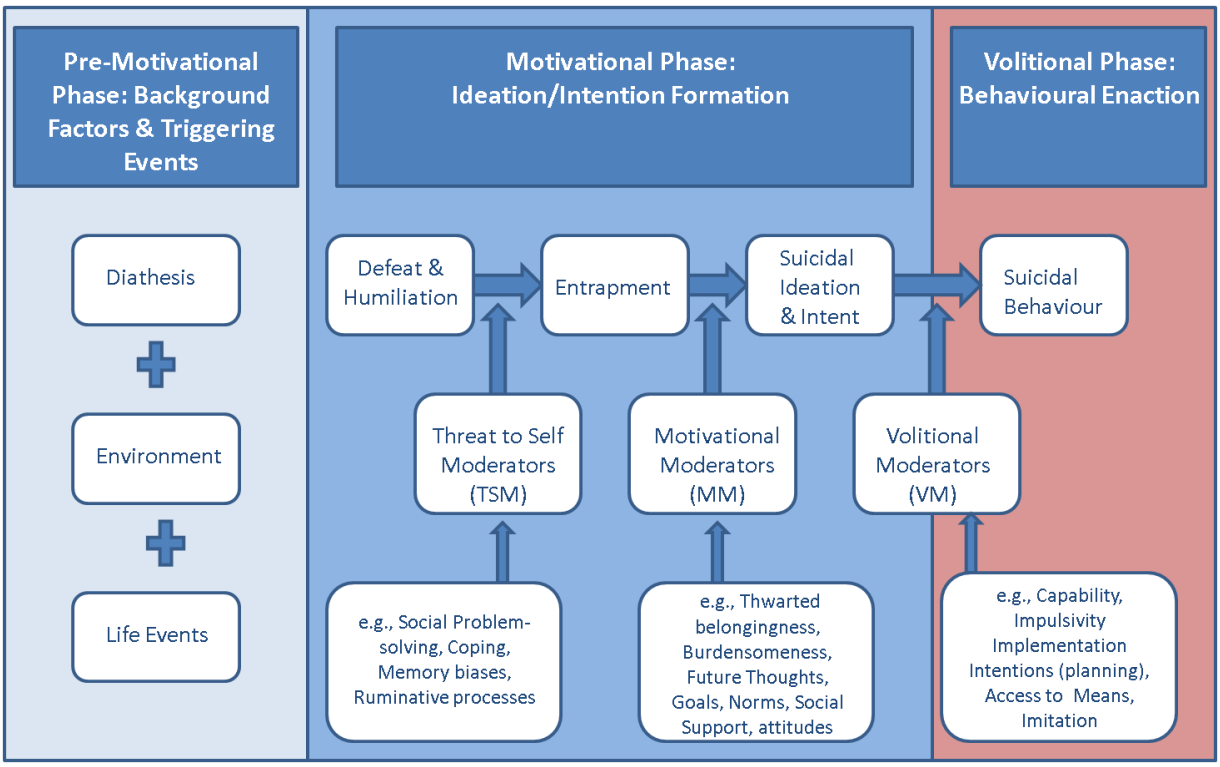
This body of research has significantly advanced our understanding and informed suicide prevention initiatives directly by highlighting the factors that can increase vulnerability to suicide. A review by O'Connor and Nock (2014) provided a comprehensive summary of what is known about the contributing role of personality and individual differences, cognitive factors, social aspects and negative life effects to suicidal behaviour; however, the authors conclude that suicidality ultimately results from a complex interplay of many factors and highlight several worthy avenues for further research.

Theories of Suicidal Behaviour

One key outstanding challenge relates to our understanding of *how* these factors are linked to suicidal behaviour and, indeed, why people try to end their lives (Hjelmeland and Knizek 2010; O'Connor and Nock 2014). Psychological theories have been developed on the basis of the existing evidence to try to explain how this complex interaction of factors might combine to increase risk of suicide. It is beyond the scope of this study to describe and critique the full range of psychological theories of suicidal behaviour; however O'Connor and Nock (2014) provide a helpful summary of the predominant models. These include Joiner's (2005) interpersonal theory of suicide which postulates that suicidal motivation develops within an interpersonal context characterised by perceived burdensomeness and low levels of belongingness. Alternatively, the cognitive model of suicidal behaviour (Wenzel and Beck 2008; Wenzel, Brown and Beck 2009) identifies several cognitive processes that are implicated in a suicide attempt, including hopelessness, attentional bias towards suicide-related cues and an attentional fixation with suicide.

The integrated motivational-volitional (IMV) model of suicide behaviour (O'Connor 2011) seeks to bring together existing perspectives and account for the full range of factors that might contribute to the emergence and progression of suicidality. In summary, the model conceptualises suicide as a behaviour that develops through motivational and volitional phases (see Figure 1). Feelings of defeat and entrapment are of most significance; when a person feels defeated and unable to escape from stressful circumstances - and where motivational moderators are present (including low social support and a thwarted sense of belonging) - suicidal motivation is more likely to emerge. The model also identifies a range of volitional factors that would then increase the likelihood of a suicide attempt occurring. There is growing empirical support for the IMV model (O'Connor 2011).

Figure 1: The Integrated Motivational-Volitional Model of Suicidal Behaviour



O'Connor (2011)

Qualitative Research on Suicide

Fitzpatrick (2011) suggested that many of the historical, relational and wider contextual factors that help us understand suicidal despair are not readily categorised or quantified. He made a case for diversifying existing methods to include approaches capable of providing more contextualised accounts of suicidality that inform and develop our understanding of the suicidal process, as delineated by models including the IMV (O'Connor 2011).

White (2016) highlighted the trend within suicidological research towards undervaluing qualitative research in particular. She recently published a review that sought to describe the extent and content of qualitative research on suicide and suicide prevention and identified just over 75 published studies. In 2010, Hjelmeland and Knizek reviewed all of the research articles published in the main suicidology journals over a two-year period (2005-2007) and found that less than 3% were based on qualitative methodologies. When these findings are contrasted with Lakeman and Fitzgerald's (2008) observation that a basic MEDLINE search (for the period 1950-2007) identified over 42,000 published articles related to suicide, it makes White's argument about qualitative approaches being largely neglected more compelling.

Hjelmeland and Knizek (2010) argued that "…extending the use of qualitative methodologies are essential to the advancement of the discipline of suicidology" (2011, p.591). Qualitative methods have much to offer, given that they are well suited to investigating individuals' viewpoints, their lived experiences and internal worlds. In her recent review of qualitative suicide research, White (2016) described how qualitative methods have been broadly applied to the exploration of different aspects of suicidality among individuals' with first-hand experience of suicide, as well as health professionals, family and friends. While embryonic in nature, White (2016) highlights the contributions that this research has made with respect to further contextualising our understanding of suicidality (including help-seeking and recovery); experiences of treatment and care; and approaches to suicide prevention.

The Role of Subjective Accounts

Given Rogers (2001) assertion that our understanding of the suicidal mind remains limited, the employment of qualitative methods to directly explore the experiences of suicidal individuals arguably holds the most promise. Furthermore, undertaking research with individuals who have attempted suicide can contribute to our understanding of the suicidal process itself, including the progression from suicidal thinking to action (Rivlin et al. 2013).

Very few studies have investigated the suicidal process by interviewing survivors of suicide attempts. The systematic review undertaken concurrently with this study identified only 17 existing studies that exclusively explored accounts of the suicidal process among those who had attempted suicide. Six studies focused on attempted suicide within specific populations including adolescents and young adults (Bennett et al. 2003; Gair et al. 2003; Orri et al. 2014; and Zayas et al 2010); older adults (Crocker et al. 2006); and male prisoners (Rivlin et al. 2013). The remaining studies explored the experiences of adults within community settings however, the majority of these explored attempted suicide in relation to specific experiences or contexts including religion (Akiota et al. 2014); aging (Crocker et al. 2006); prison (Rivlin et al. 2013); and emigration and substance abuse (Biong and Ravndal 2009). While it is helpful to study the experiences of subgroups and investigate what role specific factors might play in attempted suicide, it is also useful to study the broader experience of attempted suicide in order to identify general features that emerge more organically from participants' accounts. These can then be further explored within specific populations and contexts. This is particularly important given the developing nature of research in this area.

Two studies (Pavulans et al. 2012; Vatne and Naden 2014) adopted a more general approach to their exploration of attempted suicide. Pavulans et al. (2012) undertook individual interviews with ten Swedish adults who had attempted suicide within the preceding three-week period. Data were analysed using a qualitative content analysis. The

study identified participants' need to feel in control as a key issue in being suicidal; that the main motivation for their attempts was to seek relief from suffering; and that the final step from ideation to action was impulsive, irrespective of the degree of planning.

Vatne and Naden (2014) interviewed ten Norwegian adults two weeks after their suicide attempts. This study focused more on experiences in the aftermath of their attempts but reported sufficient data on the suicidal process to warrant inclusion in the review. The authors utilised hermeneutics to analyse the data and found that participants often experienced ambivalence and became aware of a desire to live during their suicide attempts. Overall, existing qualitative research with suicide attempters suggests that suicide can help individuals to deal with feelings of anxiety, anger and helplessness, and provide relief from stressful feelings and emotions (Rivlin et al. 2013).

Rationale for the Current Study

We continue to have a limited understanding of the nature and process of attempted suicide (Hjelmeland and Knizek 2010). In recognition of the need for further research, capable of unpacking the complexity of individuals' suicidal experiences, the current study sought to address several key gaps in the literature.

It did so by undertaking an exploration of the lived experience of suicidal behaviour among individuals who have attempted to take their own lives. The study adopted a broad and open approach to the exploration of their experiences of the suicidal process specifically, allowing the features that they considered most meaningful to emerge organically from their accounts. The emphasis moved beyond a descriptive analysis of their experiences, by utilising interpretative phenomenological analysis (IPA). This approach aims to understand how individuals make sense of their major life experiences (Smith et al. 2013). Its epistemological underpinnings include 1) its emphasis on phenomenology and efforts to understand the world from the perspective of the individual, and 2) its commitment to dual hermeneutics, namely the researcher's efforts to make sense of the individual who is making sense of their own experiences. IPA is also idiographic in nature and prioritises an in-depth exploration of individual cases. Given its inductive approach and capacity to ask questions about the lived experience of complex human phenomena, IPA was the chosen method of analysis for the current study.

Research Aim

The aim of the proposed research was to explore the lived experience of suicidal behaviour among adults with a history of attempted suicide.

Research Question

The overarching research question was:

How do people who have made a suicide attempt describe and make sense of the suicidal process?

METHOD

Design

The study used a retrospective qualitative design with semi-structured in-depth interviews, analysed using IPA.

Ethical Approval

Prior to recruitment, ethical approval for the study was obtained from the West of Scotland Research Ethics Committee and NHS Greater Glasgow and Clyde Research and Development Department (Appendix 5 and 6).

Sampling and Recruitment

Recruitment Procedures

Individuals with a history of attempted suicide were recruited from a Community Mental Health Service in Glasgow. The study sought adults aged 18 years and over who had made at least one suicide attempt within the previous 12-month period, where 'suicide attempt' was defined as a non-fatal, self-directed self-harming episode associated with evidence of some suicidal intent (O'Connor et al. 2013). The study sought to be as inclusive as possible, however individuals who were not competent in English; were imminently suicidal (i.e. stating that they intend to kill themselves within the next few hours); had a learning disability or cognitive impairment; or were experiencing a psychotic episode at the time of recruitment, were not eligible for participation.

Prior to recruitment, the researcher provided a formal presentation to clinical staff about the study, its eligibility criteria and procedures for recruitment. Clinicians were invited to review their existing caseloads in order to identify patients that met the inclusion criteria. They were asked to approach these patients and provide them with information about the study, using a participant information sheet prepared for this purpose (Appendix 7). Clinicians were briefed to inform prospective participants that involvement in the study was confidential and voluntary, and that non-participation would not impact upon their treatment or future involvement with the service in any way. Individuals who expressed an interest in participating were asked to provide verbal consent for the clinician to pass their contact information to the researcher. They were then contacted directly by telephone to arrange an appointment for interview at their convenience. Recruitment continued until the research team agreed that a saturation of themes had been achieved.

Participants were recruited to the study between November 2015 and June 2016. The research team initially sought to recruit between eight and ten participants. A total of 11

individuals were referred to the study; two individuals could not be contacted to arrange interview, and two cancelled or did not attend for interview. Therefore, a final sample of seven participants was included in the study. Smith et al. (2013) recommend a sample size of between four and ten participants for a professional doctoral research project using IPA. Given the complex and individual nature of suicidality, the sample was not expected to be representative of all suicide attempters. Rather, the aim was to generate a purposive sample that represented adult community mental health patients with experience of attempted suicide.

Sample Characteristics

Participants were four males and three females aged between 25-52 years (mean age = 37.86, SD = 10.52). They all lived in a major urban area in west central Scotland. Two participants were married and five were single. Their mental health diagnoses and suicidal histories were established through interview and consultation with referring clinicians. The number of lifetime suicide attempts ranged from one to an estimate of between 20 and 25 attempts. The amount of time that had passed since the most recent attempt and the interview ranged from four weeks to nine months. Six of the seven participants used overdose methods in their most recent attempt, while one participant lacerated himself. Further participant details are provided in Table 1.

Table 1: Sample Characteristics

Pseudonym	1. Wendy	2. Humza	3. Lily	4. Sandy	5. Annie	6. Peter	7. Andy
Gender	Female	Male	Female	Male	Female	Male	Male
Age (Years)	48	26	40	52	32	42	25
Ethnicity	White British	British Asian	White British	White British	White British	White British	White British
DEPCAT Score*	3	2	3	5	4	5	4
Psychiatric Diagnosis**	Emotionally Unstable Personality Disorder	Major Depressive Disorder	Recurrent Depressive Disorder	Major Depressive Disorder	Major Depressive Disorder Post Traumatic Stress Disorder	Recurrent Depressive Disorder	Major Depressive Disorder
Attempts	Multiple (15+)	Single	Multiple (3)	Multiple (3)	Multiple (2)	Multiple (20-25)	Multiple (2)
Method (recent attempt)	Overdose	Overdose	Overdose	Overdose	Overdose	Cut neck with glass	Overdose

**Scottish Index of Deprivation Decile. A higher score denotes a greater degree of deprivation.*

*** Psychiatric Diagnoses were confirmed by the referring clinicians*

Procedure and Interview

Interview Schedule

Individual interviews were conducted by the researcher in a clinical setting and lasted between 49 minutes and 1 hour and 29 minutes in duration. The interviews were conducted according to the interview schedule in Appendix 8. This schedule was developed through consultation with the existing literature and discussions among the research team. It was piloted on a small subset of the final sample (n=2), providing the researcher with an opportunity to practice interview technique and evaluate the appropriateness of proposed questions. No issues emerged during the piloting phase, therefore following discussion and review among the research team, no substantive changes were made.

At interview, the schedule was not followed strictly but instead used to guide a process of reflection whereby participants prioritised experiences and events that they deemed to be central to their attempted suicide. The main focus was on their most recent episode, but the interviews covered the range of their experiences, including previous attempts. The content of each interview followed the participant chronologically through accounts of their suicide attempts. This typically included exploration of their experiences immediately preceding the attempt; thoughts concerning possible causes and triggers; perceived motives and intentions for their suicidal behaviour; their affective state at the time of the attempt; and their reasoning during the attempt and in its immediate aftermath. The style of the interview was inductive, adopting a process of reflection and probing, and the interviewer often requested more detailed information to determine a richer, more insightful sense of how the participant thought about their suicide attempt. All interviews were recorded on a digital recorder, with participants' permission, and subsequently transcribed verbatim.

Interview Protocol

At the outset of each interview, the researcher provided a brief introduction to the study, outlining the nature of the interview and again providing or reading the information sheet to participants. Every effort was made to ensure that participants had a comprehensive understanding of the study's aims and what was required of them. Written consent was obtained (Appendix 9) and participants were reminded that their participation was voluntary and confidential and that they were free to withdraw at any time. Confidentiality was explained, including limits regarding risk to self or others. Participants were given a pseudonym and referred to by this pseudonym for the duration of the interview and during analysis to protect their identity. The potentially sensitive nature of the research topic was acknowledged and participants were advised that they did not have to answer any questions they did not wish to. They were also told that they could take a break during the

interview if necessary. At this stage, participants were offered an opportunity to ask any further questions.

At the start and end of each interview, a formal assessment of suicidal risk was made by the researcher using the standardised risk screening tool that is extensively used by the Suicidal Research Behaviour Laboratory (Appendix 10). No participants were identified as at imminent risk of suicide during the interviews. The researcher discussed her concerns about ongoing suicidality with other clinicians in only one case. This participant was under the care of the crisis team which was already aware of these concerns and managing risk accordingly.

Socio-demographic information was recorded for all participants, including gender, age, postcode (in order to calculate their social deprivation score) and current psychiatric diagnosis. A brief suicidal history (e.g. number of attempts, time since last attempt) was also obtained for each participant using selected questions from the Self-Injurious Thoughts and Behaviors Interview (SITBI) (Nock et al. 2007) (Appendix 11).

Potential for Participant Distress

Given the sensitive and emotive nature of the interview topic, the researcher was aware that some individuals may become upset when asked questions about their wellbeing or previous suicidal/self-harming behaviour. The voluntary nature of participation was emphasised during the recruitment process so that participation extended only to individuals who chose to be involved. Participants were assured that they did not have to answer any questions they were unwilling to and that they could take a break from interview if necessary; however, none of the participants made such requests.

Considerable attention was given to the evaluation of participants' opinion about the interview after its end. All reported that they felt comfortable discussing their experiences and several participants reported that they derived a cathartic benefit from their participation. Following each interview, participants were provided with a list of contacts for further support, including details of the duty and out-of-hours services associated with the community mental health team, Breathing Space, Samaritans and the local Accident and Emergency department. No concerns were raised by referring clinicians subsequent to the interviews.

The researcher sought additional supervision where required in order to manage the emotional load that was conferred through the process of engaging with individuals' emotive accounts of their distress.

Data Analysis

As noted previously, IPA was considered best placed to offer insight into participants' experiences. Data were analysed by hand using a six stage process as detailed by Smith et al. (2013) (p.82-107). Initially, this involved immersion in the data by reading and listening to the transcripts multiple times. The researcher commented on the transcripts in increasing depth, including consideration of descriptive, linguistic and conceptual content. A sample of an analysed transcript is included in Appendix 12. The researcher analysed each transcript individually, identifying emergent themes and how these related to one another by developing superordinate themes and subthemes for each participant. These were comparable with those identified by the researcher and any additional themes were discussed to reach consensus. Emergent themes within the group were then considered. Finally, key themes were identified that incorporated the experiences of the group overall. As suggested by Smith et al. (2013), a Microsoft Word document was created to record excerpts from the transcripts related to each emergent theme. An example of one of these documents can be found in Appendix 13. The researcher engaged in an interpretative relationship with each transcript. Two researcher supervisors read a sample of the transcripts and emergent themes were scrutinised and discussed until consensus was reached. Herein, three superordinate themes will be reported: 1) "Intentions," 2) "The Suicidal Journey," and 3) "Suicidal Dissonance."

Research Reflexivity

The role of the researcher in the process of analysis is explicitly recognised in IPA. The researcher was attuned to the ways in which her own professional and personal experiences might interact with the process of conducting and interpreting the interviews. As a trainee clinical psychologist, the researcher was familiar with psychological models and has delivered psychological therapy to adults, including individuals who are suicidal. Historically, she volunteered with the Samaritans as a listener, trainer and in a mentoring capacity to new Samaritans. In addition, the researcher conducted a systematic review of research exploring individuals' experiences of attempting suicide concurrently with this study. To ensure that her reading of existing, related research did not prejudice the emergence of themes particular to the current study, the process of reviewing and synthesising studies for the systematic review was delayed until the analysis of the interviews was complete. Throughout the process, the researcher kept reflective notes to help her to recognise her subjective views and emotional reactions to the interview content. This assisted the process of acknowledging and 'bracketing off' beliefs and expectations while analysing the data and identifying themes, as is suggested by Smith et al. (2013). As noted previously, two research supervisors independently identified emergent themes in a sample of data to verify the reliability of the analysis.

RESULTS

Three superordinate themes and seven interrelated subthemes emerged from the analysis and are summarised in Table 2.

Table 2: Superordinate Themes and Subthemes

Intentions	*"It wasn't about wanting to die":* Suicide as release
	"The only power you have left in your life": Regaining a sense of control
	"Here it is": Communicating through suicide
The Suicidal Journey	*"The straw that broke the camel's back":* Culminating distress
	"You lose your capacity to reason": Narrowing perspectives
Suicidal Dissonance	*"It feels amazing and it feels awful at the same time":* Inner conflict
	"Fear of the unknown": Consequences

These themes essentially represent how participants perceived and understood their suicidal experiences. Quotations from participants have been used to illustrate the themes and ground them within participants' lived experiences. In cases where subthemes applied differently to participants, divergent experiences are discussed.

Intentions

The first theme encapsulates how participants made sense of the underlying motives for their suicide attempts. Three primary suicidal intentions emerged from participants' accounts, representing three interrelated subthemes: 1) Using suicide as a means of releasing themselves from their despair, 2) Using suicide to regain control, and 3) Using suicide as a means of communicating with others.

"It wasn't about wanting to die": Suicide as release

For five participants, suicide provided a means of relieving themselves from their acute psychological distress. Sandy's father had physically and emotionally abused him and was an unrelenting source of distress in Sandy's life. His father directly told Sandy that he was "not worthy of being on this planet" and it is possible that Sandy internalised this view of himself and that this, in some way, contributed to the development of his suicidality. Sandy explicitly described how his first suicide attempt, at the age of 32, was motivated by a need to escape from his father, recognising the overwhelming nature of this experience:

> *"I just couldn't cope anymore. I just wanted to end my life. I wanted to end it. Because I was never going to be left alone. It was a way of getting away from my dad."*
> *(Sandy)*

Sandy's words convey a profound sense of feeling trapped and helpless in this relationship, and a belief that he would never be liberated from his father's relentless abuse. This prospect appeared to be so intolerable to Sandy that the primary motivation for his attempt was to 'get away' from his father, rather than a clear desire to be dead.

Andy described feeling overwhelmed by current problems in his life including the breakdown of a romantic relationship, financial hardship and the stress of being subjected to a fraud investigation at work. For Andy, suicide appeared to provide the means to free himself from the burden of these problems:

> *"Selfishly, you don't have to deal with anything after that point. Life is hard. Death is easy. When you're dead, you're dead. You don't have to deal with life. You don't have to deal with the problems that come with money, or relationships, or work, or friends or family."*
> *(Andy)*

Andy drew attention to the stark contrast between life being hard and death being easy. It is possible that he is commenting on the extent of his own psychological suffering, which is also reflected in the manner in which he lists the various sources of difficulty in his own life. However, it is noteworthy that he may be externalising these motives and experiences through use of the word, 'you.' This quotation also illustrates his belief that suicide can provide a quick and permanent end to his own suffering.

Wendy's account was set against a backdrop of significant early adversity and abuse, and she reflected on how these early experiences of trauma and loss had contributed to long-term mental health difficulties and associated suicidality. Wendy explained how suicide could relieve her from the traumatic intrusions and other "bad" thoughts and feelings that she experienced, and this appeared to be the primary motivation for her attempts:

> *"I would say that 90% of the time I have tried to kill myself, well a lot of the time, it wasn't about wanting to die. It was about shutting things off."*
> *(Wendy)*

Wendy's words suggest that her suicidal tendencies may have developed as a potentially instant solution to stop the ongoing, intolerable flow of her distress. She described being motivated by a need to "shut things off," and was able to acknowledge that her attempts were not typically about seeking to die. Given the chronicity of her suicidality and experience of more than 15 lifetime attempts, it may be that attempting suicide has developed as a direct learned response to her distress, in the absence of more adaptive means of coping.

"The only power you have left in your life": Regaining a sense of control

Five participants conveyed how suicide can help to establish a sense of control, in lives that are otherwise characterised by significant unpredictability and instability. Annie had experienced significant adversity in her life and it appeared that, over time, these experiences had diminished her capacity to engage with different aspects of life, reducing her sense of self-worth. In this context, it is possible that her suicidality emerged as a defence against the profound loss that she had experienced:

> *"It's sometimes the only option, the only power you have left in your life. Because life takes everything away from you. Your self-worth. Your achievements. Your community. Your friends. Your family. How you feel about yourself. Because when it is all gone, you will have a decision left and that is whether or not to live."*
> *(Annie)*

Her words imply that there is a reassuring quality to this, and that when confronted with this loss Annie may take some solace in knowing that suicide remains as a means of asserting control. Peter had experienced long-term difficulties with depression and alcoholism, and he related these difficulties directly to the conflict he experienced as an adolescent regarding his sexuality. He described a turbulent life, characterised by

unpredictable emotional experiences and explicitly made reference to suicide's capacity to provide control. He described this control as comforting, and directly contrasted this with the belief that suicidality is something to be fearful of:

> *"There was a comfort in the past that I felt some control. People used to say, "Oh feeling suicidal that must be very scary and frightening?" But in a way, you took some comfort that you had the power and control."*
> *(Peter)*

The above quotation illuminates the conscious aspect of Peter's suicidality, and the knowledge that he can actively assert power and control through his suicidal behaviour.

"Here it is": Communicating through suicide

All seven participants powerfully conveyed the extent to which they felt stigmatised, marginalised and disbelieved in relation to their experiences of adversity, mental health problems and suicidality. They commonly reflected on barriers to help-seeking in relation to their experiences of feeling suicidal, and their distress more generally. The communicative capacity of suicide, and attempting suicide specifically, emerged as a largely unconscious motivation for their suicidal behaviour, although several participants were able to consciously reflect and reason about this retrospectively at interview.

Humza had developed difficulties with depression which he related to his sociocultural context, making frequent reference to his experience as the oldest son in a traditional Muslim family. Humza was very conflicted about his religious beliefs and described the social constraints and high expectations placed upon him by his parents. He appeared to be struggling with how this limited the opportunity for his own individual expression, and this may have contributed to experience of low self-worth which he identified as a central feature of his depressive experiences. It appeared to be important for Humza to communicate the apathy that he felt about his own existence to others which may reflect this underlying sense of worthlessness:

> *"There is a real sense of, "I don't care if I live or die." And maybe just showing that to people. "Here it is."*
> *(Humza)*

The words, "here it is" have externalising qualities, and it is possible that Humza is describing a need to authenticate his distress and convey it to other people, including his parents in particular. Similarly, Peter described how his most recent suicide attempt was motivated by a desire to convey the legitimacy of his suicidal feelings to a close friend that had previously been dismissive of his suicidality:

> *"It was almost, in a way, just as much to say that to that man: "Look. I told you I was suicidal. And you didn't believe me. Well, look. I really am suicidal. And do you know what? I don't really care now. That's it. It is your problem. You deal with it.""*
> *(Peter)*

This quotation may reflect Peter's anger and frustration at not being believed. It is possibly also illustrative of Peter's need to attribute some of the responsibility for his suicidal act to this close friend. Andy expressly described fantasising about ending his own life overtly, using brutal means, at his place of work. He is clear about the communicative quality to this, describing this act as a "statement" to his employers who have caused him significant distress as a result of their recent investigation into his misconduct:

> *"Another quite vivid thought that I have about hanging is, the thought I have had about actually doing it in my work. As a statement to them. Because they are corporate arseholes. Corporate bullshit arseholes. They get on my nerves the way they treat people."*
> *(Andy)*

The Suicidal Journey

The second superordinate theme characterises the psychological processes that explain how individuals moved from thinking about suicide to taking action to end their lives. Two interrelated subthemes emerged that may be reflective of different psychological processes during a suicide attempt: 1) the effects of culminating distress, and 2) narrowing perspectives.

"The straw that broke the camel's back": Cumulating distress

Early adversity was pervasive across participants' accounts, and despair and suicidality were long-standing features of their lives. All seven participants reflected on the evolutionary aspect of their suicidality and suggested that their resources to cope with life's difficulties

had depleted over time, while their sense of hopelessness and despair had intensified. This was particularly true for Sandy, Annie and Peter. The following quote from Peter captured his own experiences of this:

> *"Over the years as my depression has got worse and it has been a more long-term experience, I think the suicide attempts, when I have felt suicidal, that feeling has been more intense. You think, "I am back at this point again. I have felt like this so many times in the past. I have tried but nothing works." So I think when it happens, there is more desperation and just wanting it to really work this time. It's a bit like you keep trying something and trying something and want it to work. You become more desperate for it to work."*
> *(Peter)*

This quotation illustrates the cyclic nature of Peter's distress, and the increasing sense of powerlessness that accompanied this. Peter reflected on his growing desperation and his words were also indicative of an intensification of his suicidal desires. He made reference to the futility of past, alternative means of coping, and it is possible that this awareness has become a more conscious feature of his suicidality over time, again contributing further to his suicidal motivation.

Sandy's account was dominated by significant interpersonal difficulties. He made reference to the overwhelming and destructive nature of his relationships and, in the following quotation, may be making reference to an increasingly fragmented sense of self:

> *"I told my wife, I can't cope with all this anymore. I just want them all to fuck off. I have had a hell of a life. People have broke me down so much. They have broke me down so much that I don't even want to be on this planet anymore."*
> *(Sandy)*

His use of the word 'planet' is significant, not only because it potentially reflects the totality of his despair, but because, as noted previously, his father had told Sandy that he was not worthy of being on this planet. This may provide further evidence that Sandy has internalised his father's abuse and this now forms part of his narrative about his suicidal experiences. It may also reflect the extent of Sandy's perceived alienation; that, despite the vastness of this earth, he believes that there is no place for him. In Annie's case, the effects of seeking, and failing, to connect with others and achieve a sense of belonging was instrumental in her suicide attempt:

> *"I just remember it feeling like the straw that broke the camel's back and I just thought, "I can't do this. I can't keep trying to fit in this world. I can't keep trying to persevere and maintain a presence. It is not possible for me anymore." And that is when I took an overdose."*
> *(Annie)*

Annie appeared to feel out of place, and, through her use of the phrase, 'trying to fit in,' she may be describing how she perceives herself to be different from other people. This may be related to her experiences of trauma and long-term mental health difficulties, including feelings of low self-worth. The enduring nature of her isolation and her efforts to try to connect to others is reflected in her use of the words, 'trying' and 'persevere.' This may be suggestive that there is a cumulative effect to her experiences and that she has been further reduced in her capacity to resolve her interpersonal difficulties over time.

"You lose your capacity to reason": Narrowing perspectives

Six participants described how their thinking changed when they felt suicidal. Peter essentially described a narrowing of perspective, which appeared to promote greater attention to the desperation of his circumstances. This may have magnified his perceived problems and increased his sense of hopelessness. The following quotation illustrates this experience, together with an accompanying impairment in the ability to be rational and problem-solve at such times:

> *"You lose your capacity to reason and rationalise and you just begin to focus on this desperate situation and how awful it is. At those times, you can't rationalise and say to yourself, "You know what? Maybe tomorrow you can phone your GP or psychiatrist or phone Samaritans."*
> *(Peter)*

This is suggestive that there may be a point in suicidality, and during a suicide attempt in particular, where internal intervention becomes less possible due to changing perspectives. This may be associated with internal entrapment: feeling trapped by psychological distress. Wendy described similar experience of a narrowing perspective when she was acutely suicidal. In this case, Wendy was no longer able to hold her daughter in mind, and consider the impact of her action on others:

> *"I know a lot of the time that I have taken overdoses, it's like she was out my head. It's like she's not a means of stopping me. It's*

not until afterwards that I am reminded by the doctor or whatever that I need to remember about her."
(Wendy)

This may be suggestive that, when Wendy feels suicidal, former protective factors, such as her daughter, are suspended from contemplation, and her priority shifts to the resolution of her acute despair. This appeared to represent a powerful shift in thinking as Wendy stated that her daughter is typically at the forefront of her mind, when she is not feeling suicidal. The following quotation from Lily reflects a similar process:

"I wasn't really thinking about anything else. I was just thinking about myself. And removing the agitation."
(Lily)

Suicidal Dissonance

The third superordinate theme characterises the 'dissonance' experienced by participants with respect to suicidality. There was a paradoxical quality to participants' accounts at times, reflecting: 1) inner conflict about attempting suicide, and 2) a fear of the consequences of their suicidal behaviour.

"It feels amazing but it feels awful at the same time": Inner conflict

All seven participants disclosed experience of inner conflict about their decisions to end their lives, although there were differences with respect to the degree of insight that individuals demonstrated about their inner struggles. The following quotation from Peter, illustrates a process of evaluating the positive and negative aspects of his life experiences and contemplating the precious and valued nature of life during a suicide attempt:

"You think of all the good things and all the bad things. It is going to sound very ironic saying this, but every time that I have attempted suicide, even in that moment while I am trying to end my life, I have still had that very powerful sense of the value of life. Do you know what I mean? It's weird. It's knowing how precious and wonderful and valuable life is, and knowing that this is the ultimate, worst thing you can do really. But I just feel, at those times, that I really don't have any other choice."
(Peter)

This quote illustrates an underlying ambivalence about suicide. Even in those moments, Peter was able to recognise the positive attributes of life more generally, and he directly contrasted this with a negative judgement of suicide, describing it as the 'ultimate, worst' thing. It is possible that Peter viewed it this way because of suicide's capacity to eliminate life; something Peter previously acknowledged as a 'precious' and 'valuable' experience. Wendy's account also reflected conflict about living and dying, as was evidenced by her behaviour during her suicide attempt. After taking an overdose, Wendy boarded a bus and went to the building where her local community health team were housed. Wendy stated that she was not consciously aware of her motivation for doing so at the time but, at interview, hesitantly acknowledged that there was a part of her that felt conflicted about dying:

> *"Do you know why you came here in the middle of that attempt?"*
> *(Researcher)*

> *"No. I don't. A wee bit of me that doesn't want to die maybe?"*
> *(Wendy)*

Use of the word, "wee" may suggest that the part of her that didn't want to die was overwhelmed by the part of her that sought resolution for her distress. This may also be reflective of an innate, unconscious process of self-preservation that can emerge during an acute suicidal crisis. Annie described the simultaneously conflicting, and seemingly irreconcilable, affective properties of her suicidality, as illustrated by the following quotation:

> *"It feels, it feels amazing and it feels awful at the same time. It feels utterly terrifying and utterly safe."*
> *(Annie)*

Annie uses the word, "utterly" for emphasis here, highlighting the polarising nature of these emotional experiences. It may be possible that suicidality can be experienced as all these things, at the same time, but that suicidal motivation increases based on how external and other factors influence the relative balance of these affective experiences.

"Fear of the unknown": Consequences

All seven participants acknowledged some fear about suicidality, but the focus and intensity of this fear varied across individual experiences. Humza described how he felt fearful of the 'unknown' and how this fear made him hesitate briefly during his attempt:

> *"I did hesitate slightly before I injected. Just, well, fear of the unknown and, 'This is really it.'"*
> *(Humza)*

This quotation reflects an acknowledgement of the finality of suicide, even in the midst of an acute suicidal crisis. In addition, there was a strong religious context to Humza's account and it may be that he was reflecting here on the prohibition of suicidality within Islam and the possibility of spiritual repercussions for his actions. Annie expressed this more directly, as illustrated by the following quotation:

> *"Every religion on this planet says it is not a good idea to kill yourself and when you see something like that repeated on a global, human scale you think, 'There is probably some truth in that.' So, yes. I am probably pretty terrified of not just death but committing suicide. I don't think it will end well."*
> *(Annie)*

It appeared that the collective religious perception of suicide as sinful is very persuasive to Annie and it is possible that it may, at times, influence the progression of her suicidal behaviour. Annie expressed fear, not only of how death itself might be experienced, but the potential punishment for suicide as sinful behaviour thereafter. It could be that she is contemplating which fate is worse: the pain of living or the perceived punishment for suicide. Rather than suicide providing a permanent solution to her distress, it may be that she thinks it may only provide temporary relief from pain in this life but is concerned that the punishment in afterlife may be worse.

Peter expressed fear about the possibility of enduring pain and suffering as the consequence of an unsuccessful suicide attempt:

> *"I did actually think to myself though, "What if it goes wrong? What if I don't die but I damage myself in some way?" And I thought, "What if it doesn't act quickly enough?" and "What if I have a period of days of pain and suffering before I die?"*
> *(Peter)*

He described this very clearly as a conscious process. His main concerns related to the potential for injuries as a consequence of his attempt; the immediacy of his death; and experience of pain. This is suggestive that he may need to feel assured of the efficiency and effectiveness of his chosen method in order to act on his suicidal thoughts.

DISCUSSION

This study examined the lived experience of suicidal behaviour by exploring how individuals who have made a suicide attempt describe and make sense of the suicidal process. Participants' accounts of their experiences were analysed using IPA and this process identified three superordinate themes: 1) Intentions, 2) The Suicidal Journey, and 3) Suicidal Dissonance. Key findings are now discussed with reference to the extant literature and the unique contributions of this study are highlighted. The methodological strengths and limitations of the research are then discussed, before the implications for clinical practice and future research.

Key Findings

This study has provided deep and rich insights into the suicidal process. These accounts were generated from individuals with direct experience of attempted suicide, and this research supports the view that providing context to individuals' experiences of suicidality and despair, and emphasising the subjective meanings of these experiences, can improve our understanding of this very complex human phenomena. While acknowledging this complexity, important patterns in individuals' experiences emerged and these patterns are now discussed further.

Intentions

Rather than expressing a clear desire to be dead, the findings highlight a range of motivations for suicidal behaviour. One primary motivation was to seek relief from psychological distress and stressful life circumstances. Individuals in this study described difficulty tolerating suffering in various forms including traumatic intrusions; agitation; depression; loneliness and rejection; and feelings of worthlessness and hopelessness. Shneidman (1985) conceptualised this intolerable suffering among suicidal individuals as, 'psychache,' suggesting that it may be a dominant stressor for suicidal behaviour. This study's findings are consistent with the extant literature which has documented similar motivations for suicide (e.g. Alder et al. 2016; Pavulans et al. 2012). These findings also lend empirical support to O'Connor's (2011) integrated motivational-volitional model of suicidal behaviour, which predicts that the inability to escape from defeating or stressful circumstances can provide the setting conditions for the emergence of suicidal motivation.

These findings may also be suggestive that a 'suicide-response' developed, among this group of individuals, as a learned coping strategy for their distress in the absence of more adaptive means of coping. Existing experimental research has demonstrated a consistent link between suicidal behaviour and deficits in problem solving and coping (see O'Connor and Nock 2014). The current findings may provide further context to this existing research;

however, further qualitative research with those who have attempted suicide, to explore the role of coping in greater detail, is warranted.

This study also identified an important communicative motive for suicide. Participants described experiences of feeling rejected, disconnected, stigmatised, misunderstood and disbelieved by others. The findings suggest that suicide attempts may emerge in response to motivations, conscious or otherwise, to communicate something to other people about this distress. In some cases, suicide appeared to provide a mechanism for validating distress to others; particularly in cases where they felt they had been dismissed or invalidated. Similarly, Orri et al. (2014) undertook qualitative research with Italian adolescents with a history of attempted suicide, and identified that each suicidal act was primarily an interpersonal act; finding that suicidal behaviour represents a means of establishing a connection between their distress and other individuals, through the suicidal act itself (p.4). Existing, qualitative research has consistently documented the significance of the interpersonal context of suicide, with particular emphasis on the role of conflict as a common trigger or precursor to attempts (e.g. Lakeman and Fitzgerald 2008). However, relatively few studies have further investigated the specific processes that may connect the individual and relational dimensions of suicidal behaviour (Orri et al. 2014), and these are worthy of exploration in further, qualitative studies of individuals experiences of attempted suicide.

The Suicidal Journey

Participants described significant adversity in their early lives and it is possible that these experiences may have given rise to particular vulnerabilities, including insecurity in their interpersonal relationships and difficulties with emotion regulation. Many studies have demonstrated a strong association between the occurrence of adverse life events in childhood and subsequent experience of suicidal behaviour (Dube et al. 2001; Bruffarets et al. 2010). The underlying processes that link these experiences are still being investigated; however, the integrated motivational-volitional model of suicidal behaviour (O'Connor 2011) identifies early adversity and diathesis as crucial pre-motivational and triggering factors in the progression of suicidal behaviour. The current study has illuminated similar processes in the accounts of individuals who have attempted suicide.

Participants' accounts of their attempts also evidenced a narrowing of their perspectives when they felt acutely suicidal. These findings are similar to those of Pavulans et al. (2012) who characterised the acute suicidal state of mind of some of their participants using the phrase 'tunnel vision' (p.6). The participants in this study also described suicide as being the only thought in their mind, leaving no possibility of concern for significant others. The authors highlighted the importance of training professionals to identify these characteristics

of the acutely suicidal mind; however, they do acknowledge the immense challenge of doing so. It is possible that further, qualitative research could explore these features in greater detail in order to identify precursors and external cues that may be more readily identifiable to other people.

Suicidal Dissonance

Participants' accounts described experience of inner conflict and fear in relation to their suicidal behaviour, and these experiences have been conceptualised as 'suicidal dissonance' in the current study. This may reflect an underlying ambivalence about suicide. Individuals described their experiences of simultaneous and polarising feelings about their suicidality, and although there is some, limited evidence of similar experiences within the existing qualitative literature research (e.g. Akiota et al. 2014; Vatne and Naden 2014), this has not emerged as a consistent theme.

With respect to fear, participants in Vatne and Naden's (2014) study described their attempted suicides as 'frightening' events and their accounts were characterised by feelings of panic. The experience of losing perspective in life, and becoming aware of their own courage to carry out an attempt also frightened them. The authors make reference to the struggle between this fear and the longing to escape something unbearable (Vatne and Naden 2014). Fearlessness of death has been identified in the literature as a factor that can increase the risk that a suicide attempt may be successful (Ribeiro and Joiner 2009). It is interesting to reflect on the fact that several of the participants in the current study identified fear as a component part of their suicidal experience, and consider how this may have mediated the outcomes of their attempts.

Methodological Strengths and Limitations

These findings are based on a small sample of individuals who agreed to be interviewed. The study represents the experiences of this particular group of individuals and the findings are therefore suggestive rather than conclusive with respect to their generalisability to other individuals with experience of attempted suicide. The individuals within the study were all very unique in their personalities, backgrounds and experiences, as evidenced by the complex and nuanced nature of the data. However, the relative homogeneity in the sample with respect to mental health diagnoses and method choice (typically overdose) may help to identify features of the experience of attempted suicide that are specific to individuals with these characteristics; but this requires further empirical examination in both similar and divergent samples.

The time that had passed since participants' most recent suicide attempts varied within the sample from four weeks to nine months. The criteria that individuals' most recent account had to have taken place within a year of the interview was applied in the interests of seeking a balance between psychological stability and preserving the integrity of their accounts; however, there remains the possibility that their accounts were subject to retrospective biases and that these recollections accommodated new experiences and insights.

The interpretative component of this research is viewed as a strength and important in relation to the original contribution of this study. The researcher and the research supervisors actively participated in constructing the aims and research questions; design of the study; and interpretation of the data. In addition, the data itself is a product of the interaction between the researcher and the participants, and alternative interpretations of the findings are plausible.

Importantly, this study represents an exploration of the experiences of those who have attempted suicide and survived. It is evidently not possible to undertake research with individuals who have completed suicide. It is possible that there are important differences between individuals with a long history of suicidality and multiple attempts, as was the case in the current study, and those who have died by suicide. Several studies have sought to get as close to this experience as possible by interviewing individuals who employed lethal means, including hanging and jumping from bridges (Biddle et al. 2010; Rosen 1975). Interestingly, additional research has shown that survivors of medically serious suicide attempts and those who die by suicide are epidemiologically similar (Daniel and Fleming 2005).

Implications for Clinical Practice

There is evidence within the literature that health professionals can assume suicidal motives including attention-seeking, particularly among individuals with long histories of attempted suicide (Pavulans et al. 2012). This study, together with the collective findings from the extant literature, suggests that individuals who attempt suicide experience motivation differently and often seek validation of their distress or relief from their own suffering. It would be helpful to provide specific education and training for health professionals who work with individuals at risk of suicide that encourages a greater, and non-judgemental, exploration and understanding of the motivational contexts for suicidal behaviour.

In addition, these findings are also suggestive that specific therapeutic interventions, including emotion regulation and problem solving strategies, could be utilised to promote a sense of control among individuals who experience ongoing suicidality. It is also imperative

to ensure that adequate psychiatric and psychological treatment of specific mental health symptoms, including trauma and agitation.

The study identified no evidence that talking about the detail of suicide attempts can increase vulnerability or suicidality. Contrastingly, several participants stated that they really valued the opportunity to discuss their experiences in depth, as they had not otherwise had the opportunity to do so. Interestingly, they also commented on how their suicide attempts had, in fact, appeared to shut down the already limited opportunities that they had to discuss their distress with family members and friends in particular. This is at odds with view that suicide attempts can be 'care-eliciting' (Bennett et al. 2003) and highlights the need to promote relationships that are permissive of emotional and suicidal expression.

Future Research

The preceding discussion has highlighted important areas for future research. In summary, further qualitative research may be capable of 1) investigating and contextualising the role of coping in attempted suicide, specifically in relation to emotional distress and significant life stressors, 2) examining validation of distress as a communicative motive in suicide, and 3) exploring and unpacking the concept of 'suicidal dissonance,' including experience of polarising thoughts and feelings towards suicide, and fear of suicide and death.

In particular, it would be helpful to investigate experience of suicidal dissonance among samples with different characteristics (including individuals with less chronic suicidal histories or more lethal method choices, for example) and to investigate how this dissonance may mediate the outcomes of suicidal behaviour. Finally, this research has explored the suicidal experiences of individuals who were already engaged with mental health services. Further research with non-clinical samples would help identify any commonalities or differences in their experiences.

Conclusions

This study explored how individuals with lived experience of attempted suicide made sense of their experiences. Participants' accounts were dominated by experience of significant adversity and psychological suffering, and they commonly felt marginalised and stigmatised by other people. Participants reflected on their often long-term and ongoing battles with suicidality and provided rich and insightful accounts of their personal experiences, highlighting the inherent value of undertaking research with individuals with lived experience of suicidal behaviour.

Given the nuanced, individual and highly complex nature of suicidality, it is not possible to arrive at a definitive account of attempted suicide. However, important patterns in individuals' experiences were identified by the study in relation to 1) suicidal motives, 2)

transitioning from suicidal thinking to making an attempt, and 3) the dissonance that characterised suicidal behaviour. Further empirical investigation of these themes, and their component features is indicated in order to directly inform suicide intervention efforts.

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APPENDIX 2: QUALITY RATING FRAMEWORK (WALSH & DOWNE 2006)

	Essential Criteria	*Prompts*
Scope & Purpose	1. Clear statement of and rationale for research question/ aims/ purpose	Clarity of focus demonstrated Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing Link between research and existing knowledge demonstrated
	2. Study thoroughly contextualised by existing literature	Evidence of systematic approach to literature review, location of literature to contextualise findings, or both
Design	3. Method/design apparent & consistent with research intent	Rationale given for use of qualitative design Discussion of epistemological/ontological grounding Rationale explored for specific qualitative method (e.g. grounded theory, phenomenology) Discussion of why particular method chosen is most appropriate/ sensitive/relevant for research question/ aims Setting appropriate
	4. Data collection strategy apparent & appropriate	Were data collection methods appropriate for the type of data required and for specific qualitative method? Were they likely to capture the complexity/ diversity of experience and illuminate context in sufficient detail? Was triangulation of data sources used if appropriate?
Sampling Strategy	5. Sample & sampling method appropriate	Selection criteria detailed, and description of how sampling was undertaken Justification for sampling strategy given Thickness of description likely to be achieved from sampling Any disparity between planned and actual sample explained
Analysis	6. Analytic approach appropriate	Approach made explicit (e.g. thematic distillation, constant comparison method, grounded theory) Was it appropriate for the qualitative method chosen? Was data managed by software package or by hand and why? Discussion of how coding systems/frameworks evolved How was context of data retained during analysis? Evidence that the subjective meanings of participants were portrayed Evidence of more than one researcher involved in stages if appropriate to epistemological/ theoretical stance Did research participants have any involvement in analysis (e.g. member checking)? Evidence provided that data reached saturation or discussion/rationale if it was not Evidence that deviant data was sought, or discussion/ rationale if it was not

Interpretation	7. Context described and taken account of in interpretation	Description of social/physical and interpersonal contexts of data collection Evidence that researcher spent time 'dwelling with the data.' Interrogating it for competing/ alternate explanations of phenomena
	8. Clear audit trail given	Sufficient discussion of research processes such that others can follow 'decision trail'
	9. Data used to support interpretation	Extensive use of field notes, entries/verbatim interview quotes in discussion of findings Clear exposition of how interpretation led to conclusions
Reflexivity	10. Researcher reflexivity demonstrated	Discussion of relationship between researcher and participants during fieldwork Demonstration of researcher's influence on stages of the research process Evidence of self-awareness/ insight Documentation of effects of the research on researcher Evidence of how problems/ complications met were dealt with
Ethical Dimensions	11. Demonstration of sensitivity to ethical concerns	Ethical committee approval granted Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants Evidence of fair dealing with all research participants Recoding of dilemmas met and how resolved in relation to ethical issues Documentation of how autonomy, consent, confidentiality, anonymity were managed
Relevance & Transferability	12. Relevance and transferability evident	Sufficient evidence for typicality specificity to be assessed Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies Discussion of how explanatory propositions/ emergent theory may fit other contexts Limitations/ weaknesses of study clearly outlined Clearly resonates with other knowledge and experience Results/ conclusions obviously supported by the evidence Interpretation plausible and 'makes sense' Provides new insights and increases understanding Significance for current policy and practice outlined Assessment of value/ empowerment for participants Outlines further directions for investigations Comment on whether aims/purposes of research were achieved
	Total Score:	

Scoring Procedure: The prompts provided by Walsh & Downe (2006) were considered for each study in order to allocate a score. Studies were allocated scores 0, 1, 2 or 3 to indicate: 'not met,' 'partially met,' 'mostly met,' or 'fully met' respectively for each of the criteria. To categorise the quality of papers overall, it was determined that those obtaining a total score of <18 would be considered poor; scores of 19-27 acceptable; and of 28-36 'Good.' (Craig 2015).

APPENDIX 3: QUALITY RATING SCORES BY STUDY

Essential Criteria	Adler et al. (2016)	Akiota et al. (2014)	Bennett et al. (2003)	Biddle et al. (2010, 2011)	Biong & Ravndal (2009)	Crocker et al. (2006)	Gair & Camilleri (2003)	Ghio et al. (2011)
Clear statement of research and rationale for research question/aim/purposes	3	3	3	3	3	3	3	3
Study thoroughly contextualised by existing literature	2	1	2	2	2	2	1	2
Method/design apparent and consistent with research intent	2	2	3	3	3	3	1	3
Data collection strategy apparent and appropriate	2	3	3	3	3	3	2	3
Sample and sampling method appropriate	2	1	3	3	3	3	1	2
Analytic approach appropriate	2	2	2	2	2	2	1	2
Context described and taken account of in interpretation	3	3	3	3	2	3	1	1
Clear audit trail given	2	1	2	3	3	2	1	1
Data used to support interpretation	3	2	3	3	3	3	1	3
Researcher reflexivity demonstrated	1	2	1	1	2	2	1	2
Demonstration of sensitivity to ethical concerns	1	2	2	2	3	2	1	3
Relevance and transferability evident	2	2	2	2	2	2	2	2
Total scores	25	24	29	30	31	30	16	27
Quality classification	Acceptable	Acceptable	Good	Good	Good	Good	Poor	Good

Essential Criteria	Keyvanara & Haghshenas (2010)	Mandal & Zalewska (2012)	Orri et al. (2014)	Pavulans et al. (2012)	Rivlin et al. (2013)	Rosen (1975)	Talseth et al. (2003)	Vatne & Naden (2014)	Zayas et al. (2010)
Clear statement of research and rationale for research question/aim/purposes	1	3	3	3	3	2	3	3	3
Study thoroughly contextualised by existing literature	1	2	2	2	2	1	2	2	2
Method/design apparent and consistent with research intent	2	2	3	2	3	1	3	3	2
Data collection strategy apparent and appropriate	2	2	2	3	3	2	3	2	3
Sample and sampling method appropriate	2	1	3	2	2	2	1	2	3
Analytic approach appropriate	2	0	3	2	2	1	2	2	2
Context described and taken account of in interpretation	3	1	2	3	3	1	3	2	3
Clear audit trail given	1	1	2	3	3	0	3	2	2
Data used to support interpretation	2	1	3	3	3	1	3	3	3
Researcher reflexivity demonstrated	1	0	2	2	1	0	2	1	1
Demonstration of sensitivity to ethical concerns	2	0	2	3	1	1	1	1	2
Relevance and transferability evident	2	1	2	2	3	2	2	2	3
Total scores	21	14	29	30	29	12	28	25	29
Quality classification	Acceptable	Poor	Good	Good	Good	Poor	Good	Acceptable	Good

Total Score = 28-36 = Good, 19-27 = Acceptable, <18 = Poor

APPENDIX 4: NARRATIVE SUMMARY OF QUALITY APPRAISAL OF THE EVIDENCE

All but two studies (Keyvanara and Haghshenas 2010; Rosen 1975) provided a clear statement of the research and its aims. The majority of studies contextualised their research in relation to the existing literature (n=13), although none stated whether they had conducted a systematic review of the literature.

The method and research designs were less apparent and not fully consistent with the research aims in two studies (Gair and Camilleri 2003; Rosen 1975). All studies specified why they had adopted a qualitative approach, although only two discussed the epistemological grounding of their chosen methodology (Biong and Ravndal 2009; Talseth et al. 2003). The data collection strategies were apparent in all studies, appeared appropriate for their aims, and capable of capturing the complexity and diversity of individuals' experiences. Four studies did not provide a sufficient account of the sampling process and their sampling criteria (Akiota et al. 2014; Gair and Camilleri 2003; Mandel and Zalewask 2012; Talseth et al. 2003). None of the studies specified what their planned sample was and if this was met.

The studies varied in how much information they provided about their analytic approach; two studies failed to provide even a brief description of how the coding systems or conceptual frameworks evolved (Gair and Camilleri 2003; Rosen 1975). None of the studies had participants' involvement in checking themes, and only one study overtly sought deviant data (Biddle et al. 2010, 2012). Three studies were more descriptive in their approach and limited in their use of verbatim extracts (Gair and Camilleri 2003; Mandal and Zalewska 2012; Rosen 1975). The majority of studies conveyed clearly how their interpretations had led to their conclusions with two exceptions (Gair and Camilleri 2003; Rosen 1975). Evidence of researcher reflexivity was a relative weakness for all included studies, and none of the studies discussed the impact that the research had on the researcher. The studies described gaining consent from participants (with the exception of Rosen 1975) although very few discussed how they managed specific ethical dilemmas. The findings were discussed in the context of existing theories and research, and all of the studies considered implications for practice and/or future research. Five studies did not acknowledge the limitations of their research (Akiota et al. 2014; Gair and Camilleri 2003; Ghio et al. 2011; Rosen et al. 1975). In all cases, the results and conclusions were supported by the evidence and the interpretations appeared plausible.

APPENDIX 5: NHS ETHICS APPROVAL

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Professor Rory O'Connor
Institute of Health & Wellbeing
College of Medical, Veterinary and Life Sciences
University of Glasgow
Mental Health & Wellbeing Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

West of Scotland REC 5
Ground Floor - Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT

Date 21 August 2015

Direct line 0141 211 2102
E-mail WoSREC5@ggc.scot.nhs.uk

Dear Professor O'Connor

Study title: **An Interpretative Phenomenological Analysis of the Lived Experience of Suicidal Behaviour**
REC reference: **15/WS/0167**
Protocol number: **N/A**
IRAS project ID: **181381**

The Research Ethics Committee reviewed the above application at the meeting held on 19 August 2015. Thank you for attending to discuss the application with Miss McDermott.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Sharon Macgregor, WoSREC5@ggc.scot.nhs.uk. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Conditions of the favourable opinion

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

1. In the Participant Information Sheet, a paragraph should be added to the end of the "What does taking part involve?" section stating the following: **"With your written consent, we would like to write to your GP to tell them that you are taking part in this study and provide them with a copy of this information sheet."**

2. A statement should also be added to the Consent form that states: **"I agree to my General Practitioner being informed of my participation in the study."**

3. It is suggested that participants are reminded about disclosure, as stated in the Information Sheet, just prior to the interview commencing. Participants should also be reminded that they do not have to answer any questions if they choose not to.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

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

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

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

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

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

NHS Sites

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

Summary of discussion at the meeting (for information only)

Ethical issues raised by the Committee in private discussion, together with responses given by the researcher when invited into the meeting

Favourable risk benefit ratio; anticipated benefit/risks for research participants (present and future)

It was noted in A26 that the researcher will carry out the interviews alone. However, the Committee was reassured that appropriate safety measures were in place.

Miss McDermott confirmed that this is what she does normally and that panic alarms will be in place.

The Participant Information Sheet advises the participant about disclosure and the possible consequences of this. However, it is also suggested that, prior to the interview commencing, the interviewer reminds participants of this statement again. Also, they should be reminded that they do not have to answer any questions they do not want to.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Committee asked what details will be in the final report as they were concerned that it may include reports of other attempted suicides that might give people ideas for future attempts. Also, the report may be upsetting to relive such events.

Dr O'Connor advised that they do not see a problem with this and that many patients find reading the results cathartic. The report will contain no more detail of suicide attempts that what can be found online.

The confidentiality arrangements for the study were satisfactory. It was noted that participants will be given a pseudonym but it was not clear how this will be done and whether the participant will know they have been given a pseudonym.

Miss McDermott advised that the pseudonym will be agreed with the participant. All other identifiable details about them or other people will be removed from the interview transcripts. However, the pseudonym will be used in the final reports and therefore people will be able to identify themselves, which some people also find helpful. The investigators advised that they could use a different identifier (ie "Person A", "Person B") if the Committee preferred.

The Committee advised that they would not insist on this change and would leave it to the applicants to decide what type of identifier they will use.

Informed consent process and the adequacy and completeness of participant information

It was noted that non-English speakers will not be included but that this had been justified.

A49-1 of the application states that participants' GPs will be informed that they are taking part. However, this is not stated in the Participant Information Sheet or Consent form.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		30 July 2014

15/WS/0167	Please quote this number on all correspondence

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

Yours sincerely

for
Canon Matt McManus
Vice-Chair

Enclosures:	List of names and professions of members who were present at the meeting and those who submitted written comments
	"After ethical review – guidance for researchers"
Copy to:	Ms Emma Jane Gault, University of Glasgow Ms Lorraine Reid, NHS Greater Glasgow & Clyde

West of Scotland REC 5

Attendance at Committee meeting on 19 August 2015

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Stewart Campbell	Consultant Physician & Gastroenterologist (CHAIR)	No	
Dr Roddy Chapman	Consultant Anaesthetist	Yes	
Dr James Curran	GP	Yes	
Dr Gillian Harold	Consultant Radiologist	No	
Mrs Naomi Hickey	Research Nurse	Yes	
Dr Gillian Kerr	Consultant Physician	Yes	
Dr Ahmed Khan	Consultant Psychiatrist	Yes	
Professor Eddie McKenzie	Statistician	Yes	
Canon Matt McManus	Parish Priest (Vice-Chair)	Yes	**In the Chair**
Ms Janis Munro	Key Account Manager	Yes	
Mrs June Russell	Retired (Research Chemist)	Yes	
Mr Charles Sargent	Retired	Yes	
Dr Marcel Strauss	Consultant Radiologist	Yes	
Mrs Liz Tregonning	Retired (Special Needs Teacher) (Alternate Vice-Chair)	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Dr Judith Godden	Scientific Officer/Manager
Mrs Sharon Macgregor	Co-ordinator

APPENDIX 6: NHS R&D APPROVAL

NHS
Greater Glasgow and Clyde

Senior Administrator: Mrs Lorraine Reid
Telephone Number: 0141 211 1743
E-Mail: lorraine.Reid2@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

R&D Management Office
Western Infirmary
Tennent Institute
1st Floor 38 Church Street
Glasgow, G11 6NT,

28 August 2015

Professor Rory O'Connor
Chair in Health Psychology
Institute of Health & Wellbeing
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

NHS GG&C Board Approval

Dear Professor O'Connor

Study Title: An Interpretative Phenomenological Analysis of the Lived Experience of Suicidal Behaviour
Chief Investigator: Professor Rory O'Connor
GG&C HB Site: Riverside Resource Centre
Sponsor: NHS GG&C Health Board
R&D reference: GN15CP298
REC reference: 15/WS/0167
Protocol no: V5 dated July 2015

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

   a. During the life span of the study GGHB requires the following information relating to this site
      i. Notification of any potential serious breaches.
      ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
   a. Recruitment Numbers on a monthly basis
   b. Any change of staff named on the original SSI form
   c. Any amendments – Substantial or Non Substantial
   d. Notification of Trial/study end including final recruitment figures

e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.
I wish you every success with this research study

Yours sincerely

L. Reid

Mrs Lorraine Reid
Senior Research Administrator

CC: **Miss Laura McDermott, Student, Glasgow**
Dr Adele Dickson, Academic Supervisor2, Edinburgh Napier University, Edinburgh
Dr Deborah McQuaid, Academic Supervisor3, Riverside Resource Centre, Glasgow
Ms Emma Jane Gault, Sponsor Contact, Glasgow

APPENDIX 7: PARTICIPANT INFORMATION SHEET

Researcher Contact Information:

Laura McDermott, Trainee Clinical Psychologist
Institute of Mental Health & Wellbeing, University of Glasgow
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Email: l.mcdermott.1@research.gla.ac.uk

PARTICIPANT INFORMATION SHEET

An explorative study of the experience of being suicidal

We would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish and please ask if there is anything that is not clear or if you would like more information.

Who is conducting the research?

The research is being carried out by Laura McDermott, Trainee Clinical Psychologist, from the University of Glasgow. It is being supervised by Professor Rory O'Connor from the University of Glasgow, Dr Adele Dickson from Napier University, and Dr Deborah McQuaid from Riverside Resource Centre.

What is the purpose of the study?

The study is being carried out as part of the requirements of the Doctorate in Clinical Psychology training course at the University of Glasgow. The purpose of the study is to try to better understand the experience of feeling suicidal. The study will involve speaking to people who have attempted suicide in the past, to talk to them about their experiences, including the things that led them to feel suicidal, any thoughts and/or feelings they had

about suicide at the time, and how they feel now about those experiences. Talking to people about their experiences of being suicidal and attempting suicide can help us to better understand what it may be like to feel suicidal and can be used to help people who may be at risk of suicide.

Why have I been invited?

We are looking for people who are currently patients of Riverside Community Mental Health Team and/or the North West Glasgow Crisis Service who have attempted suicide within the past year. We believe that you may fit this criteria and that is why we have invited you to take part.

What does taking part involve?

If you are interested in taking part, you can tell the clinician who told you about the study and they will pass your contact details to Laura McDermott, the lead researcher. Laura will then telephone you to tell you more about the study, answer any questions you have, and make an appointment for you to take part in an interview. The interviews will take place at Riverside Resource Centre and will last around 1 hour. This will feel like an informal discussion with the researcher about your experiences of being suicidal. You do not have to answer any questions that you don't want to and you can have breaks during the interview if you wish. If you disclose anything during the interview that causes the researcher concern, such as reason to believe you may harm yourself or others, the researcher will have a duty to report this but will try to discuss this with you before doing so. You will be reimbursed for your travel expenses to attend Riverside Resource Centre for the interview.

The interview will be audio recorded so that the researchers can listen back to the discussion and identify the key points that you made. Some quotes from your interview may be included in the research paper, however all information will be anonymised.

With your written consent, we would like to write to your GP to tell them that you are taking part in this study and provide them with a copy of this information sheet.

Do I have to take part?

No. It is up to you to decide if you want to take part in the study or not. If you agree to take part, you will be asked to sign a consent form at the time of the interview to show that you have agreed to take part in the study. You are free to withdraw from the study at any time until the research is written up, without giving a reason. Withdrawing from the study would not affect the standard of care you receive or your future treatment in any way.

What happens to the information?

Your identity and personal information will be completely confidential and known to the researchers. Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may also look at your personal information and records to make sure that the study is being conducted correctly. The information that is obtained will be held in accordance with the Data Protection Act, which means that we keep it safely and cannot reveal it to other people, without your permission. The interview that you take part in will be audio recorded to allow the researchers to listen to it later and identify the key points that you made. The recordings will be destroyed at the end of the study. The results of this study may be published in academic journals, conference proceedings and as a piece of work for a doctoral qualification in Clinical Psychology. Some direct quotes from your interview may be included in these reports/publications, however all information will be anonymised and it will not be possible to personally identify you from this information.

What are the possible benefits of taking part?

It is hoped that you may benefit from having the opportunity to talk about your experiences. You will also contribute to research in this area which may help people who are at risk of suicide. If, for any reason, you experience distress during or after the interview, we will ensure that you are able to access appropriate sources of support, where these are required.

Who has reviewed the study?

The study has been reviewed by the West of Scotland Research Ethics Committee and the NHS Greater Glasgow and Clyde Research & Development Department.

If you have any further questions?

We will give you a copy of the information sheet and signed consent form to keep. If you would like more information and would like to speak to someone who is not closely involved in the study, then you can contact:

Dr Sue Turnball (Research Tutor)

Institute of Health & Wellbeing, University of Glasgow
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Email: sue.turnball@gla.ac.uk

Tel: 0141 211 3920

Researcher(s) Contact Details:

Laura McDermott, Trainee Clinical Psychologist

Institute of Mental Health & Wellbeing, University of Glasgow
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Email: l.mcdermott.1@research.gla.ac.uk

Professor Rory O'Connor

Institute of Mental Health & Wellbeing
Administration Building, 1st Floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Email: rory.oconnor@glasgow.ac.uk

Tel: 0141 211 3920

What if you have a complaint about any aspect of the study?

If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance but the normal NHS complaint mechanism is also available to you.

Thank you for taking the time to read this information sheet.

APPENDIX 8: INTERVIEW SCHEDULE

Interview schedule for an interpretive phenomenological analysis of the lived experience of suicidal behaviour

I understand that some time ago you tried to end your life. I wonder if you could begin by telling me about the events that led up to this and what you remember about how you felt at that time? If you have tried to end your life more than once, please tell me about the most recent time.

Do you know why you were thinking about suicide?

What do you remember about thoughts that you were having about ending your life? Can you describe those thoughts to me?

How did thinking about suicide affect you? How did it make you feel? In what ways (if at all) were those thoughts helpful/ beneficial/ a relief for you at that time? In what ways (if at all) did the feelings you had about having suicidal thoughts change over time?

What do you remember about how the suicidal thoughts escalated or changed in the run up to your attempt? Why do you think the suicidal thoughts escalated or changed at that time?

Can you tell me about how/why you came to act on the suicidal thoughts? Can you talk me through that process? Was there anything that triggered a change from just thinking about suicide to actually taking steps to end your life?

Can you tell me about the method that you chose? Why do you think you chose to end your life that way? What other options did you consider and why did you eliminate these? What was important to you in making that decision?

What (if anything) might have changed your mind either about a) attempting to end your life or b) the methods to do so?

Can you describe what you remember about the attempt itself? Did your thoughts and feelings change at all during the course of the attempt? If so, how did they change?

How did you feel when you realised that you were still alive?

**In those who have attempted suicide more than once, explore prior attempts.* How did these previous attempts differ, if at all, from the most recent attempt? In what ways were the experiences similar and/or different from the most recent time? Were the triggers the same or different? Was the choice of method similar or different? Was the process of choosing to end your life similar or different?

Can you tell me how you feel about your experiences of trying to end your life now?

In the aftermath of the attempt(s), what kinds of things helped you most? What sources of support did you find useful? What helps you to stay well now?

Is there anything that you would like to add before we finish the interview?

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Greater Glasgow and Clyde

CONSENT FORM

Title of Project: An Exploratory Study of the Experience of Being Suicidal

Name of researcher: Laura McDermott

Patient Identification Number for this Study:

	Please Initial Box
I confirm that I have read and understand the participant information sheet (version 2, 2nd July 2015) for the above study.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without given any reason.	
I consent to the interview being audio-recorded.	
I give permission for my information to be looked at by the research team and regulatory authorities, where it is relevant to my taking part in the research.	
I agree to my General Practitioner being informed of my participation in the study.	
I understand that my information will be kept strictly confidential and that my identity will not be revealed in any reports, publications or presentations.	
I agree to take part in this study.	

Name of Participant:	
Date:	
Signature:	

Name of Person taking consent:	
Date:	
Signature:	

Thank you for agreeing to take part in this research

APPENDIX 9: SUICIDE RISK SCREENING PROTOCOL

RISK FACTORS FOR SUICIDE:

**Researcher to complete known sections in advance of the interview*

Male gender (females more attempts, males more completions)

Ethnicity (white attempt & complete more than others)

Age ≥16 years?

Current psychiatric disorder?

Current mood disorder (e.g. major depressive disorder, bipolar disorder)

Current substance use disorder (e.g. alcohol, recreational or prescription drugs)

Current psychotic disorder (e.g. bipolar disorder, schizophrenia)

Current personality disorder (esp. borderline or anti-social personality disorder)

Suicide history?

Previous suicide attempt(s) (Y/N)

Family history of suicide attempts/completions (Y/N)

Current suicidal ideation (0-10 scale)

Current plan (Y/N)

Access to lethal means (e.g. firearm, medication)? (Y/N)

Current intent (On scale 0 – 10 [0 = no intent, 10 = strong intent], what is your current intent to kill yourself? ___)

Other risk factors?

Depressed mood (On scale 0 – 10 [0 = neg, 10 = pos] how would you rate your current mood? ___)

Recent loss, separation/divorce/break-up?

Impulsiveness?

Hopelessness about the future?

Current distress, irritability, agitation or other atypical mental state?

NOTES:

PROTECTIVE FACTORS AND SAFETY PLAN:

In treatment? If so, is allocated clinician aware of risk? _____

Family/roommate/friends aware of risk? _____

Presence of children in the home, spouse/partner, or other positive relationships?

[IF YES TO ACCESS] Means restriction (firearms, drugs, family/social support/ monitoring)? _____

Steps taken to increase participant safety (check all that apply):

LOW RISK == No past attempt or current suicidal ideation, plan or intent:

Validated participant's feelings

Encourage participant to contact allocated clinician if distressed or in need of help in future

Provide contact information for sources of support as required

MODERATE RISK == Previous attempt(s), but intent ≤6:

(Check all completed above)

Participant supported to articulate own safety plan (i.e., what to do if thoughts/urges increase)

Provide participant with emergency contact numbers (999, duty nurse at Riverside Resource Centre, Samaritans and Breathing Space)

HIGH RISK == Current SI present and intent 7-8, but no plan or access to lethal means:

(Check all completed above)

Discuss with participant. Encourage them to contact support(s) and allocated clinician(s). If unwilling, researcher to directly contact allocated clinician or duty nurse at Riverside directly for advice/support.

IMMINENT RISK == Current suicidal intent 7-8 with specific plan/access to means or 9-10 regardless of plan:

(Check all completed above)

Discuss with participant. Researcher to directly contact allocated clinician or duty nurse at Riverside to refer participant immediately for further assessment/advice/support.

Call & directly inform Dr Deborah McQuaid and Professor Rory O'Connor.

NOTES:

Assessor: _____ Date: _____

APPENDIX 11: SUICIDAL INJURIOUS THOUGHTS AND BEHAVIOURS INTERVIEW

SITBI-Short Form

These questions ask about your thoughts and feelings of suicide and self-injurious behaviors. Please listen carefully and respond as accurately as you can. Do you have questions before we begin?

Suicidal Ideation

1) Have you ever had thoughts of killing yourself? 1)_____
   0) no 1) yes

2) How old were you the first time you had thoughts of killing yourself? (*age)* 2)_____

3) How old were you the last time? (*age)* 3)_____

4) During how many separate times in your life have you had thoughts of killing yourself? (Please give your best estimate.) 4)_____

5) How many separate times in the past year? 5)_____

6) How many separate times in the past month? 6)_____

7) How many separate times in the past week? 7)_____

8) When was the last time? 8)_____

Hand respondent 0-4 rating scale
Here is a scale we will use for a number of the upcoming questions.

9) On this scale of 0 to 4, at the worst point how intense were your thoughts of killing yourself? 9)_____

10) On average, how intense were these thoughts? 10)_____

11) When you've had a thought, what method did you think of using? 11)_____

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

12) When you have thoughts of killing yourself, how long do they usually last? 12)_____

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

13) On the scale of 0 to 4, what is the likelihood that you will have thoughts of killing yourself in the future? 13)_____

Nock et al. (2007). *Psychological Assessment.*

Suicide Plan

14) Have you ever actually made a plan to kill yourself? 14)_____
0) no 1) yes

We will refer to this as a suicide plan.

15) How old were you the first time you made such a plan? *(age)* 15)_____

16) How old were you the last time? *(age)* 16)_____

17) During how many separate times in your life have you made a plan? 17)_____

18) How many separate times in the past year? 18)_____

19) How many separate times in the past month? 19)_____

20) How many separate times in the past week? 20)_____

21) On the scale of 0 to 4, at the worst point, how seriously did you consider acting on the plan? 21)_____

22) On average, how seriously have you considered acting on them? 22)_____

23) When you've had a plan, what method did you think of using? 23)_____

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

24) When you've had a plan, how long have you thought about it before either moving onto something else or acting on the plan? 24)_____

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

25) On the scale of 0 to 4, what do you think the likelihood is that you will make a plan to kill yourself in the future? 25)_____

Nock et al. (2007). *Psychological Assessment.*

Suicide Gesture

Say slowly - make sure they understand exactly what you are saying

26) Have you ever done something to lead someone to believe that you wanted to kill yourself when you really had no intention of doing so? 26)_____
0) no 1) yes

Only score if there was NO suicidal intent, and they wanted someone else to BELIEVE they wanted to make a suicide attempt

We will refer to this as a suicide gesture.

27) How old were you the first time you made a suicide gesture? (*age)* 27)_____

28) How old were you the last time? (*age)* 28)_____

29) During how many separate times in your life have you made a suicide gesture? 29)_____

30) How many have you made in the past year? 30)_____

31) How many have you made in the past month? 31)_____

32) How many have you made in the past week? 32)_____

33) What have you done? 33)_____

---

34) When you've made a suicide gesture, for how long have you thought about it before doing it? 34)_____
0) 0 seconds
1) 1-60 seconds
2) 2-15 minutes
3) 16-60 minutes
4) less than one day
5) 1-2 days
6) more than 2 days
7) wide range (spans > 2 responses)
88) not applicable
99) unknown

35) On the scale of 0 to 4, what do you think the likelihood is that you will make a suicide gesture in the future? 35)_____

Nock et al. (2007). *Psychological Assessment.*

Suicide Attempt

36) Have you ever made an actual attempt to kill yourself in which you had at least some intent to die? 36)_____
0) no 1) yes

We will refer to this as a suicide attempt.

37) How old were you the first time you made a suicide attempt? *(age)* 37)_____

38) When was the **most recent** attempt? 38)___/___/_____

39) How many days was that from today? *39)*_____
88) not applicable
99) time unknown

40) How many suicide attempts have you made in your lifetime? 40)_____

41) How many have you made in the past year? 41)_____

42) How many have you made in the past month? 42)_____

43) How many have you made in the past week? 43)_____

44) What method did you use for your most recent attempt? 44)_____

1) own prescription drugs	7) hanging	13) drowning
2) illicit drugs (not rx)	8) sharp object	14) suffocation
3) over-counter drugs	9) auto exhaust	15) other's rx drugs
4) poison	10) other gases	16) other ____
5) firearms	11) train/ car	17) multiple methods _____
6) immolation	12) jump from height	88) not applicable
		99) unknown

45) What were the circumstances that contributed most to your most recent attempt?
Put in order of importance.

1) job loss/ job stress/ academic failure	8) psychiatric symptoms	45a)_____
2) dispute with family or friends	9) humiliating event	
3) dispute with spouse/lover	10) other: _____	45b)_____
4) financial problems	11) refuses to answer	
5) eviction	88) not applicable	45c)_____
6) health problems	99) unknown	
7) death of another person		

46) What kind of injuries did you have as a result of this attempt? 46)_____

Regarding the **most lethal** attempt:

47) When did it occur? 47)___/___/_____

Nock et al. (2007). *Psychological Assessment.*

48) What kind of injuries did you have as a result of this attempt? 48)_____

49) How long have you usually thought about suicide before making an attempt? 49)_____

0) 0 seconds	5) 1-2 days
1) 1-60 seconds	6) more than 2 days
2) 2-15 minutes	7) wide range (spans > 2 responses)
3) 16-60 minutes	88) not applicable
4) less than one day	99) unknown

50) On the scale of 0 to 4, what do you think the likelihood is that you will make a suicide attempt in the future? 50)_____

Thoughts of Non-Suicidal Self-Injury

51) Have you ever had thoughts of purposely hurting yourself without wanting to die? (for example, cutting or burning) 51)_____
0) no 1) yes

We will refer to this as non-suicidal self-injury.

52) How old were you the first time you thought about engaging in NSSI? *(age)* 52)_____

53) How old were you the last time? *(age)* 53)_____

54) During how many separate times in your life have you thought about engaging in NSSI? 54)_____

55) How many separate times in the past year? 55)_____

56) How many separate times in the past month? 56)_____

57) How many separate times in the past week? 57)_____

58) On the scale of 0 to 4, at the worst point, how intense were your thoughts about engaging in NSSI? 58)_____

59) On average, how intense were these thoughts? 59)_____

60) When you have had these thoughts, how long have they usually lasted? 60)_____
0) 0 seconds 5) 1-2 days
1) 1-60 seconds 6) more than 2 days
2) 2-15 minutes 7) wide range (spans > 2 responses)
3) 16-60 minutes 88) not applicable
4) less than one day 99) unknown

61) On the scale of 0 to 4, what do you think the likelihood is that you will have thoughts about engaging in NSSI in the future? 61)_____

Nock et al. (2007). *Psychological Assessment.*

Non-Suicidal Self-Injury

62) Have you ever actually engaged in NSSI? 62)_____
0) no 1) yes

63) How old were you the first time? (*age)* 63)_____

64) How old were you the last time? (*age)* 64)_____

65) How many times in your life have you engaged in NSSI? 65)_____

66) How many times in the past year? 66)_____

67) How many times in the past month? 67)_____

68) How many times in the past week? 68)_____

69) Now I'm going to go through a list of things that people have done to harm themselves. Please let me know which of these you've done: 69a)_____
1) cut or carved skin
2) hit yourself on purpose 69b)_____
3) pulled your hair out
4) gave yourself a tattoo 69c)_____
5) picked at a wound
6) burned your skin (i.e., with a cigarette, match or other hot object) 69d)_____
7) inserted objects under your nails or skin
8) bit yourself (e.g., your mouth or lip) 69e)_____
9) picked areas of your body to the point of drawing blood
10) scraped your skin
11) "erased" your skin to the point of drawing blood
12) other (specify):_____
88) not applicable
99) unknown

70) Have you ever received medical treatment for harm caused by NSSI? 70)_____
0) no 88) not applicable
1) yes 99) unknown

71) On average, for how long have you thought about NSSI before engaging in it? 71)_____
0) 0 seconds 5) 1-2 days
1) 1-60 seconds 6) more than 2 days
2) 2-15 minutes 7) wide range (spans > 2 responses)
3) 16-60 minutes 88) not applicable
4) less than one day 99) unknown

72) On the scale of 0 to 4, what do you think the likelihood is that you will engage in NSSI in the future? 72)_____

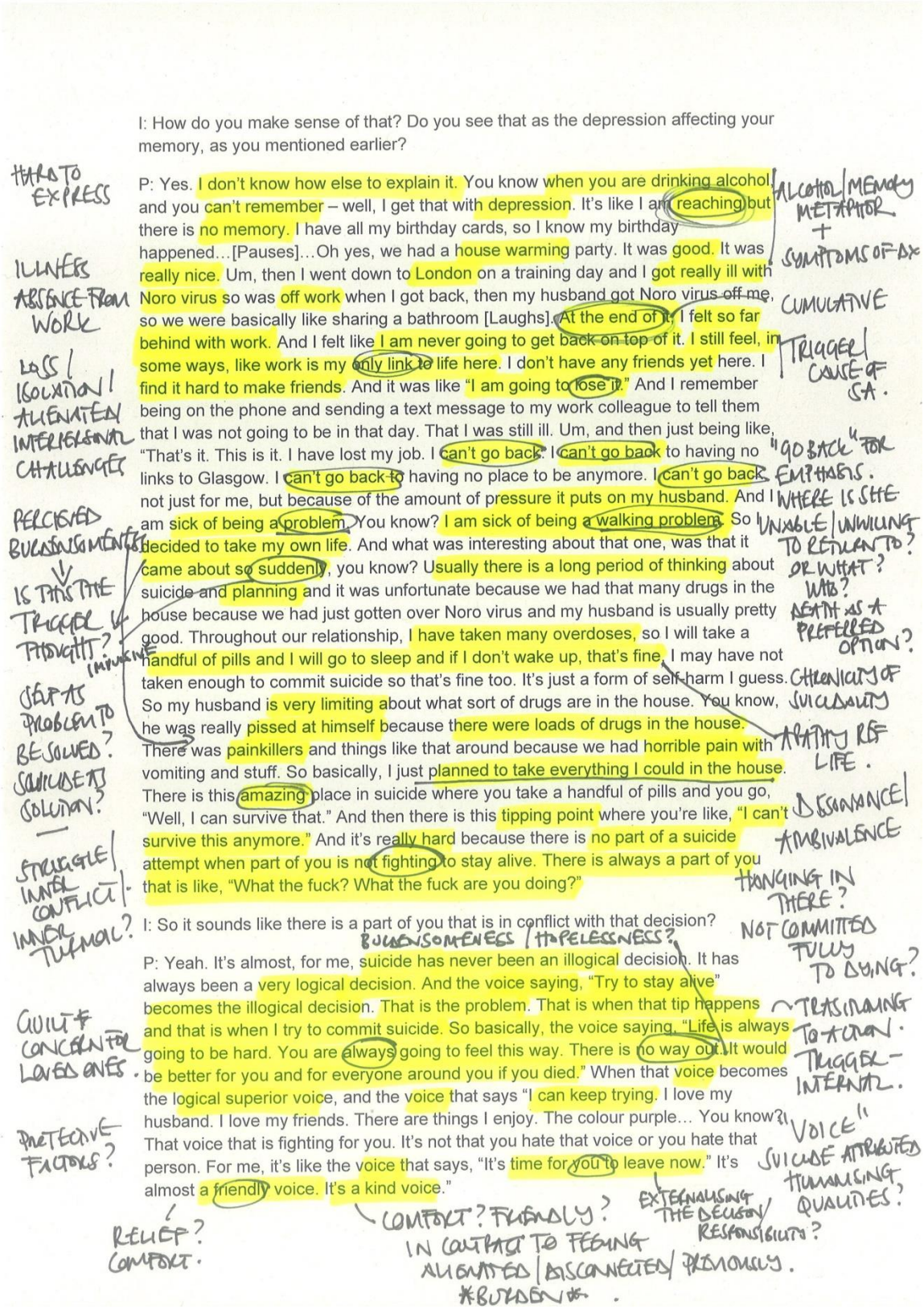
Nock et al. (2007). *Psychological Assessment.*

0	1	2	3	4
Low/little				*Very much/ Severe*

Suggested citation for this measure:

Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). The Self-Injurious Thoughts and Behaviors Interview: Development, reliability, and validity in an adolescent sample. *Psychological Assessment, 19*, 309-317.

APPENDIX 12: SAMPLE OF ANALYSED TRANSCRIPT



I: How do you make sense of that? Do you see that as the depression affecting your memory, as you mentioned earlier?

P: Yes. I don't know how else to explain it. You know when you are drinking alcohol and you can't remember – well, I get that with depression. It's like I am reaching but there is no memory. I have all my birthday cards, so I know my birthday happened…[Pauses]…Oh yes, we had a house warming party. It was good. It was really nice. Um, then I went down to London on a training day and I got really ill with Noro virus so was off work when I got back, then my husband got Noro virus off me, so we were basically like sharing a bathroom [Laughs]. At the end of it, I felt so far behind with work. And I felt like I am never going to get back on top of it. I still feel, in some ways, like work is my only link to life here. I don't have any friends yet here. I find it hard to make friends. And it was like "I am going to lose it." And I remember being on the phone and sending a text message to my work colleague to tell them that I was not going to be in that day. That I was still ill. Um, and then just being like, "That's it. This is it. I have lost my job. I can't go back. I can't go back to having no links to Glasgow. I can't go back to having no place to be anymore. I can't go back, not just for me, but because of the amount of pressure it puts on my husband. And I am sick of being a problem. You know? I am sick of being a walking problem. So I decided to take my own life. And what was interesting about that one, was that it came about so suddenly, you know? Usually there is a long period of thinking about suicide and planning and it was unfortunate because we had that many drugs in the house because we had just gotten over Noro virus and my husband is usually pretty good. Throughout our relationship, I have taken many overdoses, so I will take a handful of pills and I will go to sleep and if I don't wake up, that's fine. I may have not taken enough to commit suicide so that's fine too. It's just a form of self-harm I guess. So my husband is very limiting about what sort of drugs are in the house. You know, he was really pissed at himself because there were loads of drugs in the house. There was painkillers and things like that around because we had horrible pain with vomiting and stuff. So basically, I just planned to take everything I could in the house. There is this amazing place in suicide where you take a handful of pills and you go, "Well, I can survive that." And then there is this tipping point where you're like, "I can't survive this anymore." And it's really hard because there is no part of a suicide attempt when part of you is not fighting to stay alive. There is always a part of you that is like, "What the fuck? What the fuck are you doing?"

I: So it sounds like there is a part of you that is in conflict with that decision?

P: Yeah. It's almost, for me, suicide has never been an illogical decision. It has always been a very logical decision. And the voice saying, "Try to stay alive" becomes the illogical decision. That is the problem. That is when that tip happens and that is when I try to commit suicide. So basically, the voice saying, "Life is always going to be hard. You are always going to feel this way. There is no way out. It would be better for you and for everyone around you if you died." When that voice becomes the logical superior voice, and the voice that says "I can keep trying. I love my husband. I love my friends. There are things I enjoy. The colour purple… You know? That voice that is fighting for you. It's not that you hate that voice or you hate that person. For me, it's like the voice that says, "It's time for you to leave now." It's almost a friendly voice. It's a kind voice."

I: I wonder, how does the experience of having those thoughts and hearing that voice then make you feel?

P: It's an agonising mix of feelings. If there was a painless way to commit suicide, I would be dead. I know I would be. Many times over. It is very hard to commit suicide. Like, with what we have in this country. Basically, you need benzos. But benzos are incredibly restricted because they are so easy to commit suicide with. Um, I spend most of my life making sure that there is no easy way to commit suicide around me.

I: So, when you're not feeling suicidal you're actively trying to protect yourself from when you do?

P: Yup. Yup. It's always, it's always a niggle. I catch the subway every day and you have no idea how often I stand there and just feel that wind of the train coming towards me and just go, "That could be it. Whooosh.Over.Done." It feels, it feels amazing and it feels awful at the same time. It feels utterly terrifying and utterly safe. It feels like giving in. You know, like….[Pauses]… life is hard. And life is hard for everyone. There is relativity in experience. The hardest thing that has happened to me is the hardest thing that has happened to you. You know, it's all relative. You can't point to someone and say, "You've had a less traumatic life," because the worst they have felt, is the worst you have felt. And life is hard for everyone. And I think that is why so many people commit suicide. Because suicide is, it's sometimes the only option, the only power you have left in your life. Because life takes everything away from you. Your self worth. Your achievements. Your community. Your friends. Your family. How you feel about yourself. Because when it is all gone, you will have a decision left and that is whether or not to live. And people say, "How can we stop people from committing suicide?" But they shouldn't be. They should be saying, "How can we make life easier for everyone. Because that is the only way that changes. You see it across the board. Because when life gets harder at times of depression, and at times of austerity, suicide rates go up. At times when population levels are too high, when there is a lot of illness, suicide rates go up. It is a human being's prerogative to decide whether to stick around for the next chapter. And I often think that we fight for the rights of people who are physically disabled to take their lives, when they enter a terminal state, but what is so different about mental health if I wake up every day in agony? What is so different about that? The drugs help, they really do, but they also take away a lot as well. You know, like I've sung and I've acted and I've painted and I've written my whole life and I once I am depressed, it all stops.

I: It stifles that part of you?

P: It stifles your soul. Everything that you could think of that is connected to your soul. Making love isn't as fun. Weirdly, I am not as ticklish when I am on SSRIs. I don't enjoy music as much. I don't enjoy food as much.

APPENDIX 13: SAMPLE SUBTHEME & EXEMPLARS

Superordinate Themes	Subthemes	Exemplars	Representation
Suicidal Dissonance	Conflict	Wendy: I: Do you know why you came here in the middle of that attempt? P: No. I don't. A wee bit of me that doesn't want to die maybe? Wendy: Well, at first, it kind of gave me a wake-up call. There was somewhere in the back of my head thinking I don't want to die. Humza: I did hesitate slightly before I injected. Just, well, fear of the unknown and, 'This is really it.' Lily: I drank a bottle of wine and then another bottle of wine, and then I tanked all the Lithium that I had in the house. I started to fall asleep and then I panicked. And then I contacted a friend on Whatsapp. I told her I had taken an overdose. Lily: I: And how did you feel about dying at that point? Did you not want to die? P: Yes, I suppose so. I think I just realised what I had done by taking it all. And because of, well, everybody else. Like my family. Annie: There is this amazing place in suicide where you take a handful of pills and you go, "Well, I can survive that." And then there is this tipping point where you're like, "I can't survive this anymore." And it's really hard because there is no part of a suicide attempt when part of you is not fighting to stay alive. There is always a part of you that is like, "What the fuck? What the fuck are you doing?" Annie: The voice saying, "Life is always going to be hard. You are always going to feel this way. There is no way out. It would be better for you and for everyone around you if you died." When that voice becomes the logical superior voice, and the voice that says "I can keep trying. I love my husband. I love my friends. There are things I enjoy. The colour purple… You know? That voice that is fighting for you. Annie: I catch the subway every day and you have no idea how often I stand there and just feel that wind of the train coming towards me and just go, "That could be it. Whooosh. Over. Done."	Wendy Humza Lily Annie Peter Andy

		Annie: It feels, it feels amazing and it feels awful at the same time. It feels utterly terrifying and utterly safe. Annie: Have you ever resigned from a job in writing, and you have sent the letter? And when you resign from a job there is always part of you that is like, “Oh this is scary.” But when you post the letter is gone and you feel a sense of, “Oh my God, I have done it.” but also relief, “Thank God, I have done it.” Suicide feels a bit like that. Peter: Someone might take an overdose of paracetamol tablets and immediately think, “Oh God, what have I done?” and call an ambulance but at the time thought that was going to work. Just because they panicked and got help doesn’t mean that wasn’t serious. Peter: What if this goes badly? What if this is a really horrible and unpleasant way to die? So then I just thought, “No. I won’t do that.” Peter: Every time I have felt suicidal and during my suicide attempts, deep down I have wanted to live but not the life I was living. The feeling is always that I don’t want my life to end but I can’t live like this. It’s that feeling that maybe I don’t want to die but I cannot live like this and you get to the point where it’s really whichever feeling becomes more powerful. And even at the point where you commit to die, I think there is still a thought that, “I wish it didn’t have to be like this. I wish my life could turn around and be the life that I want it to be, and I could be happy living that life.” Peter: You think of all the good things and all the bad things. It is going to sound very ironic saying this, but every time that I have attempted suicide, even in that moment while I am trying to end my life, I have still had that very powerful sense of the value of life. Do you know what I mean? It’s weird. It’s knowing how precious and wonderful and valuable life is, and knowing that this is the ultimate, worst thing you can do really. But I just feel, at those times, that I really don’t have any other choice. Peter: There is a little part of me that says, “Well, hold on. If you just get some professional help and treatment, see the GP, see the psychiatrist…” there is another part of me that says, “Well, you know, I have done that before and I have never felt particularly better.”	

		Peter: There is no easy way of saying this, but when I have been going through a suicide attempt and I am 100% committed to it, there is still a feeling of sadness. You know what I mean? Even in those final moments, or what you believe will be your final moments, there is still a feeling of sadness and wishing that it didn't have to be like this. Peter: It is important to point out that I have never gone ahead with it with a feeling of, "Oh, that's great. I am happy that I am going to die." It's a reluctance. Reluctantly you feel you are doing it. Because you can't do anything else. There is still a sadness hanging over you. But you tell yourself, "It will be over soon. It will be over soon. And there will be peace." And that's what gets you through it. Peter: If you let those feelings of 'this is sad' and 'life is precious' get to you, then I am still left with depression. It's still a struggle. And you think, "No. I have struggled with feeling this unhappy for so long. It has been so intense and unrelenting and nothing has really made a difference. What is the point of stopping now? You might feel better for a few days or weeks but then you will go back to it and try again anyway." You know that from experience. That you will have a reprieve for a little while but it will come back. Knowing there will be a relief soon if you die, that is what keeps you going. Very soon, there will be relief. Andy: Right now, I don't want to do it again. But, at some point, I probably will do it again and that is the scary part. I don't mean I am frightened by it. I just mean it is a scary thing in general terms. Andy: Hence that every day feels like a fight. Because sometimes there is the no. There is the fight. And things feel a wee bit better that day. But then it will go back to the yes. It's constant.	

APPENDIX 14: RESEARCH PROPOSAL

Major Research Project Proposal
An Interpretative Phenomenological Analysis of the Lived Experience of Suicidal Behaviour

Trainee/Principal Researcher: Laura McDermott

Matriculation Number: 0808585M

University Supervisor: Professor Rory O'Connor

Field Supervisors: Dr Deborah McQuaid & Dr Adele Dickson

Date of Submission: 16th March 2015

Version: 5

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ABSTRACT

Background:

The existing literature on suicide is vast and growing exponentially (Lakeman & Fitzgerald 2008). However, much of it is dominated by research that has employed quantitative methods in efforts to explain suicidal phenomena. Relatively few studies have harnessed qualitative methods capable of addressing the complexity of both suicidal phenomena and human experience (Hjelmeland & Knizek 2011).

Aims:

The proposed study will seek to address this gap by using interpretative phenomenological analysis (IPA) to explore the lived experience of suicidal behaviour among 8-10 individuals recruited from community mental health services in Glasgow.

Plan of Investigation:

Individual interviews will be used to explore issues that are meaningful for participants but may include experience of the transition from suicidal ideation to action, the process of choosing a suicide method, and recovery from attempted suicide.

Practical Applications:

This research will address the relative paucity of qualitative research on suicidal behaviour and provide rich insights capable of complementing existing explanatory frameworks of suicidal phenomena. It will also help to inform efforts to help those at risk of suicide.

1.0 INTRODUCTION

1.1 Suicide Prevention

Globally, every year, over 800,000 people are estimated to complete suicide (World Health Organization 2014). In Scotland, suicide prevention is a major public health challenge, with two people, on average, dying every day due to suicide. The Scottish Government has made suicide prevention a national priority and its Choose Life strategy has sought to reduce suicide rates by 20%. Reports suggest that suicide rates fell by 19% between 2011 and 2013 in Scotland, highlighting the potential value of suicide prevention interventions (Choose Life 2015).

1.2 Suicidological Research

Any efforts to prevent suicide are aided by research, and the existing literature on suicide is vast and growing exponentially (Lakeman & Fitzgerald 2008). However, it is dominated by quantitative research that has largely focused on providing explanatory accounts of suicidal phenomena (Hjelmeland & Knizek 2011) including, for example, factors pertinent to the aetiology of attempted and completed suicide (Crocker et al. 2006). The use of qualitative methods to explore the meaning and experience of suicidal behaviour is relatively embryonic. In recognition of the potential value of subjective accounts of suicidal experiences, Hjelmeland & Knizek (2010, 2011) have called for further research that makes use of qualitative methods in order to help us better understand suicidal phenomena. Indeed, they have argued that "…extending the use of qualitative methodology are essential to the advancement of the discipline of suicidology" (2011, p.591). There is great potential for qualitative accounts of the process and experience of suicidal behaviour to complement and advance existing explanatory accounts, helping us move towards a more holistic understanding of suicidal behaviour.

A recent systematic review summarised the small body of research that has utilised qualitative methods to explore the experiences of suicidal individuals (Lakeman & Fitzgerald 2008). The review identified 12 studies published between 1997 and 2007 that addressed how people live with or recover from the experience of being suicidal. Four of the studies were undertaken in the UK, four in Canada and the remaining four studies in New Zealand, Sweden, Norway and the United States. Three studies were undertaken with young people (Bennett et al. 2002, Bostik & Everall 2007, Paulson & Everall 2003), three with older adults (Bennett 2005, Crocker et al. 2006, Moore 1997), one with First Nation women in British Columbia (Paproski 1997) and another with men recently diagnosed with HIV (Siegel & Meyer 1999). Sample sizes ranged from two to 59 participants and involved a range of recruitment methods including presentation to an Accident and Emergency department

following an attempt, the use of advertisements, and recruitment through mental health services.

The studies identified by the review focused on different aspects of suicidality and associated experience. Several studies explored pathways or processes towards recovery following a suicide attempt (Bennett et al. 2002, Cutcliffe et al. 2006), while others looked at factors helpful in recovery (Bostik & Everall 2007, Paulson & Everall 2003, Eagles et al. 2003). One study explored experiences of psychiatric care following a suicide attempt (Samuelsson et al. 2000), while others focused on how suicidality was experienced within specific contexts or populations including older people (Bennett 2005, Moore 1997), gay and bisexual men with a recent HIV diagnosis (Siegel & Meyer 1999), and First Nation British Columbian women (Paproski 1997).

The studies made use of a range of qualitative designs including grounded theory and thematic analysis; however several adopted a phenomenological approach to the study of suicidality given its capacity to develop rich and detailed idiographic accounts of the lived experience of complex human phenomena. For example, Crocker et al. (2006) used interpretative phenomenology to capture the subjective experience of 15 older adults aged between 65 and 91 who had recently made a suicide attempt. The study specifically sought to explore individuals' understanding of the 'pathway' to and from their attempt within the context of aging. This included an exploration of how suicidal thoughts evolved over time; how possible risk factors contributed to the decision to make a suicide attempt; and individuals' thoughts, feelings and experiences in the aftermath of the attempt. The study identified key themes including struggle, control, and visibility, and reflected on how these experiences were exacerbated by aging. Brooke & Horne (2010) also used interpretative phenomenological analysis to explore the meaning of self-injury and overdosing among a sample of four women with borderline personality disorder. The researchers were interested in exploring the experiences of individuals who engage in 'behaviours perceived as complex, manipulative or attention-seeking' and also sought to better understand the relationship between self-injury and overdose within this context. The study identified the context of distress and ambivalence about death as important phenomenological themes.

The wider qualitative literature on suicide has explored a range of themes including the experiences of individuals bereaved by suicide (e.g. Begley & Quayle 2007), provided accounts from clinicians who have worked with suicidal individuals (e.g. Reeves & Mintz 2006), and explored experience of mental health services in relation to suicidal ideation and behaviour (e.g. Wiklander et al. 2003). These studies have utilised IPA as well as other qualitative methods.

1.3 Rationale for Proposed Study

In summary, much of the current literature focuses on *explanations* of suicidal behaviour by drawing upon quantitative methods. Although there are promising, emergent lines of enquiry based on qualitative methods, there remains a need for further research capable of helping us to better *understand* the nature and process of attempted suicide (Hjelmeland & Knizek 2010, 2011). The proposed study seeks to address this gap directly, using IPA in order to generate rich and detailed idiographic accounts of suicidal behaviour among individuals who have directly experienced it. Interpretative phenomenological analysis lends itself particularly well to this task given its inductive approach, capacity to ask questions about the lived experience of complex human phenomena, and framework for exploring how individuals make sense of major life experiences (Smith 1996). IPA will be used in the proposed study to explore, in detail, the processes through which individuals make sense of their experiences of suicidal behaviour. The study will be capable of supplementing existing models of suicidal behaviour, derived through largely quantitative methods, by exploring the processes, meaning and context of suicidal experiences, thus leading to a more holistic understanding of these phenomena.

2.0 AIMS

The overarching aim of the proposed research is to explore the lived experience of suicidal behaviour among individuals with a history of attempted suicide. The researcher will be guided by participants in terms of specific themes, however it is likely that the study will include exploration of various aspects of suicidal phenomena, including the transition from thinking about suicide to acting on those thoughts; the process of choosing a suicidal method and the factors influencing this decision; and the experience of recovering from attempted suicide.

3.0 PLAN OF INVESTIGATION

3.1 Participants

Participants will be recruited from Community Mental Health Services within Glasgow (see Section 3.3). The study will include adults aged 18 years and over with a history of attempted suicide. Socio-demographic information will be recorded for all participants, including gender, age, post-code (as an indicator of socio-economic status) and current psychiatric diagnosis. A brief suicidal history (e.g. number of attempts, time since last attempt) will be obtained for each participant using questions from the Self-Injurious Thoughts & Behaviors Interview (SITBI) (Nock et al. 2007).

3.2 Inclusion & Exclusion Criteria

Individuals with a history of attempted suicide will be eligible for participation. Potential participants must have made at least one suicide attempt within the previous 12 month period (at the time of recruitment), where 'suicide attempt' is defined as a non-fatal, self-directed self-harming episode associated with evidence of suicidal intent (O'Connor et al. 2013). This will be ascertained through discussions with referring clinicians. At the outset of each interview, participants will be asked to clarify their suicidal history.

The study will seek to be as inclusive as possible, however there will be a few specific exclusion criteria including individuals who:

- Are not competent in English.
- Are imminently suicidal (i.e. stating that they intend to kill themselves within the next few hours).
- Are experiencing a psychotic episode at the time of recruitment.
- Have a learning disability or cognitive impairment.

3.3 Recruitment Procedures

Participants will be recruited from Riverside Community Mental Health Team (CMHT) and the North West Glasgow Crisis Service. Both are based within NHS Greater Glasgow & Clyde Health Board. The CMHT provides community focused psychiatric care for adults that present with a range of mental health difficulties including affective disorders, eating disorders, and psychotic illness. Individuals are referred to the service through a range of pathways including primary care and social work. The Crisis Service provides short-term intensive community-based care for individuals going through a period of crisis who are at risk of being admitted to inpatient psychiatric services. This service also provides support and facilitation to enable early discharge from hospital.

Prior to recruitment, the research team will provide a formal presentation to staff about the study, its eligibility criteria and procedures for recruitment. Clinical staff will be invited to review their existing caseloads in order to identify patients that meet the eligibility criteria. They will be asked to approach these patients and provide them with information about the study. The research team will prepare a participant information sheet for this purpose. Clinicians will be briefed to inform prospective participants that involvement in the study is both confidential and voluntary, and that non-participation will not impact their treatment or future involvement with the service in any way. They will also be advised that they are able to withdraw from the research at any time without explanation or consequence.

Individuals who express an interest in participating will be asked to provide verbal consent for the clinician to pass their contact information to the principal researcher. They will then be contacted directly by telephone by the principal researcher to arrange an appointment for interview at their convenience. Recruitment will continue until the required number of participants has been met or the research team agrees that a saturation of themes has been achieved. The study's Field Supervisor, Dr Deborah McQuaid (Clinical Psychologist) is based at Riverside CMHT and will provide ongoing consultation throughout the recruitment process.

3.4 Interview/Measures

Semi-structured interviews will be conducted on an individual basis by the principal researcher and are expected to last approximately one hour (see section 3.6 for further details). The interviews will be analysed using IPA and will be structured according to the interview schedule in Appendix 1. The interview schedule was developed through consultation with the existing literature and discussions among the research team. The schedule will not be followed strictly but will instead be used to guide a process of reflection whereby participants will prioritise events/experiences that they deem to be central to their attempted suicide. The schedule will be piloted on a small subset of the sample (n=2/3) to provide the principal researcher with an opportunity to practice the interview techniques and evaluate the appropriateness of proposed questions.

3.5 Design

The study will use a retrospective qualitative design with semi-structured in-depth interviews, analysed using IPA.

3.6 Research Procedures

At the outset of each interview, the researcher will provide a brief introduction to the study, outlining the nature of the interview and again providing or reading the information sheet to participants. Written consent will be obtained and participants will be reminded that their participation is voluntary and confidential and that they are free to withdraw at any time. Confidentiality will be explained, including limits regarding risk to self or others. Participants will be given a pseudonym and will be referred to by this pseudonym for the duration of the interview and during analysis to protect their identity. The potentially sensitive nature of the research topic will be acknowledged and participants will be advised that they do not have to answer any questions they do not wish to. They will also be told that they can take a break during the interview if necessary. At this stage, participants will be offered an opportunity to ask any further questions.

At the start and end of each interview, a formal assessment of suicidal risk will be made by the researcher using the standardised risk screening tool that is extensively used by the Suicidal Research Behaviour Laboratory (see Appendix 2). Participants identified as at imminent risk of suicide at any stage during interview will be referred immediately to their allocated clinician within the CMHT or Crisis Service. If the clinician is unavailable, participants will be referred directly by telephone to the duty nurse on-site at Riverside for assessment and/or support. Participants will be briefed about this possibility at the start of every interview.

The interviews will be audio recorded, with the permission of the participants.

3.7 Data Analysis

Data will be analysed by the principal researcher and using interpretative phenomenological analysis, following procedures as detailed by Smith et al. (2009, p.82-107). In brief, each interview recording will be transcribed verbatim by the principal researcher. This will be followed by a period of reading and re-reading transcripts to ensure the researcher is familiar with participants' narratives. Following this, the researcher will make initial notes, including questions, descriptive comments or observations (e.g. key words, phrases or explanations) which will be used to develop master themes. Any commonalities or differences across participants' narratives will contribute to the development and revision of major themes. A sample of transcripts will be independently analysed by a second researcher and reliability checked by a comparison of the identified themes.

3.8 Justification of Sample Size

IPA research is typically based on small sample sizes of between one and ten participants (Starks & Trinidad 2007). The proposed study will seek a sample size of between 8 and 10 participants (including pilot interviews), depending on response rates and saturation of themes. The proposed sample size for the current study was determined through consultation with existing qualitative research on suicide and guidelines provided by Smith et al. in relation to appropriate sample sizes for a study of this nature (2009, p.51).

3.9 Settings & Equipment

The interviews will be conducted within private clinic rooms at Riverside Resource Centre. Each interview will be audio recorded using a digital recorder and the recordings will be stored on an encrypted laptop provided by the University of Glasgow. Recordings will be transferred to the laptop immediately following interview. Each recording will be transcribed verbatim by the principal researcher using equipment provided by the University of Glasgow. All identifiable information will be removed to preserve the anonymity of participants. Recordings and transcripts will be treated in accordance with the

Data Protection Act (1998) and the NHS Confidentiality Code of Practice on Protecting Patient Confidentiality (2002).

4.0 HEALTH & SAFETY ISSUES

4.1 Researcher Safety Issues

The safety of the researcher and participants will be ensured by conducting the interviews during working hours at Riverside Resource Centre. All interviews will comply with local standard safety procedures. The researcher will have access to a panic alarm and it will be possible to access clinical staff on-site if required. It is possible that the experience of data collection and analysis may confer an emotional load on the principal researcher, who will meet regularly with the study's supervisors to debrief any pertinent issues. Appropriate supervision and support will be sought where required.

4.2 Participant Safety Issues

It is possible that some individuals may become upset when asked questions about their wellbeing or previous suicidal/self-harming behaviour. The voluntary nature of participation will be emphasised during the recruitment process so that participation will extend only to individuals who choose to be involved. However, participants will be reminded that they can withdraw their participation at any stage. They will also be assured that they do not have to answer any questions they are unwilling to and that they can take a break from interview if necessary.

Studies that have explored the potential benefits and risks of participation in suicide and self-harm research have demonstrated that involvement is more likely to derive benefit for individuals than cause harm. For example, Biddle et al. (2013) reviewed interview data from 63 individuals who had participated in research into suicide and self-harm and found that the majority of participants reported an improvement in their well-being subsequent to participation. Many described the 'cathartic' value of talking about their experiences. A much smaller proportion of participants reported lowering of mood subsequent to their participation but, importantly, they anticipated that this would be transient and was outweighed by their desire to be involved in the research and contribute to our understanding of suicide. Similarly, in a large randomised controlled study with over 2000 participants, Gould et al. (2005) found no evidence of iatrogenic effects of suicide screening, reporting that asking individuals about suicide did not increase suicidal ideation or distress.

In the unlikely event that a participant does become distressed, they will be encouraged to discuss any issues with their allocated clinician. A duty nurse will available on-site while the interviews are taking place should immediate assessment/support be required. Following

each interview, participants will be provided with a list of contacts for further support, including details of the duty and out-of-hours services associated with Riverside Resource Centre, Breathing Space, Samaritans and the local Accident and Emergency department at the Western Infirmary.

As noted in Section 3.6, a risk screening tool will be used at the start and end of every interview to ascertain risk of suicide specifically. Should any participant disclose information suggesting that they may be at imminent risk, this will be discussed directly with them and they will be referred immediately to the on-site duty nurse for further assessment and support. This possibility will be made clear to each participant when the limits of confidentiality are explained.

5.0 ETHICAL ISSUES

5.1 Ethical Approval

The proposed study already has the consent and support of Mr Stephen Campbell, the Service Lead for both Riverside CMHT and the North West Glasgow Crisis Service. Given that the research will involve access to a clinical sample, ethics approval will be sought from the NHS Ethics Committee and local Research & Development department.

Efforts will be made to ensure that participants have a comprehensive understanding of the study's aims and what is required of them. This will be achieved by briefing them at the point of recruitment and again at the start of each interview, and through the provision of a Participant Information Sheet. As noted previously, the voluntary and confidential nature of their involvement will be made explicit and they will be assured they can withdraw their participation at any time. They will also be assured that their data will be anonymised and will remain confidential in accordance with the Data Protection Act (1998), Freedom of Information Act (2000), and the NHS Confidentiality Code of Practice on Protecting Patient Confidentiality (2002). Participants will not be personally identified in any report or publication which results from the study. A summary of results will be made available to participants who would like feedback about the research upon completion of data collection and analysis.

5.2 The Research Team

The research team has significant experience in the proposed topic area. The principal researcher is experienced in qualitative research and has volunteered for the Samaritans in a voluntary capacity for four years. She is skilled in sensitively exploring issues relating to wellbeing and suicide. Between 2013 and 2014 she undertook a year-long placement at Riverside CMHT as part of her training as a clinical psychologist. Through this experience,

she developed good working relationships with staff based within the service and is familiar with local protocols regarding risk and confidentiality.

Professor Rory O'Connor, the study's academic supervisor, has over 20 years' experience and considerable expertise in suicidal, clinical and health research. He is President of the International Academy for Suicide Research, UK National Representative of the International Association for Suicide Prevention and a member of the American Association of Suicidology. He also leads the Suicidal Behaviour Research Laboratory at the University of Glasgow, the leading suicide and self-harm research group in Scotland. Professor O'Connor's experience of undertaking research on suicide and self-harm has suggested that participants do not find participation to be a burden but instead report their participation to be of interest, and that they value the opportunity to learn about and contribute to this area of research.

The study will also benefit from the expertise of Dr Deborah McQuaid, a Clinical Psychologist with many years' experience of working clinically with individuals at risk of suicide or self-harm, and Dr Adele Dickson, a leading international expert in interpretative phenomenological analysis. Linda Campsie, Consultant Clinical Psychologist and the lead Psychologist at Riverside Resource Centre, will also provide additional advice and expertise, particularly in relation to issues of sampling and recruitment.

6.0 FINANCIAL ISSUES

Equipment costs will amount to one digital recorder and transcribing kit (to be borrowed from the University of Glasgow) and photocopying costs. Travel expenses for participants will be paid from Professor O'Connor's research funds account.

7.0 TIMETABLE

The proposed timetable for the research is summarised in the table overleaf.

March 2015	Submit final proposal to University for approval
May 2015	Apply for ethical approval
August 2015	Commence recruitment & data collection
November 2015	Data analysis
March 2016	Submit draft MRP to supervisors
May/June 2016	Submit research to University
September 2016	Viva Voce

8.0 PRACTICAL APPLICATIONS

The research will seek to improve knowledge of suicidal ideation and behaviour, including the factors that influence individuals towards acting upon suicidal thoughts. This research is important in terms of assisting clinicians to better understand and help those at risk of suicide. It will also supplement existing explanatory accounts of suicidal behaviour and highlight potential areas for future research.

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