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Re-Vitalizing Worthiness: A Theory of Transcending Suicidality Among Young Men

A thesis presented to Dublin City University for the Degree of Doctor in Philosophy

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Degree of Doctor in Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: ______________________ **Date: 30th October 2009**

Student ID No: 56122527

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Last but by no means least I would like to extend my thanks to my family and friends for their support and patience as I continually put my PhD work ahead of family and social life. In particular, I appreciate gestures of calm encouragement from Maeve and Agnes in times of stress.

Operational Definitions

Suicide-ality

Suicidality is a term used to incorporate a range of thoughts and behaviours that form a continuum from the absence of suicidal ideation through to completed suicide (Maris et al., 2000). Suicide is a term generally used to refer to completed suicide. The term suicide will be used to denote completed suicide, and the term suicidality to denote other aspects of this continuum, regardless of intent. The hyphenated term suicide-ality will be used to refer to both completed suicide and other dimensions of suicidality.

Survivor

The term survivor is usually used to refer to those bereaved by suicide. However, it has been argued that this term could be applied to the person who survives a suicide attempt. In this text the term will be used to refer to both groups but the particular status of the person will be identified as necessary for clarification purposes.

ED

ED is an acronym for Emergency Department, formerly known as Accident and Emergency Departments (A&E) located within General Hospitals in Ireland and is similar to the Emergency Room (ER) and Casualty Department (CD) in other countries.

Therapeutic Responses

While the term care frequently refers to nursing interventions, treatment to medical interventions, and therapy to counselling / psychotherapy interventions, these terms will be used interchangeably in this text, as the vast majority of issues discussed in this thesis relate to all mental health disciplines and responses. Similarly, the terms therapeutic response and therapeutic engagement will be used to refer to all forms of therapeutic contact between clients and health professionals. However, when referring to a specific study the terminology used in this text will be consistent with that used in that study.

Patient / Client

While the term patient is frequently used in public medical and psychiatric parlance and client in private health care settings these terms are also used interchangeably in the literature. In this text the terms will be used interchangeably, unless referring to a study that uses a specific term. All participants in this study were involved with the public services, while some also availed of private health services.

Re-vitalizing

Re-vitalizing refers to the process whereby the young men brought life to a part of their being that had hitherto been dormant.

Worthiness

Worthiness is an umbrella term referring to the young men's sense of being worthy as individuals and being worthy of life.

Turning Point

A turning point refers to a life event, positive or negative, that significantly changes a person and his life (Strauss, 1969).

Dialogue

Dialogue refers to an intrapersonal and / or interpersonal communicative exchange that brings about a transformation in one's thinking and acting (Seikkula et al., 1995).

Text Organization

Designations

The male noun will be used throughout this text to refer to the client / patient and the female noun will be used to refer to the practitioner, unless referring to a particular document where these genders are reversed. The main text will be written in the third person.

Referencing

Some of the references used in this thesis are quite dated as the author chose, where possible, to reference those associated with the origins of particular ideas in addition to those who have advanced such ideas.

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Re-Vitalizing Worthiness: A Theory of Transcending Suicidality Among Young Men

Abstract

Suicide-ality poses social, political and health concerns worldwide due to the significant psychological and social burden incurred (Maltsberger & Goldblatt, 1996; Hawton, 2005). In Ireland, rates for completed suicide are notably high among young men aged 15-34 years, who accounted for almost 40% of deaths by suicide in 2003 (NOSP, 2005). While a range of response initiatives have been developed, aimed at addressing suicide-ality at preventive, interventive and post-ventive levels, there has not been a corresponding decrease in prevalence rates of youth suicide in many countries, including Ireland (NOSP, 2009).

The field of suicidology has expanded in recent years, giving rise to substantial theoretical, practice and policy literature. Research in the field has been helpful in: identifying rates and trends in suicide-ality in general and among specific groups, identifying risk and protective factors, and designing and evaluating response strategies. It has been argued that research has been dominated by quantitative methodology and has primarily concentrated on prediction and control rather than understanding (Maris et al., 2000; Leenaars, 2004). Consequently understanding of the suicidal process (Aldridge, 1998) and suicidal person (Webb, 2002) is limited and there is inadequate guidance for professionals working in the area (Maltsberger & Goldblatt, 1996; Ting et al., 2006; Cutcliffe & Stevenson, 2007).

This Grounded Theory study aimed to address these gaps by developing a substantive theory pertaining to the phenomena of suicide-ality among young Irish men that could be utilized to inform mental health theory and practice (Glaser & Strauss, 1967). This involved interviewing seventeen formerly suicidal young men who had contact with mental health services and eliciting their views about their

suicidality and what they considered constituted meaningful responses to them in their particular situation.

The study lead to the development of a substantive theory that explains how these young men transcended suicidality when facilitated to re-vitalize their worthiness as persons of value and deserving of life. The theory incorporated a two-stage psychosocial process wherein the young men moved from a death orientation to a life orientation. This was a complex and unpredictable process that entailed identity re-configuration and was punctuated by turning points (Strauss, 1969). Turning points involved profound moments of inner and outer dialogue (Seikkula et al., 1995) that significantly influenced the young men's lives and their journies on their suicide trajectories and life pathways. It is proposed that the mental health practitioner can play a key role in enhancing worthiness by providing and promoting validating interpersonal dialogic encounters, thereby facilitating young men to transcend suicidality.

Chapter 1. Introduction: Setting the Scene

1.1 Introduction

This Classic Grounded Theory (GT) study (Glaser & Strauss, 1967) explored suicidality among young men in contemporary Ireland who had involvement with mental health services. A substantive theory was developed that explained the processes whereby these young men transcended suicidality by re-vitalizing their worthiness as individuals of value and deserving of life. This introductory chapter will set the scene for the research study and emergent theory. It will: provide a brief description of the background and rationale for and aims of the study, describe the methodology, design, and procedures employed to ensure theory emergence and ethicality, introduce the emergent theory, and provide an outline of the chapters to follow.

1.2 Background, Rationale and Aims

Suicide-ality poses significant social, political and health concerns worldwide due to the psychological and social burden incurred (Maltsberger & Goldblatt, 1996; Maris et al., 2000; Hawton, 2005). This incorporates individual psychological suffering and disability in terms of daily living, family distress and grief, community unease, and national concerns related to the costs incurred in health and social service provision (Maltsberger & Goldblatt, 1996; NOSP 2005, 2007). Rates of suicide-ality have increased significantly in recent years in many countries, including Ireland, where it has been described as reaching "epidemic" proportion (Neville, 2007). It is estimated that around one million people complete suicide each year worldwide and suicide is a leading cause of death among young people (WHO, 2004). The rate of completed suicide is significantly higher among men, accounting for approximately 80% of total suicides, while there is higher rate of attempted suicide among women, approximately 75% of total recorded attempts (WHO, 2004). In Ireland, rates for completed suicide are notably higher among young men aged 15-34 years, who accounted for almost 40% of deaths by suicide in 2003 (NOSP, 2005). There has also been an increase in attempted suicide, with approximately 11,000 people attending EDs each year following acts of deliberate self harm (DSH) (NOSP, 2005). While a range of

response initiatives have been developed, aimed at addressing suicide-ality at preventive, interventive and post-ventive levels, there has not been a corresponding decrease in prevalence rates in youth suicide-ality in many countries, including Ireland (NOSP, 2009).

These trends have led to notable growth in the field of suicidology, producing considerable academic literature and policy documentation. To date, research has focused primarily on identifying prevalence rates and trends in suicide-ality in general and among specific high-risk groups, identifying causal and contributory factors, and evaluating response strategies. However, it has been argued that research has been limited at a number of levels, for example, there has been an emphasis on quantitative methodology and etic accounts, a primary focus on prediction and control rather than understanding, and a lack of conceptual coherence across studies (Maris et al., 2000; Leenaars, 2004; Silverman et al., 2007a, 2007b). Consequently understanding of the suicidal process (Aldridge, 1998) and suicidal person (Shneidman, 2001; Webb, 2002) is limited. Explanations for such limitations have been proposed in terms of the ethical and practical concerns associated with conducting research with a "vulnerable" population (Stoff & Mann, 1997; Rouf, 2004), and in relation to a "sensitive" topic (Renzetti & Lee, 1993; Grad, 2005).

While suicide-ality has been firmly placed in the domain of mental health, many suicidal people, in particular young men, do not seek professional help. This has been explained in terms of gender related factors (Kelleher, 1996; Cleary, 2005a). Furthermore, there is a high treatment drop-out rate and related poor therapeutic outcomes among this group. These trends are understandable in the context of on-going social and professional debate about how best to understand the phenomena of suicide-ality. While it has been argued that the majority of people who complete suicide are mentally ill (Kelleher, 1996; Maris et al, 2000), it has also been suggested that many suicidal people may be philosophically rather than psychiatrically troubled (Webb, 2002; Mulholland, 2005). Furthermore, it has been suggested that many mental health professionals who come into contact with the suicidal person are ill-equipped to respond in a meaningful way and that there is inadequate guidance for professionals in this area (Maltsberger & Goldblatt, 1996; Ting et al., 2006; Cutcliffe & Stevenson, 2007).

In view of these concerns and anomalies, this GT study explored patterns of suicidality with young men aged 16-34 years who had involvement with mental health services and elicited their views about what they found constituted meaningful responses to their suicidality and particular life situation. The purpose of the study was to develop a substantive theory that could be utilized to inform mental health practice (Glaser & Strauss, 1967). The theory that evolved was conceptualized as *re-vitalizing worthiness in transcending suicidality*, which explains how young men in contemporary Ireland transcended their suicidality by re-establishing their worthiness as individuals deserving of life. The study suggests that social and professional responses to the young men can paradoxically mirror their dilemmas in suicidal crises, proving unhelpful and indeed exacerbating their fears and anxieties. Therefore, it is proposed that the time has arrived to re-consider professional, social, and political values and practices so that opportunities for validation of worthiness are enhanced. It is also suggested that the mental health practitioner can contribute significantly to this development as she is ideally placed to provide and promote worth-enhancing encounters with this population and to advocate for this with them and on their behalf.

1.3 Methodology, Design and Ethicality

The methodology utilized in this study was GT which allows the researcher to enter the field and to explore the area of interest without preconceived ideas about the study outcome (Glaser & Strauss, 1967). GT seeks to understand and explain how people define and act in relation to their reality, by illuminating latent patterns relating to a particular social or psychological phenomenon. The purpose of generating a substantive theory is to inform knowledge and action in the substantive area (Glaser & Strauss, 1967). Although a number of theoretical perspectives on suicide-ality can be identified in the literature, none speaks comprehensively and directly to the issue of young male suicidality. Therefore, the substantive theory developed in this study contributes to the field by offering a theoretical explanation for the process of transcending suicidality and a concept-based model that and can be utilized to inform how the mental health practitioner can facilitate this process.

Within GT the emergent theory is grounded in the data while also subject to researcher conceptualization and is viewed as temporary and tentative (Glaser, 1998). The originators of the methodology highlighted a central challenge for the GT researcher in utilizing her knowledge, while also allowing the theory to emerge from the data without "forcing" (Glaser & Strauss, 1967). Two steps were taken to address this issue. Firstly, the researcher used the literature to inform her "theoretical sensitivity" by gradually incorporating additional layers of literature into the study that informed each phase of the study as it progressed (Glaser, 1998). Secondly, the substantive theory was judged against the GT rigour criteria, which assessed it in terms of the sense it made and the value it added to the substantive area and the fields of suicidology and mental health.

In GT, data collection and analysis are concurrent and recursively influencing processes that inform, clarify and critique each other throughout the inquiry (Glaser, 1998). Data gathering commenced with selective / purposive sampling, which refers to targeting data sources that can directly inform the phenomenon under study. This was followed by theoretical sampling, which refers to seeking data to add depth to emerging categories. Data were analysed using the Constant Comparative Analytic Method, the objective of which is to compare and integrate data, so that all instances of variation are captured in the emerging theory (Glaser, 1998). Analysis involved moving from descriptive labelling to theoretical categorisation and eventually to a core variable.

One-to-one interviews, most of which were tape recorded with participant consent, were conducted with seventeen participants. To ensure that the study was conducted in accordance with the core ethical values that underpin research, consideration was given to potential participant, researcher and contextual risks in advance of commencing the study, and unanticipated ethical issues were also identified and managed as the study progressed (Robson, 2002). The researcher adopted an "ethics as process" approach (Ramcharin & Cutliffe, 2001), which views ethical values as contextually bound and ethical decision-making as a continuously evolving process throughout the study (Stewart & Amundson, 1995; Mc Carthy, 2005).

In the course of conducting this study, the researcher encountered a number of philosophical, methodological and ethical challenges. Philosophical challenges centred on examining the consequences of holding privileged understandings of suicide-ality and the suicidal person. Ethical dilemmas centred on balancing values that promoted a safe research context with the research agenda, and methodological issues centred on enacting these values in all research practices in a congruent manner to promote study integrity.

1.4 Chapter Outline

The thesis comprises ten further chapters. Chapters two, three and four provide a pre-view of different aspects of the suicidology literature, incorporating epidemiological data, theoretical perspectives and dominant professional and policy responses, respectively. Chapters five and six provide an outline of the classic GT methodology as developed by sociologist Barney Glaser and describe how it was applied in this study. Chapters seven, eight, and nine provide a detailed description of the core concern, core variable and substantive theory, outlining the psychosocial process in which the young men engaged to *re-vitalize worthiness*. Chapter ten situates the substantive theory in the wider knowledge domain by reviewing it in the light of the literature pre-view and incorporating literature that resonates with key aspects of the emergent theory. Chapter eleven, the final chapter, discusses some implications of the substantive theory for clinical practice, professional education and training, research and government policy, and examines study robustness.

1.5 Summary

This introductory chapter provided a broad overview of the purpose, aims and approach to this classic GT study and outlined the chapters to follow. It also introduced the substantive theory that emerged, *re-vitalizing worthiness in transcending suicidality*, which specifically relates to the process of how the young men in this study transcended suicidality by re-vitalizing their worthiness to be in the world. The following three chapters provide an overview of the suicidology literature, particularly in relation to young men and the domain of mental health.

Chapter 2. Literature Pre-View 1: The Known and Un-known about Suicide-ality

"Suicidal behaviour has been a feature of civilisation throughout history (Alvarez, 1974) and will continue to be so. Total eradication of suicidal behaviour will never be feasible. In education of both clinicians and the public this point should not be omitted, or else a suicidal event is likely to lead to demoralizing condemnation of those trying hardest to prevent such an outcome."

(Hawton, 1994, p.76)

2.1 Introduction

The next three chapters provide an overview of pre-existing knowledge in the field of suicidology, particularly in relation to the domain of mental health, thereby providing a context for and illuminating the rationale for this study. This chapter will outline: the evolution of the field of suicidology, epidemiological data on prevalence rates and trends, and socio-demographic data highlighting risk and protective factors worldwide and within Ireland, particularly among the young male population. The following two chapters will discuss theoretical explanations of suicide from a range of perspectives and response strategies and dilemmas in relation to practice and policy. This overview will highlight contemporary debates within the suicidology field and identify some challenges associated with conducting research and developing professional practice in the substantive area.

2.2 The Evolving Field of Suicidology: Progress and Challenges

Suicidology, is a term coined by Shneidman to describe the study of suicide and related phenomena (Maltsberger & Goldblatt, 1996), that seeks to understand, describe and explain suicide-ality so that more effective prevention strategies and treatment interventions can be developed (Webb, 2003). Suicidology has roots in the eighteenth century and the literature is widespread across a range of professional disciplines, reflecting its multidisciplinary nature (Maltsberger & Goldblatt, 1996).

However, in the last forty years the field has grown robustly, corresponding with growing recognition of the extent and burden of suicide-ality (Hawton, 2005).

A substantial literature exists in the field, incorporating empirical / research reports, theoretical literature, technique / practice oriented material, and personal accounts of survivors of suicide, suicidal people and those bereft by suicide. Research has been dominated by quantitative study that has been helpful in examining the epidemiology of suicide, identifying risk and protective factors and specific high risk groups, and enhancing understanding of individual cases (Maris et al., 2000; Shneidman, 2001). Despite the traditional nomothetic approach in research generally, an idiographic approach to scientific investigation and knowledge generation has grown, which relies on introspective or experiential accounts of events, thereby providing an opportunity to directly study the person (Shneidman, 2001). This trend has been reflected within suicidology, with an expansion of qualitative research that explores emic or subjective accounts and situated meanings of suicide-ality. Hence, a relatively smaller but nonetheless growing, literature base is concerned with exploration of the unique experiences of suicidal people, those working with them, and those bereaved by suicide (Samuelsson et al., 2000; Cutcliffe & Stevenson, 2007; Begley & Quayle, 2007). Combined idiographic and nomothetic approaches have provided an abundance of literature and a solid starting point to anchor further research in the field of suicidology.

It is interesting that this literature pre-view revealed a pattern of similar concerns within the field over time. These include: methodological concerns such as an overemphasis on quantitative methodological study and an over reliance on etic accounts with little emphasis on subjective experiential accounts, terminological variations across studies rendering findings inconclusive regarding profiles and factors, reliance on post-fact and indirect information that is frequently based on reconstruction of events with potential for distortion, and recording and reporting inaccuracies making statistics unreliable (Durkheim, 1952; Kelleher, 1996; Aldridge, 1998; Maris et al., 2000; Shneidman, 2001). Hence, it is argued that research to date fails to capture the complexity of the phenomena as it provides inadequate theorizing about the suicidal process (Aldridge, 1998; Rogers, 2001), offers limited understanding of the experience of the suicidal person (Webb, 2002), and lacks

practical guidance for professionals in responding to the suicidal person (Maltsberger & Goldblatt, 1996; Sammuelsson et al., 2000; Ting et al., 2006; Cutcliffe & Stevenson, 2007). Furthermore, the absence of internationally agreed definitions of terms in common use in the field has lead to conceptual confusion (Gibbs, 1990; Maris et al., 2000; Silverman et al., 2007a, 2007b).

Whilst it is easy to be critical of study to date it is also important to acknowledge the challenges associated with conducting research in the area of suicide-ality. Ethical challenges arise in relation to participant safety and informed consent when engaging with a "vulnerable" population (Rouf, 2004) and exploring a "sensitive" topic (Renzetti & Lee, 1993). For example, issues around justice and informed consent arise when engaging in experiments and / or withholding treatment (Stoff & Mann, 1997). Post-vention research has been limited due to recruitment difficulties, which may reflect reluctance on the part of potential participants to discuss the sensitive issues of death by suicide and grief, and / or, fear of intrusion by researchers (Grad, 2005). Thus, in addition to methodological issues, there are pragmatic and ethical challenges that warrant consideration.

The theoretical literature has proposed frameworks for understanding and responding to the suicidal person, drawing upon biological, psychiatric, psychological, spiritual, moral, social and integrated perspectives (Maris et al., 2000; Shneidman, 2001). However, it has been argued that research has been technological rather than theoretical in its focus (Rogers, 2001; Westefeld et al., 2000), and that current theory reflects professional assumptions and suppositions rather than scientific study (Maris et al., 2000). Nevertheless, there is a range of theoretical perspectives that have enabled understanding, however partial this might be, and fuelled curiosity in the field. This has led to a desire to develop theory from, rather than apply it to, different aspects of suicide-ality.

Practice oriented literature has focused on developing clinical and political interventions specifically designed to reduce and control suicidal risk and behaviours. While it has proven difficult to demonstrate clinical effectiveness in terms of reduction of subsequent suicide attempts, some promise for specific psychosocial, psychotherapeutic and biopsychosocial interventions has been demonstrated (Hawton

& van Heeringer, 2006; Crawford et al., 2007). However, it has been argued that many common practices lack empirical evidence (Weiss, 2001) and that the effectiveness of prevention strategies is poorly documented in the literature (Qin et al., 2005). Research on specific clinical interventions carries with it the challenges of conducting real world studies while replicating laboratory conditions by controlling multiple variables. However, despite these limitations there is ample literature available on dominant responses, and indeed some traditional practices, viewed as oppressive and outdated, have been strongly critiqued (Schwartz et al., 1996; Cutcliffe & Stevenson, 2007; Marsh, 2008).

In summary, despite the growth of suicidology and the wealth of available literature, multiple alternative understandings of the phenomena of suicide-ality abound. There is confusion about terminology, significant aspects of this phenomenon remain vague and response strategies are not empirically supported, demonstrating clear knowledge gaps that require further explication. However, on-going debate about these issues has led theorists and practitioners to begin to appreciate the multidimensional and complex nature of the phenomena of suicide-ality, which it is argued should be reflected in research, clinical practice and government policy (Shneidman, 2001).

2.3 Why worry? - The Facts about Suicide and Suicide as a Fact

"Statistics reflect by themselves only numbers and are, at best, only a representation of the true figures."

(Leenaars, 2004, p. 40)

Epidemiological study in suicidology has provided information on suicide-ality trends worldwide and in Ireland and has highlighted some key issues for consideration in terms of response at multiple levels. Despite concerns about the accuracy of official statistics there is consensus among leading suicidologists worldwide that sufficient evidence exists in support of some trends and commonalities (Kelleher, 1996; Maris et al., 2000; Shneidman, 2001), which are elaborated below.

Prevalence Rates and Trends

The science of statistics came into existence in the eighteenth century and continues to hold a prominent position within the natural and social sciences. The reliability of statistical data lies in their power to draw generalizable conclusions through systematic and accurate data gathering and analysis. Hence, they are frequently used to provide evidence pertaining to phenomena in our daily lives and predict future trends. However, within suicidology the reliability of statistical data has been viewed with some scepticism due to variations in reporting and recording methods and the subjective nature of categorization of suicide-ality. These concerns have been mirrored within the Irish context, influenced significantly by cultural values that reflect the stigma associated with suicide-ality. This has rendered existing statistics inconclusive (Kelleher, 1996), hence it is suggested that they represent only the "tip of the iceberg" (NOSP, 2005). The discrepancy between occurrence and registration of mortality statistics is generally due to caution in reporting and interpretation of suicidal acts and delay in aligning occurrence and registration rates when a coroner's inquest is necessary, as is the case with suspected suicides (Corcoran et al., 2004). Furthermore, recording practices vary internationally. Therefore, one of the objectives in government strategy is to improve morbidity and mortality data collection (DoHC, 2005; NOSP, 2005). Nevertheless, while prevalence rates for suicide-ality vary worldwide and there are significant variations for sub-groups within each nation, some international commonalities have been identified (Leenaars, 2004), which include:

- *A Suicide Trajectory: Suicidal ideation, deliberate self-harm (DSH), attempted suicide and completed suicide.*

  There is considerable disagreement on many of the terms associated with suicide-ality (O'Donovan & Gijbels, 2006; O'Donovan, 2007; Silverman et al., 2007a, 2007b). For example, there is on-going debate about the distinction and overlap between populations who engage in different levels of suicidal thinking and behaviours (Beautrais, 2001). However, a suicide trajectory has been elaborated that incorporates different levels of suicide-ality, ranging from suicidal ideation to completed suicide, with multiple levels in between. These include deliberate

self-harm (DSH) and suicide attempt that are said to reflect the level of suicidal *intent* of the person engaging in such behaviours. Following a number of years of work Silverman et al. (2007a, 2007b) proposed a three dimensional nomenclature that comprises suicide-related ideations, suicide-related communications (any interpersonal act of imparting suicidal thoughts, wishes or intent) and suicide-related behaviours (self-inflicted, intentionally injurious behaviour). They suggested that a precise classification system that incorporates categories for levels of intent, lethality and intensity of suicidality be developed alongside their broader nomenclature for clinical efficiency and effectiveness

Suicidal ideation is a relatively common experience, for example, it is estimated that 24% of the adult general population and 31% of the clinical population in the US have considered suicide and that 7-12% of children and adolescents have some serious suicidal ideation at some time in their lives (Maris et al., 2000). The incidence of suicidal thoughts is around 30% higher in females than males (Gunnell et al., 2004).

According to the 2004 annual report of the National Parasuicide Registry of Ireland (NPRI) (NSRF, 2004), in 2003 the rate of DSH in Ireland was 241 per 100,000 for women and 177 per 100,000 for men, with 21% accounting for repeat acts of DSH in 2003. More than 11,000 cases of DSH, involving 8,600 individuals, presented to Irish hospitals in 2004 for assessment and treatment (NSRF, 2004). A proportion of these episodes were described as serious suicide attempts and 87% of this group were under the age of 50 years (NOSP, 2005).

The ratio of attempted suicide to completed suicide is about 7:1 below the age of 65 years and increases to 2:1 above 65 years. It is estimated that a general practitioner (GP) in the United Kingdom (UK) is likely to encounter 100 people per year who report suicidal ideation, compared with one person in every four years who completes suicide (Booth & Owens, 2000). Approximately 71% of psychotherapists report working with at least one client who has attempted suicide and 28% report working with a client who completed suicide (Toth et al., 2007). It is estimated that psychologists carry a 20% risk of "losing" a patient through suicide, while psychiatrists carry up to a 50% risk. Hence, Maris et al.

(2000) conclude that suicide and self-destruction are fairly common problems among psychologically and psychiatrically distressed populations for which practitioners need to be prepared.

It is estimated that about one million people die by suicide each year worldwide, exceeding the combined numbers for homicide and war, and that rate exceeds the numbers for road traffic accidents in most European countries (Hawton, 2005). Suicide rates in Ireland doubled between 1987 and 1998, and appear to have levelled off since that time. Between 2000 and 2002 it was estimated that suicide occurred in approximately 12.9 per 100,000 of the Irish population, about 500 people per annum, which is average when compared with other European Union (EU) countries (Corcoran et al., 2004).

There are reported increases in the rates of suicide and DSH among young people in many countries. For example, there was a significant increase in the UK and Ireland during the 1980s and 1990s (Hawton, 2005; NOSP, 2005), in particular completed suicide among males aged 15-24 years, and DSH among females aged 15-18 years (Anderson, 1999). Suicide is the third leading cause of death in the 15-24 year age group in the United States (US) (Pope & Vasquez, 2007). The rate of youth suicide in Ireland is the fifth highest in the EU at 15.7 per 100,000 for 15-24 year olds, and higher among those in their 20s and 30s, with all men under 35 years accounting for approximately 40% of all Irish suicides in 2003 (NOSP, 2005). This pattern contrasts with traditional patterns in Ireland and most other countries where suicide peaks in older men, making male youth suicide-ality a growing social and health concern in Ireland; hence the focus on young men within the 16-34 year age bracket in this study.

It could be argued that increases in suicide rates in recent years reflect a reduction in other causes of natural death, thereby distorting figures. For example, improved public health due to healthier lifestyles and better medical technology could be said to lead to more successful treatment and a related reduction in mortality rates. However, the rate of suicide has remained relatively constant over time (Maris et al., 2000).

- *A Link Between Suicidality and Completed Suicide*

A history of attempted suicide is said to be the strongest predictor of eventual suicide (Maris et al., 2000; Hawton, 2005). It is estimated that between 40-80% of completed suicides have a history of attempted suicide, and approximately 10-15% of those who attempt suicide eventually die by suicide (Qin et al., 2005; Pope & Vasquez, 2007), in comparison with 1.5% of the general population (Leenaars, 2004). People who have engaged in DSH are said to be 100 times more likely to complete suicide than the general population (Hawton & Fagg, 1992) and approximately 15% of suicide attempters will reattempt suicide within the first year following their initial attempt (Schmidtke et al., 1996; Van Der Sande et al., 1997). However, despite the well recorded link between attempted and completed suicide, the NPRI report of 2004 highlights that ED is the only treatment provided for 45% of DSH patients.

- *Socio-demographic Variations*

Gender variations in suicide-ality are evident. Completed suicide is more prevalent among males than females worldwide, at a ratio of approximately 4:1 (Hawton, 2005). Attempted suicide is about three times higher for women, with the exception of rural China where the rate of completed suicide is higher among women (Hawton, 2005).

There is a positive association between age and suicide rates across the lifespan, notably strongest for white males aged 55-65 years, with increasing rates among young men aged 15-34 years (Hawton, 2005), while the rate for white females peaks between 45-54 years (Maris et al., 2000). DSH is higher among young people, peaking at 15-19 years for females, and 20-24 years for males. While there is currently a warranted emphasis on suicide-ality among young men, it is important to note that among older people, non-fatal acts tend to be more serious and completed suicides are more common (Corcoran et al., 2004). Furthermore, some countries, such as New Zealand (Beautrais, 2008), have identified increasing rates of completed suicides among females.

Trends have also been identified in terms of area of domicile and socio-economic status (SES). People who are socially isolated in cities and those living in rural regions, particularly in farming communities, have higher completed suicide rates than in the general population (Hawton, 1994; Maris et al., 2000). The rate is also higher for those from lower SES groups, when other risk factors are also at play (Qin et al., 2005). However, in general, suicide is represented proportionately across all levels of society (Leenaars, 2004).

- *Methods and Lethality*

Internationally it has been noted that males tend to use more lethal methods than females, perhaps accounting for the lower rate of completed suicides among women. This difference in method has been associated with higher aggression and knowledge of lethal means among males, less concern among males about disfiguration arising from failed attempts, and / or the non-suicidal motivation of many females (Hawton, 2005). Irish records demonstrate that the most frequently used methods are hanging, drowning and poisoning. Drug overdose is more common among females and self-cutting is more common among males, a contrast noted between Ireland and other countries where self-cutting appears to be typically used by women (NSRF, 2004).

- *Clustering and Contagion*

Patterns of clustering in completed suicides and suicidal behaviours have been noted in multiple contexts, such as: families, schools, local communities, ethnic groups and specialist facilities such as mental health treatment settings (Qin et al., 2005). Clustering has been explained in terms of contagion, which refers to the effect on public perception of the moral message conveyed in describing a phenomenon. Such messages can be conveyed through social and media discourses. Hence, concerns have been expressed about media reporting of suicide, for example, glamorizing or simplifying a suicide event can positively influence perceptions and in some cases has been attributed to copycat episodes, while the use of pejorative and pathologizing language can increase stigma by

conveying a message that the act is abnormal (Cullen, 2006). Such concerns have resulted in the publication of media guidelines that encourage sensitive and responsible reporting of such events. Cullen (2006) notes that in Ireland most printed media reports on suicide tend to discuss it in terms of a clinical or epidemiological issue, highlighting links with depression. Many reports fail to adhere to reporting guidelines by using loaded language such as "commit" suicide, which implies a sinful or criminal act (Cullen, 2006).

- *Suicide and Mental Health*

The presence of mental health problems poses a particular risk of suicide-ality. Those diagnosed with a psychiatric illnesses, such as affective disorders, personality disorders and psychosis, as well as those with co-morbid psychiatric disorder and substance abuse, are estimated to be 7-10 times more likely to complete suicide than the general population (Maris et al., 2000; NOSP, 2005). It has also been suggested that many young people who complete suicide have a pre-existing psychiatric disorder characterized by impulsivity and anti-social behaviour (Espasito-Smythers et al., 2004).

The rate of completed suicide for people with clinical depression is about twenty times greater than for the general population, therefore, it has been suggested that effective treatment of depression may lower the risk of suicide (Pope & Vasquez, 2007). However, rather than assuming a direct relationship between depression and suicide, it has been proposed that hopelessness is a key mediating variable (Beck et al., 1978). It is noteworthy that up to 50% of suicides are associated with the presence of alcohol (Pope & Vasquez, 2007) and Irish records suggest that alcohol use was involved in almost half (47%) of male DSH episodes, and in 39% of female DSH episodes in 2003 (NOSP, 2005).

Psychiatric hospitals have a suicide rate more than 35% greater than the community (Pope & Vasquez, 2007) and 1% of suicides occur in psychiatric hospitals (Maris et al., 2000). Approximately 25% of people who complete suicide are in psychiatric treatment at the time of death and the risk of suicide in the first month following discharge from hospital is between 3-7 times higher

than at a later time, regardless of gender (Cutcliffe & Stevenson, 2007). Physical illness, particularly chronic illness, is also associated with higher risk of suicide-ality (Qin et al., 2005).

While there is variation in mortality and morbidity rates and trends worldwide and within each country, some patterns can be identified that are of particular relevance to this study. These include increasing rates in male and youth suicide-ality, a strong association between suicidality and completed suicide, and a link between suicide-ality and mental health issues. Therefore, this study was concerned primarily with understanding male suicidality and can contribute significantly to research and practice in the substantive area, as elaborated in later chapters.

Risk and Protective Factors

While it is overly simplistic to assume a linear cause and effect relationship between single predisposing and precipitating factors in relation to such complex phenomena as suicide and suicidality, both risk and protective factors have been identified, some of which are highlighted above. General risk factors incorporate social, psychological, psychiatric, spiritual and religiosity elements. Social factors include poor social integration and social instability, limited educational attainment and poor employment opportunities, and role confusion (Kelleher, 1996; Cleary, 2005a). Psychological factors include the absence of hope, limited resilience, and low self-esteem (Shneidman, 2001). Personality factors include impulsivity and external locus of control (O'Connor & Sheehy, 2001; Espasito-Smythers, 2004). Psychiatric factors include a personal or family history of mental illness (Stoff & Mann, 1997). Spiritual factors include absence of meaning and purpose in living and low levels of satisfaction with life (Webb, 2002; Heisel & Flett, 2006). In terms of religiosity, suicide rates among Protestants tend to be higher than among Catholics and rates are higher among those who abstain from religious affiliation and practice, regardless of religion (Stack, 2008). In Ireland the increase in suicide-ality has been associated with contextual change over the past two decades such as economic boom and downfall, growth in multiculturalism, emigration return, and lessening of church influence. The last fact has also been associated with less value being placed on the

sanctity of life, ironically making suicide-ality a more acceptable response to stress despite cultural stigma (Kelleher, 1996; Cleary, 2005a; Cullen, 2006).

Protective factors contrast sharply with identified risk factors, with those who are socially stable, psychologically well adjusted, physically and mentally well, and spiritually at ease deemed to be least at risk of suicide-ality. Additional protective factors for females include pregnancy, having a young child and a tendency to identify and seek help for psychological distress. Marriage (Hawton, 2005), and fatherhood, when in a stable family environment (Qin et al., 2005), are deemed to be protective factors for men. Although suicides are typically low among married people, joint suicides involving terminal illness have been reported in recent decades (Battin, 1994). According to Heisel and Flett (2006), it is the combination of absence of positive and presence of negative biopsychosocial factors that evoke suicidality.

Help-Seeking Trends

Although a range of health professionals is available to work with suicidal people there are concerns about help-seeking patterns. There is some discrepancy regarding the numbers of completed suicides among those who have been in contact with health services. According to Eagles et al. (2003), one UK national study indicated that in the region of 25% of people who completed suicide had been in contact with the mental health services in the year prior to their death. A Department of Public Health National Study (DPH, 2001) found that the time lapse between a GP visit and death by suicide was over one year or unknown for 30% of the sample. In a UK study of 50 adolescents aged 15-18 years admitted to hospital following overdose, 24% had seen their GP in the week before the act of DSH and 50% in the previous month. However, it is notable that a substantial number of suicidal people do not come to the attention of health services; therefore, the figures outlined above are not representative of the total problem (Hawton, 2005). Indeed, in a large-scale cross-sectional study involving almost 4,000 Irish adolescents aged 15-17 years, 12% reported suicidal behaviours while only 11% of these young people attended hospital, posing a challenge in terms of how to engage with this population (Sullivan et al., 2004).

The low uptake of mental health services by suicidal people and the high drop-out rate for initial psychiatric consultation is a growing concern (NOSP, 2005; 2009). Some reasons suggested for poor uptake include system obstacles such as prolonged waiting times, lack of provision, over reliance on medical models and paternalistic practices, cost, and a dearth of evidence-based interventions in the area of suicide-ality which impacts significantly on capacity to provide equitable, timely and accessible services (Burke et al., 2008). Patient centred obstacles such as gender related help-seeking patterns and negative perceptions about mental illness, mental health professionals and mental health services also significantly impact engagement with services (Burke et al., 2008). A report commissioned by the Mental Health Commission (MHC) in Ireland, based on a comprehensive survey of service users' experiences, suggests that service users hold stigmatized views of some professionals, experience treatment as paternalistic and exclusionary, view practice as overly medicalized and custodial, and desire more collaboration about their treatment (Dunne, 2006).

2.4 The Act, Process and Person

While there is much interchangeability of terminology in the area of suicide-ality (O'Donovan & Gijbels, 2006; O'Donovan, 2007; Silverman et al., 2007a, 2007b), there have been attempts to understand and describe the suicidal act, process and person in different ways. This practice has been welcomed in terms of enhancing shared understanding (Silverman et al., 2007a) and criticized in terms of compromising individuality (Webb, 2002, 2003).

It is common practice to assess the severity of the suicidal *act* by measuring the medical lethality of the act, *intent* (the desired outcome), and *motive* (the reasons), of the individual engaging in the act. To this end, distinctions have been drawn between DSH and attempted suicide. The former deemed to be a less serious act, intended to attain some form of social response such as attention, power or revenge, while the latter is deemed to be more serious as the intended goal is death. DSH is frequently viewed as a means of communicating distress, a cry for help, or a way of influencing change in one's environment (Gibbs, 1990; Linehan, 1993), and Leenaars (2004) suggests that the goal of attempted suicide is not always to end one's life but to change it. However, as with much of the terminology in the field, there remains a

debate about the meaning of intent (Anderson, 1999; Morton et al., 2007a, 2007b), therefore these distinctions are far from clear-cut. Furthermore, it is suggested that the choice of term may indicate the attitudinal frame of the speaker (Gibbs, 1990).

In attempting to capture a profile of the suicidal *person* similarities and differences among persons who attempt and complete suicide have been examined and those who self-harm and attempt suicide (Maris et al., 2000; Beautrais, 2001). It has also been suggested that there is considerable overlap between these two groups (Aldridge, 1998; Leenaars, 2004), therefore these distinctions remain contested. Rudd (2006) suggests that a distinction be drawn between acute and chronic sucidality, with people who have made two or more suicide attempts more likely to have a chronic aspect to their presentation. As a result of such micro-distinctions, the suicidal person has variously been described as an *ideator / contemplator*, or harbourer of suicidal thoughts, an *attempter*, or one who self-harms with greater or lesser intent to die, a *repeater*, or one who makes repeated suicide attempts, and a *completer*, or one who successfully kills himself.

The suicidal *process* has been described both in terms of an isolated acute reactive response to a personal crisis, and as an event on a gradually evolving suicide pathway / career, representing a convergence of multiple factors over time that reflects the bio-psycho-social history of the person (Maris, 1981). The latter description perhaps better allows for the complexity and multi-dimensional nature of suicide-ality.

While it can be argued that these distinctions have been clinically helpful in terms of identifying those at higher risk of suicide through assessment of risk factors and warning signs (Rudd, 2006), and assisting in treatment planning as the needs of these populations are deemed to be different (Maris et al, 2000; Rudd, 2006; O'Donovan, 2007), the practice of labelling the suicidal person has also been strongly criticized. It has been suggested that labelling perpetuates the stigma of suicide through the use of pejorative language (Evans et al., 2005), reflects a scientific approach in which persons are objectified thereby minimizing their psychological pain (Sommer-Rothenberg, 1998; Webb, 2002), privileges a medical / psychiatric model which serves to position the practitioner as the expert on the patient / client, legitimizing a stance of expertise rather than collaboration (Johnstone, 1997), and causes conceptual

confusion, as many of these terms lack clarity (O'Donovan & Gijbels, 2006; O'Donovan, 2007). Furthermore, people's living circumstances change and their distress and pain tolerance levels fluctuate over time and context, highlighting the need to use professional terminology cautiously and fluidly. Therefore, it is important to clarify the use of terminology within this text without becoming embroiled in debate about "correct" interpretations. For that reason a glossary of key terms is provided at the beginning of the thesis.

Suicide-ality and Young People

"It has to be said, however, that there is very little certain knowledge on the key mediating features for the rise in suicidal behaviour during the adolescent age period."

(Rutter, 2007a, p.107)

Youth suicide has been specifically associated with an increase in the prevalence of depressive disorders and substance abuse (Rutter, 2007a), extended adolescence and increased pressures associated with this time of transition, changes in attitudes towards suicidal behaviour making it a more acceptable response to stress, and an increase in the availability of suicide methods (Aldridge, 1998; Orbach, 2001). It has also been associated with increased exposure to media violence (Hawton et al., 2002), and increased personal exposure to suicide and suicidality (Cleary, 2005a). Familial patterns associated with suicidality in young people include rigidity, disorganization, instability, unclear boundaries, inflexibility, poor conflict resolution skills and unhealthy communication patterns, such as double-binding and secretiveness (Bonger et al., 2000), poor attachment and family disruption and break-up (Tousignant & Hanigan, 1993).

Young Irish people identified relationship problems, concern with sexual orientation, educational stress, abusive experiences, and family disharmony as significant contributory factors in suicidality and DSH (Sullivan et al., 2004). These findings are similar to other studies that support links between suicide-ality and widespread alcohol consumption and significant use of illicit drugs, higher levels of psychological distress among females, lack of awareness of available help and a tendency not to seek help for their distress, and stress due to life problems (Maris et al., 2000;

Hawton, 2005). Sullivan et al. (2004) suggest that while the majority of Irish adolescents are psychologically well adjusted, a number experience psychological distress and engage in self-destructive behaviours. They conclude that this group of young people may be at risk of serious health problems if they remain unrecognized and unreachable, therefore, *"…creative means of reaching young people at risk of mental health problems that involve young people in their design and implementation"* need to be developed (Sullivan et al., 2004, p.7).

Suicide-ality and Gender

"The issue of male suicide is one of great concern in Ireland. Suicide rates, particularly among young men, have been increasing since the seventies. Today suicide is the principle cause of death among 15-24 yr old males."

(Katherine Howard Foundation, 2005, p.2)

There is no doubt that gender differences are striking, and suicide has been described primarily as a male phenomenon. It has been posited that gender role rather than inherent biological or psychological factors may more significantly influence these trends (Shneidman, 1985; Leenaars, 2004; Katherine Howard Foundation, 2005). This may encompass changes in male SES, role confusion (Shneidman, 1985; Leenaars, 2004; Cleary, 2005a) and changing relationship patterns (McClure, 1994). Cleary (2005b) hypothesizes that social and cultural change in Ireland has psychologically impacted men in a way that is different to women, for example, the changing SES of men and increased competition in third level education and the labour market has challenged men's assumptions regarding their sense of masculinity. It is also proposed that this kind of social change influences power relations in the family and workplace and reduces the availability of psychological support to men from women (Stack, 1998; Cleary , 2005a).

Traditionally, women have been described as more emotionally intelligent than men, making it easier for them to recognize, acknowledge and discuss emotional issues, while men have been described as more rational / logical than women. For example, while it is estimated that 80% of women who are concerned about their mental health will seek help, only 50% of men will do so and this figure is reduced to 20% for men under 25 years of age (Mulholland, 2005). Hence, men are less likely to recognize the

need for, avail of, engage with, and consequently benefit from professional help than women (Hawton et al, 2000; Leenaars, 2004).

While negative help-seeking trends may reflect gendered attitudes associated with traditional views of masculinity as strong, unemotional and capable of working out problems alone, it has also been suggested that they may reflect male responses to the type of help offered (Cleary , 2005a; Mayor, 2000). For example, psychotherapy focuses primarily on talking, frequently about emotions, which may be more attractive to females (Leenaars, 2004). Indeed, Cleary (2005a) found that suicidal young men's experience of psychotherapy was negative; describing it as intrusive and doubting its effectiveness. The study found that participants were aware of their inability to disclose problems and had *"...carefully concealed their difficulties"* (Cleary, 2005a, p.33). Indeed some of those who had disclosed their distress to family members found that this was rejected, perhaps perpetuating the social taboo about mental ill-health and the gender prohibition against emotional vulnerability (Weeks, 2005). Cleary (2005a) also hypothesized that men may have problems having their distress recognized as they frequently present with masking conditions, such as alcohol and drug misuse.

As engaging with appropriate help is recognized as a generic protective factor in mental health and even brief intervention can significantly reduce suicidality (Rickwood et al., 2007), there exists a challenge in addressing negative help-seeking patterns among men. According to Mayor (2000), services need to be appropriate and attractive to young men and set out deliberately to initiate contact with this group.

The issue of sexual orientation has also been linked with increased vulnerability to suicide-ality. Indeed, Wexler et al. (2009) suggest that suicide-ality is one of the most troubling consequences of discrimination and victimization of those whose sexual orientation is viewed as outside the norm of heterosexuality. Concerns about sexual orientation are also frequently associated with substance misuse and depression, both of which can in turn increase the risk of suicide-ality.

2.5 The Impact of Suicide-ality

"At times people have wondered – and indeed I have wondered myself – why I am still so troubled a quarter of a century after Dennis' death… In the end, I think it makes no sense to look for the reason his death was so difficult. No one really gets over the death of a loved one. And it is particularly difficult when the person has taken his own life."

(Simon, 2003, p.1597)

Suicide-ality has posed serious social and health concerns worldwide for some time given the growing human, social and financial burden incurred. As the rates of completed and attempted suicide rise, increasing numbers of people are exposed to and affected by these phenomena (NOSP, 2005). A study by Begley et al. (2004) involving a community sample of young Irish men aged 18-34 years revealed that: 78% knew someone who had died by suicide, 42% knew more than one person, and 17% had a close friend who completed suicide. Immeasurable psychological pain is experienced by the suicidal person and his family, friends and peers, and completed suicide is experienced as traumatic for those connected with the deceased (Sommer-Rothenberg, 1998; Simon, 2003).

Each suicide is said to have on average a major impact on six people (Hawton, 2005). While this seems like a modest calculation, nevertheless, it suggests that at least six million people worldwide are affected by the suicide of someone close each year (Grad, 2005). It has been suggested that while each bereavement is unique and personal and the process depends on a range of factors, such as family and social support, bereavement following suicide shares many of the features of bereavement in general. However, it is also distinguished by more extreme feelings of shame, stigmatization, abandonment and rejection, can take longer, be more ambiguous, and be accompanied by extreme and unexpected mood changes (Grad, 2005). An Irish study exploring the experiences of adults bereaved by suicide concurred with these findings, identifying characteristics unique to suicide bereavement such as intense shame, stigma, confusion and self-blame (Begley & Quayle, 2007). Ironically, such responses mirror the experience of the deceased and reflect the impact of social and moral stigma on those left behind.

In terms of economic impact, Kennedy et al. (2005) estimated the direct and indirect costs associated with suicide in Ireland at approximately 870 million euro per annum and DSH at 29.4 million euro for the year 2002, taking account potential loss of productivity and the provision of care and treatment. Thus, Kennedy et al. (2005, p.72) conclude that effective suicide prevention strategies and mental health promotion could *"...generate significant economic returns in addition to bringing obvious benefits in the form of lives saved and emotional trauma avoided"*.

Given that the aim of this study was to develop a theory that could be utilized to inform mental health practice, it was important to note the impact of suicide-ality on the practitioner. Death by suicide or repeated suicide attempts by clients can have a profound impact on those engaged in a helping capacity, leading to feelings of rejection of their efforts to help and failure due to their inability to prevent a death or injury (Hale, 1997). In a survey conducted by the Canadian Psychiatric Association Practice Research Network a number of psychiatrists who had lost a patient through suicide reported profound changes in their professional lives and experienced feelings of self-recrimination and doubt (Links, 2001). Thomyangkoon and Leenaars (2008), also found that more than half of the psychiatrists who participated in their study (n=94), reported experiencing personal sadness, depression, hopelessness and guilt, and two thirds reported changes in their professional practice in terms of more aggressive suicide assessment. The participants found that the support of peers, family and friends and religiosity helped in the aftermath. The study concluded that while the reactions of participants were similar to those reported in other studies in the US and UK, cultural sensitivity is important in understanding psychiatrists' unique responses to suicide and its impact on them.

Gijbles (2003) conducted a qualitative study with fourteen community psychiatric nurses that explored their practices with people deemed to be at risk of suicide. This study revealed that they and other professional colleagues across disciplines experienced a range of disparate responses to suicide attempts ranging from shock, anguish, pain, guilt and resentment to surprise and acceptance. Gijbles (2003) developed a conceptual framework, "accommodating uncertainty", to explain participants' struggle to manage the uncertainty associated with working with people who are at risk of suicide in a context of competing demands.

A qualitative study exploring the impact of client suicide on mental health social workers in the US reported similar professional and personal reactions. These included: symptoms associated with grief, such as anger, denial and acceptance, symptoms of Secondary Traumatic Stress (STS), such as avoidance behaviour and intrusive thoughts, and feelings of professional incompetence and responsibility for the death leading to isolation from peers, self-blame and self-justification (Ting et al., 2006). Such reactions may explain and reflect the ambivalent attitudes of some professionals toward the suicidal person, as elaborated in chapter four. Hence, there is a need for self-awareness and reflection on the part of the professional who may unknowingly harbour and enact pejorative views. However, some positive impacts on practitioners have also been reported including: increased awareness of the complexity of suicide-ality and uniqueness of each client, improved and more proactive screening and response practices, enhanced communication and teamwork, engagement in community education programmes, and more emphasis on self care (Ting et al., 2006). Positive impacts were associated with strong support systems for practitioners whereas negative impacts were frequently associated with poor support structures and leadership (Ting et al., 2006; Thomyangkoon & Leenaars, 2008).

2.6 Summary

In summary, it could be said that the impact of suicide-ality on others has been a significant factor in bringing these phenomena into public awareness. This in turn, has led to more vigorous attempts to address these issues. It can be seen from the above discussion that an abundance of epidemiological and socio-demographic information is available in relation to suicide-ality prevalence rates, trends, and risk and protective factors, which assists in identifying those who may present a higher risk of repeated attempts and completed suicide. Available statistics, while not entirely accurate, indicate an increase in suicide-ality among young men in recent years in some Western countries, including Ireland, giving rise to increased concern about this particular population (NOSP, 20005). While there is variation in suicide-ality rates and trends worldwide and nationwide, some patterns have been identified. These include increasing rates in male and youth suicide-ality in recent years in many countries including Ireland, and a strong association between suicide-ality and mental health concerns with mental distress being central to suicide-ality. Important risk and

protective factors have been identified which include: social stability, integration and status in terms of educational, economic and gender role achievement (Durkheim, 1952; Hawton et al., 2000; Cleary, 2005a); degree of psychological resilience, self-esteem and hope (Beck et al., 1975, Shneidman, 2001); mental and physical health (Maris et al., 2000); spiritual well-being (Kelleher, 1996; Webb, 2002); and religiosity (Stack, 2008). Of course it is important to acknowledge that a person's life, his relationship with living and life context are not static, therefore his risk status can change over time.

A rich vocabulary has evolved to describe and define the client group who presents following self-destructive acts, with much debate about the accuracy and usefulness of definitions such as DSH, attempted suicide and so on. These definitions are said to facilitate clinical assessment and treatment planning and to bring coherence to research endeavours (Silverman et al., 2007a, 2007b). However, they have been critiqued due to the negative connotations inherent in such terms which increase stigma and negatively impact help-seeking patterns (Cullen, 2006; Burke et al., 2008). Failure to acknowledge the unique experience and contextual nature of suicide-ality has in part led to an overemphasis on risk management and confining practices (Maltsberger & Goldbaltt, 1996; Webb, 2002, 2003).

There has been growing recognition of the psychosocial and economic impact of suicide-ality, making suicide a central focus in social and mental health policy and practice and increasing endeavours to address these issues (Hawton, 2005). Some positive impact has been reported, such as increased public and professional awareness and sensitivity, and reduced stigma (Ting et al., 2006). Given current knowledge in the field, it has been proposed that to address the issue of suicide-ality appropriately, interventions that target the reduction of risk factors, promote protective factors, and are relevant and acceptable to the target group be developed and delivered (Qin et al., 2005; NOSP, 2005; 2007), and that research, clinical practice and political strategy reflect the complex and multidimensional nature of these phenomena (Shneidman, 2001; Leenaars, 2004).

This literature provides a broad context for the current study in terms of explicating the level and nature of suicide-ality in general and highlighting specific issues related

to the target population. The next chapter explores theoretical understandings of suicide-ality.

Chapter 3. Literature Pre-View 2: Discourses on Suicide-ality – A Template for Action

3.1 Introduction

"Briefly defined, suicide is the human act of self inflicted, self-intentioned cessation. Suicide is not a disease (although there are many who think so); it is not a biological anomaly (although biological factors may play a role in some suicides); it is not an immorality (although it has been treated as such); and it is not a crime in most countries around the world (although it was so for centuries)."

(Leenaars, 2004, p.3)

The way that suicide-ality is conceptualized has consequences for how one responds to the act itself and persons associated with it, both those who engage in suicidal behaviours and those who are connected to them (Gibbs, 1990; Maris et al., 2000; Shneidman, 2001). The meaning of suicide-ality has evolved over time, incorporating profound epistemological shifts that reflect dominant social discourses and cultural norms which have been influenced by governing bodies such as religion and the law. Within this movement perspectives on suicide have evolved from viewing it as an act that violated natural (rational) and divine law, to a philosophical crisis, an evolution from "*sin to selfhood*" (Shneidman, 2001, p.5). A review of the Encyclopaedia Britannica, from the seventeenth through to the nineteenth century, provides a flavour of this movement (Shneidman, 1998). In the seventeenth century suicide-ality was viewed as an act of evil, a sin and a crime against self, God and state that warranted punishment, with insanity as the only acceptable explanation. In the eighteenth century suicide-ality was viewed as a social malaise, with emphasis on the constancy of suicide and the folly of enacting laws against it. In the nineteenth century there was a greater emphasis on the statistical reality and complexity of these phenomena, such as their aetiology, and a growing acknowledgement of their psychological aspects and survivor impact.

Suicide-ality has been theorized in different ways over time, spanning medical, psychiatric, psychological, existential, moral, sociological and integrated perspectives

(Maris et al., 2000; Shneidman, 2001). In general, theories have been uni-dimensional, each reflecting an underpinning moral position and proposing directives for response at macro and micro levels. However, it is argued that despite these changing social and academic discourses, suicide and related behaviours remain sensitive and stigmatized topics (Sommer-Rothenberg, 1998; NOSP, 2007). Similarly, Marsh (2008, p.21) draws attention to how discourses evolve and suggests that *"...knowledges produced in relation to suicide and the suicidal may be said to 'intervene' as part of a dynamic process rather than merely represent an unchanging reality"*. This chapter aims to map evolving suicide discourses and their impact, particularly in relation to young men and the field of mental health. Proposed explanations are discussed under two key headings: as phenomena that are internally located, within the person, in his body, mind or soul; and, as phenomena that are externally located, within the interpersonal and wider social domain, such as social discourses and social organization. It is acknowledged that there is inevitable overlap and recursive influence across these divisions.

3.2 Internally Mediated Phenomena: Body, Mind or Soul

Internal theories, or theories that locate suicide-ality within the person - in his body, psyche or soul - incorporate medical, psychiatric, psychological and spiritual perspectives. While they each offer a different view on the location of pathology and different directives for moral and professional action, they all focus on a discrete component of the person. Medical and psychiatric perspectives abound in mental health, with a lesser but growing emphasis on psychological and sociological perspectives, and these combined far over-shadow spiritual perspectives within the field (Barker et al., 1999; Walsh et al., 2008; Pesut, 2009).

Medical and Psychiatric Perspectives: No Brain no Mind

"Substantial uncertainty still remains on the precise connections between brain structure and functioning on the one hand and the workings of the mind on the other. Nevertheless, a recent study seeking to link brain changes with changes in psychological functioning begins to provide specific evidence on possible

Connections…….Findings are complex and not easy to interpret but the general implication is that there are meaningful connections…"

(Rutter, 2007a, p.103)

Two main sub-discourses have been proposed within medicine: biological and psychiatric / mental. Suicide, as a medical phenomenon, was first described by Jean-Etienne Esquirol in 1821 in the Dictionnairé des Sciences Medicales, as a disease or symptom of a disease that required medical assessment and treatment. This followed a gradual increase in the numbers of completed suicides being described as insane during the late seventeenth and early eighteenth centuries. This move opened the way for viewing insanity as the only rational explanation for suicide, which firmly placed suicide-ality within the medical domain, and indeed suicide, without any other evidence of insanity was adequate to make a diagnosis of illness. Medicine thereby claimed expertise and authority in knowledge related to suicide, establishing its internal, individualistic and pathological origins (Marsh, 2008). While medicalizing rather than criminalizing suicide might be said to be a more humane attempt to protect the family of the deceased, this shift did not reflect any fundamental change in an underlying belief in the pathological nature of suicide-ality (Leenaars, 2004; Marsh, 2008).

The production of medical knowledge in relation to suicide in the first half of the nineteenth century offered much promise in relation to gaining a better understanding and treatment of the suicidal person. In biological psychiatry, organic origins for dysfunction are primarily proposed (genetic, physiological or neurological) with abnormalities of the brain anatomy or neuro-physiology accounting directly for psychiatric disorder. Due to a paucity of empirical findings, and hence little practical application, physical pathology began to fade and gave way to more psychiatric explanations such as despair, as the psyche became the site of suicide, ironically relocating suicide-ality in another portion of the brain. However, in recent years some advances have been made in biological / medical psychiatry. Biological theories in mental health are currently concerned with the influence of brain chemical levels such as serotonin on suicide-ality (Turecki et al, 2001; Hawton 2005). It is argued that while such explanations are in their infancy they hold promise for treatment and thus

they require further attention (Rutter, 2007a). Both the biological and the psychiatric discourse tend to sit alongside each other in contemporary psychiatry.

Psychiatry proper, as a discipline distinct form general medicine, began to emerge around mid nineteenth century, leading to an increase in the number of asylums with suicide-ality being firmly located within this specialist branch of healthcare (Marsh, 2008). This shift saw psychiatry reformulate suicide-ality in terms of morbid innate impulses or forces that resided within, weakened reason and the instinct for self-preservation, were difficult to detect, and might be hereditary. However, while cure was viewed possible, the person was still deemed to have minimal control over his disease and consequent actions thereby being excused from moral responsibility (Battin, 1994), with the psychiatric practitioner becoming the protector of society against "*…the threat of the irrational madman*" (Marsh, 2008, p132). Psychiatric accounts emphasize the link between psychiatric illness and suicidality, in particular depression, schizophrenia and co-morbid depression and substance addiction (Maris et al., 2000), usually suggesting a causal relationship (Kelleher, 1996; Stoff & Mann, 1997). Suicide-ality has also been linked with other illnesses in terms of their physical and socio-emotional impact, for example Anorexia Nervosa, Muscular Dystrophy and chronic physical illnesses (Leenaars, 2004). In a national study in Ireland it was estimated that almost half of those who died by suicide (47%), for whom a GP could be identified, had been referred to mental health services, and 43% were suffering from a diagnosable mental health problem at their last GP visit (DOPH, 2001).

The anti-psychiatry movement of the 1970s and the more recent post-psychiatry movement of the 1990s formed a firm platform for critique of psychiatry and associated disciplines by deconstructing the dominant discourses based on medical psychiatry and offering robust debate about alternative explanations (Bracken & Thomas, 2001; Thomas & Bracken, 2004). These critical arguments seek to question the assumptions that underpin psychiatry, and their limitations and harm potential, thereby challenging practice conventions and power hierarchies (Watkins, 2007). The association between psychiatric illness and suicide-ality has been challenged, and it has been argued that not all suicidal people are depressed and not all depressed people are suicidal (Shneidman, 2001). Therefore, it is a myth to suggest that depression and

suicide are equivalent and it is suggested that mental illness is concomitant with, rather than a causative factor in suicide (Shneidman, 2001; Leenaars, 2004). It has also been proposed that suicidality represents a philosophical or psychological, rather than a psychiatric, crisis and is strongly influenced by external conditions (Maris et al., 2000; Shneidman, 2001; Mulholland, 2005). In her study with suicidal young Irish men (Cleary, 2005a, p.45) found that the majority of participants *"…were not categorized as having a recognizable psychiatric condition by the referring psychiatrist."*

Some specific research methodologies in the field of suicidology that seek to establish biological and / or psychiatric origins of suicide have been critiqued. The physical autopsy is a method used to examine the corpses of suicides in an effort to locate the site of physiological dysfunction or anatomical abnormality. Despite lack of consistent empirical evidence in support of claims to link specific body parts or functions to a suicidal propensity (Maris et al, 2000; Rutter, 2007b), it has been suggested that such formulations have been presented as scientific truths (Lakeman & Cutcliffe, 2009), further drawing attention to the power of dominant discourses.

The psychiatric discourse that proposes a causal relationship between internal, invisible forces / passions and suicide-ality challenged traditional means of investigation based on the observable and measurable and brought with it additional challenges in terms of making empirical claims. The psychological autopsy is a method for determining retrospectively the mental status of the deceased person prior to their suicide, through the use of private data, medical documentation and retrospective accounts of surviving relatives and friends. These studies have been viewed as a valid and reliable method for understanding completed suicide and suicidal persons, and have become important in establishing a link between mental illness and suicide, indicating that about 90% of those who complete suicide have a diagnosable mental illness at the time of their death (Kelleher, 1996; Hawton, 2005). Methodological difficulties in relation to the psychological autopsy include biased recall of information by those close to the deceased who may favour a particular understanding of the death of their loved one, and reluctance to participate in research of this nature (Qin et al., 2005). Another method for gaining retrospective understanding of individual suicide acts entails the analysis of suicide notes.

Leenaars (2004) found that people in middle adulthood were more indirect and ambivalent about their suicide than late adults, young adults appeared to be more concerned with their inability to cope with life events than middle and late adults, and young adults felt more relationally isolated and were more distressed about this than older adults. He concluded that these differences may reflect age related stressors and concerns across the life span that need to be acknowledged in working with the suicidal person. Others argue that this form of inquiry has yielded little information as notes, written by about 30% of those who complete suicide, tend to be brief and pragmatic in focus (Shneidman, 1973; Maris et al., 2000).

In summary, there has been robust debate regarding the contribution and limitations of medical and psychiatric discourse from the late nineteenth and twentieth centuries through to today, both within and beyond psychiatry. Psychiatric discourses can be viewed as having a positive impact that diminishes individual moral responsibility for the suicidal self and act, providing a framework for understanding and acting, presenting possibilities for cure through psychiatric treatments, and reducing feelings of blame and shame in survivors. Critique of psychiatric discourses centres on foreclosure of alternative discourses overshadowing the complexity of suicide-ality, an emphasis on cure which supports judgments that those who do not respond to treatment are difficult cases, lack of scientific evidence for their claims, and portrayal of suicide-ality as madness and shameful supporting of a moral position of irrationality (Battin, 1994; Leenaars, 2004; Marsh, 2008). The nineteenth century saw the emergence of psychological / psychotherapeutic and sociological theories proposing alternative explanations and modes of intervention and reflecting a move toward positive psychology (Watkins, 2007). However, within the domain of mental health in Ireland, medical and psychiatric discourses remain strong (O'Donovan, 2007) and their historical roots in risk containment are evident (Mac Gabhann, 2008).

Psychological Perspectives: I think therefore I am

"I believe suicide is essentially a drama in the mind, where the suicidal drama is almost always driven by psychological pain – what I call psychache. Psychache is at the dark heart of suicide, no psychache, no suicide."

(Shneidman, 2001, p.200)

Following the psychiatric model, psychological models proposed that the psyche is the site of suicide-ality in terms of an internal battle ground, container of painful emotions, misconstruer of life events and self, and director of self-destructive behaviours. These models brought about the emergence of new treatments that required the patient to disclose his inner thoughts, feelings and desires, in order to revive his self-preservation instinct, making the practitioner the expert interpreter of the dynamics of the psyche. This move advanced a number of psychological theories on suicide-ality in the last century, each with its own psychotherapeutic response model, some of which are briefly described below.

Psychodynamic Theories

The psychological study of suicide began around the turn of the twentieth century with the investigations of Sigmund Freud from the psychoanalytic school of thought, which dominated psychological theory for many years (Leenars, 2004). Psychoanalytic theory elaborated the existing psychiatric discourse of internal impulses and drives, locating these in a specific component of the psyche, the ID. While not writing extensively on his theories of suicide-ality, Freud proposed the *retroflective hostility theory*. This theory proposed that suicide results from hostility turned against the self, as conflicting life (Eros) and death (Thantos) instincts residing within the person reached ultimate expression in the death instinct (Litman, 1996). Freud hypothesized that the root cause of suicide was the loss or rejection of a significant other that the person unconsciously wished to kill, eventually turning this death wish against the self. While psychodynamic theories have tended to focus primarily on the aggressive component of suicide, viewing it as self-execution or punishment, Maltsberger and Buie (1996) suggest that other motives need to be considered, such as the desire for a new life, or rebirth, and riddance of a life that is intolerable. Lacan introduced *passage a l'acte*, an unconscious process that describes "*…an attempted solution, a flight from the scene of phantacy, which aims at a final solution a 'new being'*" (Skelton, 2006, p353). Thus, while it might be considered that this way of conceptualizing suicide emphasizes "the dark side of man", it also promotes the positive motive of seeking or gaining life through the suicidal act.

Following Freud's observation that some accidental injuries are purposefully self-inflicted, Menninger (1938), an American psychiatrist / psychoanalyst, explicated two

categories of suicide: explicit or overt suicidal acts and malignant self destruction. The latter refers to covert suicidal behaviour where one capitalizes on or generates opportunities for death. Shneidman (2001, p.92) likens this latter category to his own concept of subintentional death, or the unconscious bringing forward of death. Menninger (1996) was significant in introducing the psychodynamic worldview and perspective on suicide to the public and professional worlds. He demonstrated how a view of unconscious ambivalence about death permeates common parlance, as exemplified in phrases such as *'he must want to kill himself'* or he did it *'accidentally on purpose'*.

Consistent with its theory of causality, psychoanalytic interventions with the suicidal person focus on unearthing and gaining insight into unconscious internal desires, forces and conflicts (Maltsberger & Buie, 1996). Psychodynamic formulations on suicide have been critiqued as unscientific as they rely primarily on clinical case analysis, with the conclusion that the retroflective hostility theory has not been confirmed (Beck et al., 1999). However, debate continues about the usefulness of both clinical and empirical evidence in the field of psychotherapy (Carr, 2007).

Cognitive and Behaviour Theories

Cognitive and behaviour theories differ in terms of their emphasis on cognition and behaviour respectively. However, in recent years these approaches have been combined and they generally advocate that behaviour, physiology, cognition and emotions are intimately and inextricably linked, and that behaviour is learned or conditioned. Conditioning refers to how behaviour can be shaped in response to one's environment, primarily through reinforcement or feedback regarding stress relief or avoidance and positive rewards (Beck, 1978). Based on social learning theory, Bandura (1989) and others suggest that the suicidal person has learned to inhibit the outward expression of aggression which he turns inward upon himself and which is mediated by environmental factors, the person's engagement with his environment, and his mood (Leenaars, 2004).

Cognitive accounts of suicide-ality were developed from cognitive theories of depression, assuming a high frequency of negative thinking compounded by logical errors and a tendency for long-term negative cognitive schemas activated by life

events (Williams et al., 2005). The work of Beck and his colleagues, in the early 1960s, hypothesized that suicide is caused by depressed mood and that critical links between depression and suicidal intent are levels of hopelessness, imbalance between reasons for living and reasons for dying, and impairment in interpersonal problem-solving (O'Connor & Sheehy, 2001; Williams et al., 2005). According to cognitive theory, the person's cognitions are said to be overly negative and rigid with cognitive distortions / errors, or ideas that are not in keeping with the reality of his situation. There is also an overly negative conceptualization of his situation as untenable or hopeless, seeing suicide as the only possible solution to or escape from his situation (Beck et al., 1975; 1999). Hence, Beck et al. (1999) propose a formulation of suicide-ality that incorporates two themes, hopelessness as a catalyst and the role of impaired reason in hopelessness and suicidality. The proposal that hopelessness, or negative future expectation, (Beck et al., 1999), is a key mediating variable linking depression to suicide was a significant contribution to the study of suicide. Hopelessness identifies those at higher risk of suicide thereby challenging the assumption of an automatic link between depression and suicide-ality.

Another cognitive behavioural perspective, the *entrapment model*, proposes the view that escape is central in suicide-ality, emphasizing the place of helplessness which was defined as *"...the inability (or perceived inability) to get away from an aversive environment after one has suffered a defeat, loss, or humiliation"* (Williams et al., 2005, p.72). Orbach (2001) extends entrapment theory to incorporate self-entrapment whereby the individual develops coping mechanisms that increase his sense of being trapped. Entrapment theory has been further developed to incorporate the *cry of pain model* which explicates the entrapment process in more detail (Williams et al., 2005). Three key features of entrapment include: sensitivity to environmental cues signalling defeat, giving rise to an overwhelming urge to escape; a sense of being unable to escape; and a sense that the situation will continue indefinitely. Williams et al. (2005, p.76) conclude that *"...defeat and entrapment are likely to be key contributory factors in understanding suicidal behaviour with perceived opportunity for rescue playing a mediating role"* , explaining how one can become caught in a fantasy about dying and how to bring this about.

Therapeutic interventions based on cognitive and behaviour theories focus on changing cognitions, associated behaviour patterns, and emotional responses. Therapy facilitates the individual to become less cognitively restricted through a process of cognitive restructuring, aiming to introduce more viable alternatives to suicide. According to Beck et al. (1999) targeting hopelessness is more likely to be productive in alleviating suicidal crisis than focusing on the person's suicidal behaviours. Cognitive and behaviour theories have been critiqued for their emphasis on the here and now of a person's situation, failing to attend to his historical context. However, each psychological theory has been critiqued in terms of its preferred emphasis and therefore its omissions (Flaskas & Perlesz, 1996).

Systemic Theories

Aldridge (1998) proposed a systemic perspective on suicide-ality, which focuses primarily on the systems within which one is embedded. It emphasizes: the reciprocal nature of relationships among system parts, challenging linear cause and effect assumptions; circular causality, whereby all system actors contribute to the structure and functioning of the system; and context, or the relationship between micro and macro meaning-making networks and social practices (Burnham, 1986; Dallos & Draper, 2000). A systems approach, therefore, elaborates the relational and contextual elements of suicide-ality, suggesting that this emerges from intrapersonal and / or interpersonal conflict that escalates over time (Aldridge, 1998), negatively influencing one's relationship with oneself and the world. According to systemic theory behaviour arises out of the person's desire to communicate about and / or influence the context within and from which their conflict emerges. Thus, suicide-ality can be considered a socially interactive phenomenon that is intimately connected with one's sense of personhood and place in the world (McNamee & Gergen, 1992) and reflects the person's coping mechanism in an attempt to regulate change. *"It is a political act with a small 'p'. In this process the original relational nexus becomes disturbed and a person becomes threatened with isolation, alienation or banishment."* (Aldridge, 1998, p.39).

Therapy based on this theoretical framework aims to locate the person in his unique context and to facilitate him to re-interpret and enact new and more liberating relational connections and narratives with and between self and other persons and / or

events (White, 1995; Freedman & Combs, 1996). While systemic theories clearly acknowledge the living context of the person they have been critiqued for their lack of attention to emotional and intrapsychic processes. This imbalance has been redressed in recent years to acknowledge the interface between the person's internal and external world, and embodied and embedded selves (Flaskas & Perlez, 1996).

Person-Centred Theories

Leenaars (2004, p.44) writing *"..suicide is an intrapsychic drama on an interpersonal stage"*, suggests that suicide-ality can be understood as both an intrapsychic and interpersonal phenomenon where the person is not only mentally depressed and constricted but also socially estranged. The person-centred approach of Rogers (1961) emphasizes the importance of the therapeutic relationship, and outlines the core conditions for therapeutic change: empathy, congruence and acceptance (non-conditional positive regard). Leenaars (2004) proposes a similar non-judgemental and non-directive approach to psychotherapy with the suicidal person. This approach resembles the systemic approach in that it addresses both the person's internal and external being.

Integrated Psychological Theories: "No psychache, no suicide"

Some psychological theorists have attempted to integrate elements from different psychological theories. For example, Shneidman's (2001) *cubic model* proposes that suicide results from *psychache*, intense and intolerable psychological pain, coupled with dysphoria arising from blocked or frustrated psychological needs, constriction of perceptual range, and a desire to escape that supports the idea of death as preferable to life. Shneidman (1996a) describes psychache as the key variable that relates to suicide; mediated by one's threshold for pain tolerance, hence minor mollification of one's frustrated needs can avert a suicide. His anodyne therapy is a form of psychotherapy aimed at reducing this psychological pain through liberating the client from "*…narrow, truncating, unhealthy, life-endangering views of the "self"*" (Shneidman, 1996b, p.202).

Shneidman (2001) summarizes the key aspects of psychological suicide theories as emphasizing: fight, the desire to lash out at self or other; flight, the desire to escape; fright, the experience of isolation and fear; and / or freight, the psychological burden

arising from family history, structure and / or functioning. Similarly, Leenaars (2006) suggests that there is common ground across psychological theories in the way that an element of internal or external conflict escalates over time, and the suicidal behaviour can be viewed as an attempt to coerce, manipulate, validate, communicate or negotiate some mutual goal. Thus, psychological theories share the idea that suicide has a history of psychological conflict or trauma that evolves within an individual situation, whether this is viewed as intrapersonal or interpersonal, conscious or unconscious, learned or acquired. Thus, each theory subscribes to the idea that there exists a pre-determining psychological context for suicide and some also acknowledge the impact of the wider socio-cultural context on one's being.

Personality Theories

Some personality characteristics have been linked with suicide-ality, such as: rigid and pessimistic thinking and hopelessness, (Beck et al., 1975, 1999), increased tendency toward impulsivity and external locus of control (Espasito-Smythers, 2004), and perfectionism and rumination (O'Connor & Sheehy, 2001). There is also recognition of how life experiences and environmental factors, such as abuse, trauma, relationship difficulties and the contagion effect of the suicide of an important person, shape personality and stress responses and can precipitate or ameliorate suicide-ality. For example, a link has been established between experiences of childhood bereavement and suicide attempts in adult life. Bereavement is also a significant precipitator in suicide with up to 50% of suicides having lost their mothers within the 3 years prior to suicide compared with 20% among controls, and 22% having lost their fathers compared with 9% of controls (Pope & Vasquez, 2007). Child sexual abuse (CSA) and multiple incidents of sexual assault are said to increase the risk for DSH and suicide (Smith, 2009). Family distress and breakup is also disproportionately represented among suicidal young people (Tousignant & Hannigan, 1993). Early positive emotional and bodily care and attachment have been persistently associated with life-preservation attitudes and a sense of well-being while negative and lack of emotional and bodily care can lead to dissociation in bodily experiences, distancing from the body, self destructive behaviours and self-hate (Orbach et al., 2006). Hence, the *stress-diathesis* model of suicide that takes distal and recent life events and factors into account is proposed (O'Connor & Sheehy, 2001).

Psychological perspectives have been criticized at a number of levels for: their pathologizing effect as a result of their emphasis on the abnormal, their objectifying effect with emphasis on typologies, their dismantling effect with a focus on parts of the person and his experience, and their stigmatizing effect by creating and utilizing alienating language and practices (Webb, 2002; 2003). In psychotherapeutic practice there is an expectation that clients will inhabit a role of *"…talking and emoting a lot"*, activities that are generally associated with femininity and not valued from a masculinity perspective (Cleary, 2005a, p.11). Webb (2002) critiques psychiatry in particular, and psychology to a lesser extent, for ignoring the centrality and holistic nature of the self in suicide-ality, and defining this purely in terms of mind. He emphasizes that hopelessness and helplessness are personal, intimate and subjective feelings that cannot be captured by an objectivist and rational approach. Dineen (2004, p.3) critiques the psychological disciplines for manufacturing victims and for promoting *"…a subtle sphere of psychological influence that pervades our culture"*, placing the psychological person at the centre of the universe as a form of "*governance by the psychological*".

In summary, a range of psychological theories and psycho-therapeutic models have been applied to the phenomena of suicide-ality. Some efforts have been made to integrate different psychological perspectives, however division between the main schools continues. While psychological perspectives on suicide are viewed as more humane than psychiatric perspectives, most have been criticized in similar way to psychiatry for emphasizing pathology and focusing on the mind to the exclusion of other aspects of the person (Webb, 2002; 2003).

Existentialist / Phemenological / Spiritual Perspectives: I am therefore I think

'Suicide, the self killing the self, is a crisis of self.'

(Webb, 2002, p.3)

Existential philosophy was popular between the 1930s and 1950s in Europe and has re-emerged again in recent years. Existentialism proposes that humans are challenged by the reality of temporary existence, that life has no inherent meaning as meaning has to be created, and that a dialectic exists between one's choice to 'BE' or not to be. To BE refers to living an authentic (honest, insightful and morally correct) life, or

living genuinely despite inevitable death. The alternative is to retreat into nothingness through living an unauthentic life or choosing suicide (Frankl, 1959; Baechler, 1978). Frankl, a Viennese psychiatrist, was a prominent figure in introducing an existential perspective in psychiatry and psychology and his book *Man's Search for Meaning* (1959) has had a profound influence on scholars and the general public. Based on his own traumatic life experiences, including a period in a concentration camp, Frankl (1959) proposed that people who have spiritual meaning in their lives, personally and collectively, can withstand pain and resist despair. Thus, he developed a form of psychotherapy known as *logotherapy*, devised to help people find meaning in their lives.

Baechler proposed an existentialist / phenomenological conceptualization of suicide in 1978, which according to Shneidman (2001) brought a refreshing approach to a subject that had hitherto been primarily understood in moralistic, psychiatric, psychological or sociological terms. Baechler's theory, while not totally dismissing the contribution of these earlier theories, posits that suicide is a crisis of self and selfhood or living, a dis-ease of the soul / spirit rather than the brain or mind, focusing attention on the centrality of meaning and quality of life. Akin to psychological theories, Baechler (1978) explicated four typical meanings of suicide. These included escape from an intolerable life situation, revenge or an expression of aggression, sacrifice to a higher order, and finally, testing fate. However, he also emphasized the personal nature of the suicidal crisis; therefore, he did not advocate that these categories were exclusive, exhaustive or indeed accurate.

Existential theories have been supported by others in more recent years, for example David Webb, a survivor of suicide attempts and a sucidologist, suggests that understanding of suicide cannot be progressed in the absence of understanding the self (sui) that the suicidal person seeks to destroy (Webb, 2003). He explains suicide-ality in terms of a loss of an internal innate life force mediated by spiritual and psychological well-being, as opposed to psychopathology. Similar to Shneidmans' concept of psychache he suggests that extinguishing this life force becomes possible when life and living are experienced as intolerable. However, while Shneidman sees this pain purely in psychological terms, Webb sees it as extending to a deeper spiritual level, arguing for an *'I am therefore I think'* approach rather than the dominant

Descartian mind-body dualism explicated in the dictum *'I think therefore I am'*. As mentioned, existential explanations for suicide-ality are not popular within the mental health field. This may be because spirituality has tended to be placed in the domain of faith rather than science (Pesut, 2009) and because it challenges the dominant mind-body dualism (Barker et al., 1999).

Summary

"What we are forced to consider is a complex process involving life events and personal social variables as multiple causal chains."

(Aldridge, 1998, p.18)

In summary, a number of internal explanations have been proposed to explain suicide-ality. Each theory has its unique emphasis on a part of the person, body, mind or soul, depending upon one' persuasion, and proposes a recipe for response. There appears to be agreement that these models for understanding and the typologies they uphold have obscured some aspects of the person in favour of a focus on discrete parts. It is argued that these approaches can at best provide a partial understanding that over-shadows the wholeness of the suicidal experience and person, thus, a more holistic and humane perspective is advocated (Fisher, 1999; Webb, 2003).

3.3 Externally Mediated Phenomena: Socio-cultural Perspectives

External theories, or those that locate suicide-ality outside of the person, within his social and interpersonal domain, include: social discourses, moral doctrine and theories on social organization and order that influence society and one's place therein.

Moral Doctrines and Theological Positioning: From censure to concern

"There is but one philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy. All the rest…comes afterwards."

(Camus, 1945, p106)

Moral doctrine refers to the moral or philosophical values that underpin societal beliefs and behaviours, and Camus (1945) suggests that suicide is the most fundamental philosophical question facing man. Whilst acknowledging the challenges in interpreting history and unfamiliar contexts from the limitations of contemporary understandings, it has been suggested that suicide-ality has been viewed as morally and socially acceptable in some cultural contexts, demonstrating an act of heroic courage and / or conviction in one's beliefs. In the Roman Death the act of self-accomplished death reflected and sometimes elevated a sense of honour in a society that valued status and was socially rather than individually oriented, with suicide frequently publicly performed and politically motivated (Battin, 1994). Similarly, Christian Martyrs are said to have sought death due to *"…an inherent ambivalence about the worth of earthly existence"* (Marsh, 2008, p.105). Today suicide bombers sacrifice their lives for a greater cause, such as religious beliefs.

Moral debates relating to suicide-ality have existed for some time and reflect moral positioning, such as modernist, libertarian and relativist, each positing a discourse that promotes some forms of social and professional actions, whilst precluding others (Cutcliffe & Stevenson, 2007). The *modernist* position contends that the act of suicide is wrong. Emmanuel Kant espoused this position arguing that human life is sacred and should be preserved at any cost (Leenaars, 2004), and that the ideal person is a *"…rational agent with autonomy of will"* (Maris et al., 2000, p.475). Kantians view life as belonging to God rather than the individual, making suicide an affront to God, as well as a violation of one's duty to oneself and a degradation of humanity. From this perspective the moral response to suicide is prevention. The *libertarian* position contends that the individual has a right to choose his own fate, including suicide, thus there exists no obligation on the part of others to act to prevent this outcome. David Hume, renowned for supporting this perspective, lobbied to decriminalize suicide, asserting that suicide is not a transgression of one's duty to God, state or self, but a right to be enacted when one chooses (Leenaars, 2004). This perspective leans on the other end of the life-ownership spectrum and promotes the idea that one should not endure life for the sake of others, hence, the moral response to suicide is to allow and perhaps assist it. From this perspective suicide prevention can be viewed as a patriarchal position that downgrades individual responsibility for life and death as it can compromise autonomy by supporting prevention at all costs.

Szasz (1986), supporting a libertarian perspective, proposes that while professionals have a legal and moral obligation to intervene when a client is known to have suicidal intent, if the person refuses help the professional has a duty to respect this wish. He argues that the suicidal person be allowed to make choices as they do not have a mental abnormality. The *relativist* position perhaps reflects the middle ground between these two extremes, whereby the morality of suicide is judged in relation to situational and cultural variables and the consequences of the act for all concerned. Therefore, some suicides might be viewed as morally right as the event betters some individuals. The appropriate response from a relativist perspective will vary across contexts and with different judgment makers. Each of these moral positions is reflected in research and practice dilemmas and frequently there are clashes of moral values among professionals regarding best practice in this area.

Alarm at the high rates of death by suicide influenced the early Christian church in promoting a moral climate that prohibited suicide, redefining it as an immoral act. Some religions support the modernist position and proscribe suicide as hubris by putting one's own individual will ahead of God's will, or as a violation of a scriptural commandment such as *"thou shalt not kill"* (Maris et al., 2000, p.457). Hence, it has been suggested that fading religious values and practices have influenced the meaning of life and death for many young Irish people as they have lost their fundamental philosophical attachment to the sanctity of life, posing an additional risk factor for suicide in Ireland in recent years (Kelleher, 1996; Cleary, 2005a). The modernist position was reflected in law, and around 500 AD Canon Law sought to criminalize suicide, describing it as a self-murder, and determining that church rites be withdrawn and sanctions imposed on the surviving family. Suicide was deemed a crime in Ireland until 1993 (DoJLF), punished by denying funeral rites and sometimes confiscating the property of the deceased. According to Kelleher (1996) the criminalization of suicide stigmatized it and made it a hidden and shameful act. Grad (2005) muses about whether historical punitive responses to suicide perhaps reflect a belief that the surviving family members contributed in some way to the suicide, or serve as a social defence against fear of suicide by associating it with the mad and the bad, or indeed represent a crude prevention strategy based on social control.

Hence, through a process of re-description by the authority of the Church and State suicide-ality was variously conceptualized as an act of bravery, a moral transgression, and a sign of insanity over time. Sommer-Rothenberg (1998) argues that despite the evolution of doctrine and the shift from censure to concern for those who engage in and are affected by suicide-ality, contemporary language is morally imprecise and continues to promote a negative connotation of illegality and dishonour. This *"...disallows compassion and understanding",* as genuine sympathy and sharing are denied (Sommer-Rothenberg, 1998, p.239). Grad (2005) similarly suggests that while traces of traditional negative values are more disguised and hidden than in the past, pain following suicide is still denied as the death is not morally acceptable. In view of this contention it is useful to examine how social and professional language, discourses and practices with the suicidal person and those associated with him are influenced by prevailing moral doctrine, whether implicit or explicit.

In summary, the timeless question about living and dying seems to have occupied man, perhaps philosophers in particular, for many centuries. Nevertheless, there remains intrigue regarding suicide-ality and debate about how best to understand and respond to the suicidal act and person, socially and professionally. While the person who completes suicide, for whatever reasons, takes a position on this question, the survivors (family, community, clinicians, researchers and theorists) continue to debate the morality of such action.

Social Discourse: Myths, misconceptions and mysteries

"The public discourse on suicide in Ireland has been mostly informed by medical and psychological explanations, which analyse the epidemiology of suicide in terms of risk factors, linking suicide alcohol and substance abuse, with mental illnesses such as depression, and with stress associated with transition to adulthood and role adaptation. Such an approach, while useful in understanding individual cases, has not contributed significantly to our understanding of why the overall pattern of death by suicide in Ireland changed over the final decades of the twentieth century."

(Smyth et al., 2006, p. 18)

Many social and cultural myths, misconceptions and mysteries surround death, suicide in particular, making it a taboo subject (Glaser & Strauss, 1965; Shneidman,

2001; Leenaars, 2004). These include ideas such as: talking about suicide will make it more acceptable or make the person feel worse; suicidal people are psychologically or morally weak or mentally ill; suicide is always an irrational and impulsive act even when planned; those who fail to complete suicide are not serious about killing themselves; and, suicidal people do not seek or want help. These myths are shared and portrayed in many facets of living and are frequently mirrored in professional discourse and action. They have contributed to the stigma associated with suicide-ality and mental ill-health and consequently, help-seeking attitudes and behaviours (NOSP, 2005).

Cullen (2006) suggests that the media, in all its forms, is influential in shaping public behaviours and attitudes positively and negatively by implicitly or explicitly challenging or supporting certain discourses. He highlights the fact that journalists share certain "consensual assumptions" about the world that mobilize support for some interests and interest groups whilst precluding alternative views. Links (2001, p.418) also suggests that the *"...portrayal of suicide in the popular media has an impact on the health of the community",* and suggests that journalists be aware of the *"side-effects"* of their intervention in this area. Therefore, caution is prudent, particularly when dealing with young people who may be more impressionable (Cullen, 2006). For example, Midgley (2008) warns against the danger in glamorizing suicide in a way that gives recognition in death to those who may experience a lack of recognition in life. In view of these concerns, media guidelines seek to promote responsible reporting, such as appropriate use of language, avoiding glamorization or simplification of the act, and minimal reporting of the technical details of a suicide (Cullen, 2006).

According to Evans et al. (2005) social stigma may impact the course of mental health problems by interfering with treatment access, commitment and compliance: this is especially relevant to young people as many mental health problems begin during the early adulthood years (Rutter, 2007a; Burns et al., 2007). Evans et al. (2005) suggest that stigma is perpetuated by pejorative language about and labelling of people experiencing mental health problems and / or suicide-ality, misinformation about mental health problems, and treatment options and outcomes, and negative perceptions of professionals and services. A qualitative study with eighteen Irish

male students aged 15-18 years, exploring attitudes towards mental illness and mental health services, supported this view and identified concerns about confidentiality, professional competence and compromising masculinity (Burke et al., 2008). Sullivan et al. (2004) suggest that the stigma attached to seeking help needs to be challenged so that a vulnerable and hidden population of distressed young people can be accessed by those who can help or initiate help-seeking.

Findings from a survey conducted by the National Office for Suicide Prevention (NOSP) in Ireland with 1,000 people suggests that stigma about mental health may be a real issue in Irish society. The survey, examining mental health awareness and attitudes, found that 11% reported experiencing a mental health problem compared to WHO estimates that up to 25% of people experience a mental health problem in their lifetime. While 85% agreed that anyone can experience a mental health problem, 62% would not want others to know if they had such a problem. It also revealed that there was a high level of ignorance regarding where and how to seek help although the vast majority agreed that talking and social support is helpful (NOSP, 2007). These figures indicate an underestimation of prevalence of mental health problems among the Irish population and / or a reluctance to acknowledge these, ambivalence about associating oneself or making public that one has experienced a mental health problem, and a sense that one has less control over his mental health compared to his physical health (Chambers, 2007). Thus, the stigma associated with mental ill-health remains a challenge in Irish society and confusion exists between mental health, well-being and illness (Cullivan, 2007). While many suicidal people do not access health services (DPH, 2001), a significant number make contact or are advised to seek professional help during a suicidal crisis. It is proposed that by *"…effectively developing an anti-stigma campaign (general population) and by promoting awareness of positive mental health, the likelihood of vulnerable individuals with signs of mental health problems (more high risk) seeking help through the health service will increase"* (NOSP, 2005, p.16-17). However, promoting help-seeking in a context where appropriate responses are not available can be viewed as counter-productive and indeed irresponsible as it can lead to further frustration and disappointment.

In summary, socio-cultural influences on suicide-ality have been noted in terms of dominant discourses, norms and myths that inform understanding of and response to the topic of suicide and the suicidal person, such as gender norms, and social sensitivity to the topic. These discourses can be perpetuated by the media and promote stigma, which impacts help-seeking attitudes and behaviours. This poses additional challenges for the mental health practitioner in terms of engaging with the suicidal person and providing helpful responses as the practitioner is also influenced by social discourses. Thus, the kind of image portrayed by mental health services and professionals, the nature of the initial response, and the availability and quality of services provided to a person in acute and prolonged distress need to be the priority foci if access and responses are to be improved.

Sociological Perspectives: Social order

"...We have in fact shown that for each social group there is a specific tendency to suicide explained neither by the organic-psychic constitution of individuals nor the nature of the physical environment. Consequently, by elimination, it must necessarily depend upon social causes and be in itself a collective phenomenon..."

(Durkheim, 1952, p.145)

Durkheim's (1952) sociological theory, *anomie*, is probably the most critical sociological explanation of suicide. It proposes that suicide is explicable aetiologically with reference to social structures and functions within which the person lives. Durkheim (1952) suggested that every society has a collective inclination towards suicide / self-homicide, a reality that is exterior to the individual and exercises a coercive effect upon him. He described two central social processes, integration and regulation, that mediate individual connectedness and social change with extreme imbalance in either force affecting individual action and suicidal currents. Based on this thesis he explicated three categories of suicide, namely, *egoistic, altruistic* and *anomic* suicide, the former two associated with social integration and the latter associated with social regulation.

*Egoistic s*uicide is said to result from inadequate social integration of the individual self into society including, family structure and role. On the other extreme of this continuum lies *altruistic* suicide, in which the person has an overly integrated sense of

self and community and a lack of regard for individual life. This can lead to suicide based on commitment to a higher order, for example, religious or political sacrifice. *Anomic* suicide is said to result from a lack of regulation of the individual by society, or a form of social disorder due to excessive change such as sudden enrichment or divorce. Individual needs and satisfaction are embodied in a collective conscience, which, when upset beyond endurance or contradicted unduly maximizes conditions for suicide, as one's sense of self in community becomes disparate or irreconcilable. Spalding & Simpson (1952) suggest that inherent in Durkheim's theory lies a fourth type of suicide, occupying the extreme opposite of the anomic regulation spectrum - suicide deriving from excessive regulation which they call *fatalistic* suicide.

It has been suggested that the notable increase in suicide rates in Japan in the 1990s, particularly among young people, was associated with its rapid economic growth resulting in elevated aspirations and expectations which were not necessarily matched with adequate means of attainment; the consequent result was disappointment and an increase in anomic suicides (Iga, 1986). It has also been hypothesized that sociological theory could explain the increase in mortality rates by suicide in post-war settings, when the united or collective cause that prevented a person from focusing on individual troubles no longer exists, which ironically provided a protective factor for suicide-ality. However, Durkheim (1952) believed that social isolation was the mediating factor, as many soldiers lack strong family ties, and perhaps due to their training learn to set little value on their lives. Indeed it has been shown that in European countries there is a higher incidence of suicide among soldiers than in the civilian population outside of war times. Therefore, it cannot be concluded that war on balance lowers suicide rates. However, interestingly, the rates of suicide in Northern Ireland have increased since the end of the civil war, commonly known as the "troubles", and it has been hypothesised that this directly related to the resulting decrease in social cohesion in peace time (McGowan et al., 2005).

In the Irish context, anomie theory has been drawn upon to explain the marked increase in suicide rates during the 1980s and 1990s. This was a time of considerable social transition, when the stability of traditional institutions such as church, law and family were challenged by changing values that reflected a more economically developed, secular and individualized society (Cleary, 2005a; NOSP, 2005). During

this time significant legislative changes were made including the decriminalization of suicide in 1993, the last European country to do so, and the introduction of divorce in 1997, following intense social and political lobbying. Cleary (2005a, p.13) describes Ireland as a *"...fragmented, fast changing, society…with less clearly defined norms and values……increasing individuality but paradoxically less personal control"*. She suggests that these cultural transformations have adversely psychologically affected some groups of young men such as those marginalized in urban areas, and those economically and socially isolated in rural regions. She concludes that a more detailed examination of this proposed causal link is required. Similarly, Begley et al. (2004) suggest that while *"...anomie contributes to our overall understanding of suicide as a social problem, as a symptom of social transition, it may be difficult to apply to the understanding of individual deaths by suicide"*, hence, engaging directly with the narratives of young men is endorsed. Interestingly, Clarke (1998) suggests that the historical influence of colonization on the Irish may in part explain the Irish loss of identity and melancholic mood. Therefore, it could be hypothesized that multiple contradictory social changes over time have influenced the Irish psyche and suicide-ality trends.

Sociological theories have been critiqued at a number of levels. Firstly, for their inherent ecological fallacy, or the generalizing assumption that what is true for groups is necessarily true for individuals within the group. One such generalisation relates to gender theories which promote the idea that there exists "*…a unitary notion of men, that all men have the same level of resources, control and power in their lives which is clearly not true"* Cleary (2005a, p.7), and, that there are fundamental differences between men and women that account for their different ways of thinking, feeling and acting, thereby ignoring the complexity of social living (Weeks, 2005). Furthermore, sociological theories tend to rely on versions of the self that are relational which, while important, do not represent the wholeness of the self (Webb, 2002).

Summary

In summary, viewing suicide-ality as externally mediated draws attention to the influence of socio-cultural discourses, whether they are located in legend, formal theory, or prevailing morality, and contextual factors on one's being and place in the world. It is proposed that being socially displaced and experiencing extreme

disruption of social and cultural life can contribute to suicide-ality trends. Therefore, an appreciation of the person-in-situation can broaden understanding of and response to suicide-ality.

3.4 Integrated Perspectives: Moving beyond dichotomies

There is growing acceptance of the multidimensional and complex nature of suicide-ality, encouraging methodological pluralism and a trans-disciplinary approach to suicidology. Thus, a number of theorists have attempted to bridge the gaps between competing models proposing that it is more fruitful to consider the contribution and limitations of each perspective in understanding and responding to the suicidal individual (Aldridge, 1998; Maris et al., 2000; Cutcliffe et al, 2006). Maris (1997) advocates a biopsychosocial perspective, Rogers (2001) suggests a combined existentialist and constructivist response model, and Leenaars (2004) proposes drawing together intrapsychic and interpersonal perspectives. Nevertheless, traditional competitive posturing among theorists, researchers and professionals in the field can be clearly seen in contemporary debates. This competitiveness reinforces uni-dimensional perspectives and a disjointed and partial response model that serves to further alienate the suicidal person, as the response frequently mirrors his own sense of disintegration and confusion.

3.5 Summary

"...suicide is best defined as an event with a biological (including biochemical), psychological, interpersonal, situational, sociological, cultural, and philosophical / existential components. Each of these components can be a legitimate avenue to assessment."

(Leenaars, 2004, p. 98)

A number of theoretical perspectives on suicide-ality have been proposed, which the author has situated within the broad categories of internal and external models. Each of these models contains a number of sub-theories that emphasize unique aspects of the person and his world and provide guidance for social, moral and professional action. Each theory poses certain limitations in understanding the complex

phenomena of suicide-ality, hence, recent efforts to combine previously disparate perspectives.

Of particular relevance to this study are dominant discourses within the field of mental health, which in contemporary Ireland, reflect primarily medical and psychiatric and secondarily psychological and sociological perspectives. The former have assisted understanding of the potential contribution of biological and psychiatric aspects of the person to his suicidal crisis, while clearly more research is indicated to substantiate some of the claims made in their support (Maris et al., 2000; Rutter, 2007a). These discourses have been critiqued for excluding alternative perspectives, thereby furthering the professional, rather than the client, agenda. They also promote a narrow focus that fails to see the person holistically and within his wider historical and social context. Finally, they have been critiqued for their pathologizing effects associated with promoting paternalistic and confining attitudes and practices (Szasz, 1970).

The following chapter, and final part of the literature pre-view, explores dominant responses to suicide-ality within the field of mental health policy and practice. It also highlights challenges and barriers to change in the field, many of which are associated with the discourses outlined above.

Chapter 4. Literature Pre-View 3: Dominant Responses to Suicide-ality in Mental Health

4.1 Introduction

Suicide-ality is firmly located within the domain of mental health, which is dominated by medical and psychiatric discourses. Hence, with growing awareness of the extent and impact of suicide-ality, there have been increasing attempts to address these phenomena from such perspectives, whilst simultaneously alternative views are emerging with some force (Bracken, & Thomas, 2001). This is reflected in government policy and academic literature, of which the researcher will provide an overview in this chapter. Responses, while interrelated, incorporate those that are proactive (proposing measures at preventative levels) and those that are reactive (proposing responses at interventive and post-ventive levels). In order to highlight how services have been experienced by clients, this discussion will be interspersed with personal narratives from survivors, including those who have attempted suicide (Webb, 2002, 2003), family members of completed suicides (Sommer-Rothenberg, 1998; Simon, 2003), and professionals treating the suicidal person (Links, 2001; Ting et al., 2006; Thomyangkoon & Leenaars, 2008). The discussion will highlight complexities and confusions within the mental health practice domain and challenges inherent in addressing these issues.

4.2 Government Policy: Proactive and Reactive Responses

"Most Suicide Strategies make assumptions that are not appropriate to young men…"

(Mayor, 2000, p18)

Increased social and professional attention to the issue of suicide-ality has resulted in a corresponding increase in associated policy literature in many countries (Scottish executive, 2002; DOH 2005), including Ireland (DoHC, 2001; NOSP, 2005). These policy documents have highlighted suicide as a major cause of death, identified particularly high rates of suicide-ality among certain sub-groups, and noted the connection between mental ill-health and suicide-ality. They also have acknowledged the ripple effect of suicide on families, peers and communities, emphasized the need

to address these issues at multiple levels, and have set targets for the reduction of suicide and suicidal behaviour (NOSP, 2005; 2007). In addition to and influenced by social and moral discourses, government policy has established a framework for social and professional response, which is briefly outlined below.

The Irish National Health Strategy *Quality and Fairness: A Health System For You* (DoHC, 2002), reflects international approaches to health promotion and illness reduction. It provides guiding principles and goals for quality health service delivery which commits to promoting, protecting and improving health, reducing premature mortality, and intensifying responses at multiple levels and across a number of domains. Within mental health it proposes that: particular attention be paid to improving pre-discharge and transfer planning between services and health personnel in order to address the high suicide rate among recently discharged patients, basic suicide awareness training programmes and on-going support mechanisms for mental health practitioners be planned and delivered to address skill and knowledge deficits, and standardized systems for investigating and reporting in-patient suicides be developed and implemented. It also proposes that specialist response teams and interventions across community and hospital domains be delivered and evaluated, effective responses be developed for people who present with DSH, and that strategies be designed to connect with those who self-harm but do not come to professional attention.

The Mental Health Act (DoHC, 2001) provides a legislative framework for mental health services, while the mental health service strategy, *A Vision for Change* (2006), sets out a framework for mental health services in Ireland. This policy was developed based on the core values of: promoting a person-centred and recovery approach, delivering services by skilled professionals, and providing interventions based on best practice in a specific area. It highlights the importance of local and national systems to monitor service developments, ensure service equity, and evaluate the performance of practitioners. The *Quality Framework for Mental Health Services in Ireland* (MHC, 2006, p.7) "*…provides a mechanism for services to continuously improve the quality of mental health services*", also emphasizing the need for on-going evaluation of service provision.

These values and goals are reflected in the *National Strategy for Suicide Prevention - Reach Out* (NOSP, 2005), which promotes post-vention responses, information sharing and research, and sets out two key interlinked approaches to suicide-ality, at general population and targeted levels. The general population response aims to "*…promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population"* (NOSP, 2005, p.20). This response level incorporates: awareness raising and stigma reduction, responsible media reporting, support structures for family, schools and workplaces, training for professional and non-professional groups and partnership building. The targeted approach, aims to "*…reduce the risk of suicidal behaviour among high risk groups and vulnerable people"* (NOSP, 2005, p.33). This response level incorporates a range of specifically designed action plans for developing and resourcing effective health service responses for people who present with any form of suicidality and for reaching out to those who pose a suicidal risk but are reluctant to access, or engage with traditional services and support systems. This document identifies two priority strategic goals: promoting relevant research and education in order to enhance professional knowledge and skills, and improving suicide and DSH reporting processes and procedures.

In summary, policy documents on mental health and suicide-ality aspire to uphold well recognised international values and protocols for best practice in the field. They have been welcomed in the main by mental health practitioners and service users alike as they promote individually tailored, respectful and collaborative practices. However, there has been much critique of how they have failed in terms of delivery due to inadequate resourcing and training, and poor levels of monitoring within the health care system in general and mental health in particular (DoHC, 2009). Hence, it can be hypothesized that there remains an epistemological gap between policy and practice as to date these aims have only been achieved partially.

4.3 The Approach: Prevention, intervention and post-vention

Three key inter-related health response foci have been identified: prevention, intervention and post-vention. Within general medicine there has been a shift in emphasis from prevention in the 19th century, to intervention (care and treatment) in

the 20th century, and a return to prevention in recent times. This latter shift reflects the identification of important contributing factors to disease which can be reduced or prevented, thereby controlling prevalence rates of many illnesses, impacting significantly on morbidity and mortality rates (Paykel & Jenkins, 1994).

Developments in prevention in mental health have been slower and more tentative. Specific challenges posed in establishing preventative and intervention measures centre on defining the boundary between pre-disorder and disorder which is difficult as these are usually based on the degree to which a symptom is present rather than difference among symptoms, raising questions about the benefits of early screening and detection in terms of health and cost-effectiveness. Additional challenges include variations in definition of illnesses that are amenable to intervention, difficulty identifying precise causality factors, and developing the right intervention (Paykel & Jenkins, 1994). Multi-factorial causation in psychiatric / psychological problems means developing response measures that address a range of related issues rather than a single specific issue, and given the recurrent nature of some psychological / psychiatric problems, making a distinction between prevention and intervention is difficult as these may overlap and complement each other (Paykel & Jenkins, 1994). Furthermore, the overall approach taken may focus on positive mental health / well-being, or treatment of problems. This is a crucial distinction in terms of whether a specific issue falls within the public health or mental health domain, despite recent efforts in Ireland to make these more seamless.

Paykel and Jenkins (1994, p.7) identify suicidal behaviour as one of the few areas that *"…can respond to improvements in psychiatric services*". This they attribute to the dominance of precipitating factors which are known and easier to modify than pre-disposing factors, the appropriateness of targeted response measures which are more successful as they aim to modify specific micro (mental health services) rather than macro (society) environments, and amenability to a multidisciplinary and multiple domain approach that enhances continuity of and coherence in care provided. However, conceptual and practice inconsistencies with the suicidal person have been identified (Gibbs, 1990; Cutcliffe & Stevenson, 2008). This is perhaps due to the assumption that suicidality is a more straightforward phenomenon, as suggested by Paykel and Jenkins (1994), in terms of clear causality and micro response initiatives

and that multidisciplinary work actually happens. Thus, challenges in establishing responses across the prevention-intervention and primary-mental health care boundaries, and ones that are relevant along the entire suicidality severity spectrum require consideration.

In recent years the dominant focus in the area of suicide-ality policy and practice has been on *prevention*, which is viewed as a community or primary level response that focuses on healthy living and well-being in the general population and early intervention for low risk groups and unidentified individuals (NOSP, 2005). Preventative strategies seek to reduce the stigma associated with suicide, promote suicide awareness, increase help-seeking behaviours and access to helping services, and control access to popular suicide methods. Prevention has been critiqued as upholding the modernist moralistic perspective that suicide-ality should and can be eliminated or at least radically reduced. Furthermore, this approach has been critiqued as simplistic (Szasz, 1986). Despite general agreement that opportunity factors are linked to suicide and attempted suicide rates, debate exists about the effectiveness of environmental control measures. Stack (1998) argues that many of the studies that examined environmental control initiatives were methodologically unsound, failing to account for control variables and the displacement effect of these initiatives. Therefore, he suggests that when common methods, such as firearms, are restricted, it is not always clear whether there is concurrent increase in the use of alternative methods.

Intervention refers to actions initiated during and following a suicidal crisis, specifically targeted responses designed at secondary and tertiary levels of care that aim to protect life and sometimes have the additional goal of reducing or eliminating the cause of suicidality. Fairbairn (1995) describes three approaches to intervention: discursive, persuasive and coercive. Discussion describes a neutral intervention with open dialogue that maximizes autonomy. Persuasion involves attempts to dissuade the person from suicide, while coercion involves active attempts to prevent the person from acting upon his suicidal wish. The emphasis in intervention to date has mirrored the modernist yearning to control suicidality, reflecting a coercive and at best a persuasive approach, for example emphasizing risk assessment and containment (Leenaars, 2004; Cutcliffe et al., 2006).

Weiss (2001) is critical of the lack of empirical evidence supporting many commonly used intervention strategies, such as "no suicide contracts". While a number of studies have examined the efficacy and effectiveness of interventions following self destructive acts, the findings are somewhat disparate. It has been proposed that pharmacology is effective in lowering suicide rates in people with depression (Verkes & Cowan, 2000), and the long-term use of lithium is deemed effective for people with mood disorders (Burgess, 2002). However, Hawton et al. (2002b) conducted a Randomized Control Trial (RCT) of psychosocial and psychopharmacological treatment versus treatment as usual (TAU) of aftercare following self-harm. They concluded that although there was a trend towards reduced repetition of DSH for problem-solving therapy, emergency contact cards, intense aftercare and outreach, and antidepressant treatment, considerable uncertainty remains about which form of psychosocial or psychopharmacological interventions are most effective. A contemporary controversy in the field surrounds the place of antidepressant medications in both preventing and increasing the risk of suicide, particularly the use of Selective Serotonin Re-uptake Inhibitor's (SSRIs) in young people (Qin et al., 2005). Hence, pharmacological treatments of suicidality require further examination.

Specific reviews of psychosocial interventions indicate similar discrepancies. It is proposed that some progress has been made with interventions designed to enhance problem-solving strategies and reduce hopelessness, and specific intervention programmes for people with a diagnosis of borderline personality disorder (BPD) (Links et al., 2003), and for those with repeated suicide attempts (Heard, 2003; Bergmans et al., 2007). Heard (2003) argues that a problem-solving approach combined with intensive outreach care offers the best opportunity for effective treatment. However, Crawford et al. (2007) conducted a meta-analysis of RCTs of psychosocial interventions following self-harm and concluded that there was no evidence that such interventions have a marked effect on the likelihood of subsequent suicide. They noted methodological limitations in the studies involved and the importance of taking account of clinical as well as statistical significance when using small samples and examining rare phenomena. The above brief overview could be said to reflect the divisions between philosophical approaches that favour hard versus soft evidence rather than providing clear evidence of intervention effectiveness.

Therefore, it seems that there is much scope for work that examines the specific elements of the various interventions that impact suicidality.

The term *post-vention* has been used to describe responses to the event of suicide. These incorporate a range of support, counselling and treatment interventions for survivors of the deceased, family, friends, peers and communities (Westefeld et al., 2000). Post-vention strategies have been described as preventive in their capacity to reduce suicides among the bereaved (Campbell, 2008). Post-vention responses are targeted at two levels: crisis intervention to help and support the survivor(s) following discovery of a body or notification of death, and longer-term help with the grieving process, such as group, family or individual psycho-educational and psychosocial interventions (Grad, 2005). Services for suicide survivors are limited in many countries and have only recently thrived in countries that *"…officially recognize the problem"* (Grad, 2005, p.356), with a fourfold increase from 1997 to 2005 when seventeen countries had some services available. However, even in countries where survivor movements are active, it is estimated that only one quarter of those bereaved by suicide seek help. There are many possible reasons for this trend, such as the survivor feeling that s / he does not need or deserve help, uncertainty about the kind of help that is available and / or fear of the impact of help (Grad, 2005). Such initiatives are in their infancy in Ireland and while welcomed in some contexts (Begley & Quayle, 2007), have also been critiqued for further stigmatizing suicide and pathologizing survivors by placing such services within the domain of mental health (Walter, 2005). Hence, it seems that the bereaved experience similar challenges to the suicidal person in terms of exclusion and marginalisation when it comes to seeking support.

In summary, responses to suicide-ality have been targeted at different levels, from prevention to post-vention. There is overlap across these response levels, highlighting the complexity in responding to suicide-ality. There is also much debate about the effectiveness of such responses, such as psychopharmacological and psychosocial interventions. Hence, there is a need for further evaluation and perhaps creativity in combining disparate responses.

4.4 Mental Health Services and Practices

"The current care emphasis for this client group can be described as 'defensive', 'observation led' and short term."

(Cutcliffe et al., 2006, p.792)

Although it has been argued that suicide-ality is not a mental health problem per se, mental health professionals generally accept that suicide-ality is a relevant issue that warrants professional attention. This view is reflected across disciplines in, for example, psychiatry (Stoff & Mann, 1997), psychology (O'Connor & Sheehy, 2001; Williams et al., 2005), psychotherapy (Leenaars, 2004), social work (Ting et al., 2006), and psychiatric / mental health nursing (Cutcliffe & Stevenson, 2007). While each of these professional groups supports a sub-discourse that articulates a slightly different version of suicide-ality, all share a beginning premise that suicide-ality belongs to some extent within the domain of mental health, which may inadvertently support *"…an ontology of pathology"* (Marsh, 2008, p.35). Analysis of the assumptions and practices surrounding suicide-ality in the Western world, suggests that particular regimes of truth locating suicide-ality within mental ill-health inevitably incorporate and operationalize certain power relations and truth effects that objectify the suicidal person. This becomes possible through dividing practices such as separation of sick and healthy and the mad and sane (Szasz, 1970; Marsh, 2008). Hazelton (1999) suggests that mental health settings have become containers of danger, security and risk, which can be understood in terms of the fear, anxiety and apprehension associated with mental ill-health and suicide-ality, including among mental health practitioners (Gibbs, 1990; Toth et al., 2007). Nevertheless, despite this debate a range of services has been developed over time within the mental health arena to respond to suicide-ality. These are delivered by different professional groups, in different treatment / therapeutic settings, and are supported by statutory and voluntary agencies. Hence, debates about locating suicide-ality within mental health seem to be academic, impacting minimally on actual practice in many countries.

Nevertheless, while a number of suicidal people enter the mental health services, it is important to note that the initial point of contact for the suicidal person is frequently at primary care GP and ED service level, and many more do not have any contact

with health care systems. It has been suggested that the initial care received by individuals who engage in suicidal behaviour has the potential to influence profoundly their help-seeking pathway, which directly impacts future episodes of suicidal behaviour and completed suicide (Hemmings, 1999; Strike et al., 2006). Negative staff attitudes at initial contact, such as lack of sympathy and motivation to help, can set the scene for future expectations of professionals and services, and consequently the patient's disposition toward professional staff. This in turn can influence the response of professionals who may interpret patient frustration and scepticism about treatment credibility as resistance, perpetuating a negative cycle of interaction. Hence, there is a need to build rapport that enhances therapeutic possibilities (Gibbs, 1990). It is noteworthy that 13% of patients self-discharged from Irish EDs in 2004, and negative staff attitudes have been shown to be directly related to self-discharge rates (Barr, 2004). While it is beyond the scope of this study to comment in detail on response levels at primary care levels, some tentative links will be made between the experiences of patients and patterns of professional response, outside and within mental health services, as highlighted by this study.

Professional Attitudes

"[The] groups with the most adverse attitudes to those with mental illness are...their treating staff, those who gate keep the facilities and services dealing with mental illness."

(Joyce et al., 2007, p.374)

Attitudes towards suicide-ality vary hugely among mental health professionals, depending on a range of personal and contextual variables. Professional attitudes profoundly influence care processes and practices, therefore a broad overview of some of the literature that examines this relationship is explored. The literature suggests that suicidal patients evoke uneasiness and negative attitudes among staff involved in their care (Gibbs, 1990; Links, 2001; Ting et al., 2006), and that these stresses are managed by various coping and defence mechanisms (Hale, 1997). These defences generally serve to protect the professional and allow her to continue with work. However, occasionally they fail or become excessive leading to ill health and / or poor practice, and they seldom benefit the client (Hale, 1997).

Hale (1997, p.254), drawing on the work of Isobel Menzes, suggests that professionals *"...build defensive structures both at an individual and institutional level",* such as, medicalizing or intellectualizing problems and sustaining patient-unfriendly routines. A study by Talseth et al. (1999, p1035) showed that "*...nurses avoided the subject*" of suicide, and that they showed "*…a considerable incidence of non-sympathetic attitudes*". Gibbs (1990) suggests that professionals may avoid communication with the suicidal person by rationalizing this. For example, by believing that the person is too distressed to talk about their situation or that talking might reinforce their distress, thereby increasing the suicidal person's level of isolation. Samuelsson et al. (1997) similarly hypothesize that avoiding close contact with the suicidal patient might shield nurses, who are uncertain about how to respond, from the emotional stress evoked in encountering such patients, while unfortunately also de-legitimizing the patients pain. These authors note that a high proportion of suicide survivors voiced complaints about the psychiatric care provided to their deceased relatives, citing in particular hostile attitudes of caregivers and failure to take the suicidal behaviour seriously. Joiner (2005), reflecting on his own experience following the suicide of a family member, comments on how ill-equipped his professional colleagues were to respond, perhaps based on their fear of the subject and subsequent desire to intellectualise it. Mehlum (2005) suggests that issues associated with suicide-ality, such as childhood sexual abuse (CSA), are frequently overlooked due to the stigma associated with these taboo subjects, hence, the trauma that may have precipitated or exacerbated the person's suicidal crisis remains unexplored and unresolved. It appears that professionals, in an effort to protect themselves from the discomfort associated with the issue of suicide-ality and some of the disturbing events that might surround this, perpetuate the silence that characterizes the topic, further alienating the suicidal person.

The terminology and connotations associated with suicide-ality may add to practitioner ambivalence, for example, debate regarding real intent conjures notions of insincerity and manipulation on the part of one whose goal is not death. This is reflected in and perpetuates the use of terms such as "attempters" and "cutters" that objectify the person and lead to breakdown in dialogue (Gibbs, 1990). Ambivalence towards the suicidal person can also be understood as his contravening the drive of self-preservation, which directly challenges the practitioner's drive to save lives

(McAllister, 2003). Samuelsson et al. (2000, p.636) note the dilemma for professionals associated with *"...balancing the right to control one's own destiny, the value of saving human lives and the insecurity that this dilemma may engender."* Such challenges may explain the parallel responses of health professionals and bereaved family members in the aftermath of suicide, in terms of felt rejection, hurt and anger (Buie, 1996; Links, 2001; Thomyangkon & Leenaars, 2008).

Another important issue concerns expectations of practitioners to be professional, which sometimes means being non-involved and devoid of emotional response. Vetere and Cooper (2003) demonstrate this in recounting feedback they received from a professional group following a presentation on domestic violence. It was suggested that it is unprofessional to express emotional distress about the clients trauma and suffering, which they interpreted as an invitation to occupy a more objective position vis a vis the client presenting with a taboo issue. Thus, there is a paradox for the professional in speaking about the unspeakable to clients and colleagues, being simultaneously present with and distant from the client, and being both objective and reflective about their own practice.

It is interesting to note that a critical issue in the field of mental health centres on inadequate acknowledgement of and preparation for professionals dealing with the issue of suicide-ality, despite recognition of the frequency with which such issues arise in practice (Maris et al., 2000). Two prominent psychiatrists in the US, Maltsberger and Goldblatt (1996), are critical of the limited training for psychiatrists which is primarily focused on a biological model, with emphasis on diagnosis of psychiatric illness at the expense of understanding individual anguish. From a social work perspective, Ting et al. (2006) argue that mental health social workers are inadequately prepared for dealing with suicidal clients and the aftermath of suicide. Cutcliffe and Stevenson (2007) are critical of psychiatric / mental health nurse training and on-going education, as it lacks adequate attention to the interpersonal process between the nurse and suicidal patient and promotes custodial practices. It has also been argued that psychotherapists are not adequately trained to work with the suicidal person and are not prepared for the possibility of suicide, leading to strong feelings of grief and a sense of failure as a professional (Pope & Vasquez, 2007).

In light of these practice concerns, some recommendations have been made. Pope and Vasquez (2007) suggest that professionals need to be alert to negative responses that may be aroused toward the client in order to avoid harmful action, such as conveying inability to work with the issue of suicide-ality. They advocate familiarity with risk and protective factors, and an understanding that these provide only a guide and need to be considered thoughtfully, as factors and profiles of at risk groups are changing rapidly and no list is exhaustive. Samuelsson et al. (2000) conclude that working with the suicidal person can be challenging and stressful, and nurses need on-going professional development opportunities to up-skill, update their knowledge base and manage the stress associated with this work. Cutcliffe and Stevenson (2007) also acknowledge the stress associated with caring for the suicidal person and suggest that nurses working in such environments engage in clinical supervision and be provided with formal restorative support structures to enable them to develop the therapeutic skills, knowledge and attitudes necessary for this highly demanding work. Being prepared for the inevitability of suicide-ality in the course of one's work (Hawton, 1994; Links, 2001) and being able to respond constructively in its aftermath (Toth et al., 2006), have also been identified as important professional skills across disciplines. Hence, it can be seen that there are a number of challenges associated with working with the suicidal person and his relatives that have come to the attention of those in the field. However, addressing these concerns seems to be a delicate matter given the complexity of the issues involved and the competing demands that are made on the professional.

It is worthwhile noting that the Samaritans, a community response established to befriend and listen to the *"suicidal and despairing"*, which may sound simplistic or tepid in comparison with more sophisticated professional responses, *"...demonstrates a human power akin to a steamroller"* (Varah 1973, p.169). It could be hypothesised that the professional finds herself in a place of contradiction and confusion when dealing with suicide-ality, and desiring clarity, becomes embroiled in complexity, thereby missing opportunities for simple human engagement. In a similar vein, Joiner (2005) suggests that natural humanity can be hampered by an inclination to grasp the issue intellectually. Hence, while further education, training and support may well be indicated, simple humane gestures should not be overshadowed in favour of more elaborate strategies, and clearly there is scope for both.

Finally, it is interesting to consider how unrealistic some professional expectations may be in relation to the suicidal client. There is widespread recognition of the importance of variables such as client expectations and treatment congruence on the engagement process and outcome of therapy / treatment (Hubble et al., 1999). However, it has been suggested that such factors are undervalued and ill considered when contracting for treatment (Greenberg et al., 2005), resulting in a misfit between practitioner and client expectations. There are also some additional subtle challenges inherent in establishing congruent practitioner-client expectations when working with the suicidal person. For example, given the centrality of hopelessness and helplessness in the suicidal experience (Beck et al., 1975; Williams et al., 2005), the issue of enhancing positive prognostic expectancy is somewhat daunting, as hope that change is possible and a belief that one can influence the course of treatment, and ultimately one's life, appear to be foreign concepts to the suicidal person. Therefore, time spent negotiating treatment expectations and responsibilities and examining practices that actively deter engagement may be worthwhile. For example, routine referral, follow up and discharge procedures that do not adequately consider individual concerns and challenges, may be addressed through individually tailored and focused practices. Additionally, those who may be particularly vulnerable, such as those recently discharged from hospital, those failing to take up initial therapy / treatment appointments, and those who drop out of therapy / treatment could benefit from more assertive outreach (Ryan & Morgan, 2004). Hence, it seems that attention to these practice issues in training and education might well be useful in bringing about more debate in relation to client safety and autonomy, practitioner safety and dignity, and the power relations that influence professional responses and client engagement.

Client Experiences

"This lack of confirmation, together with not being seen, made patients feel like objects which had been stored away. After a while patients felt empty and infringed on, hopelessness grew in them as they felt redundant as human beings."

(Talseth et al., 1999, p.1039)

There is a small but growing literature that focuses on the suicidal person's experience of professional treatment. These studies have identified helpful and

unhelpful practices at primary, secondary and tertiary levels of intervention. Within mental health much criticism has been levelled at professionals working in the field and the practices in which they routinely engage, many of which have been described as outdated and indeed inhumane (Barker et al., 1999; Samuelsson et al., 2000; O'Donovan, 2007).

A study by Talseth et al. (1999, p.1035) exploring suicidal patients' experiences of care by mental health nurses, reported that patients *"...expressed feelings of isolation through lack of communication with professional staff."* The views of suicidal patients in a specialized in-patient psychiatric unit were explored by Samuelsson et al. (2000). It emerged that being identified and treated as a psychiatric patient engendered ambivalent feelings of shame and relief, and that patients held contradictory perceptions of care and caregivers. Positive responses were described as caring, competent, committed, respectful and individualized care, that engendered feelings of security, and being understood, well cared for and confirmed. These practices were viewed as essential for the healing process and in enhancing a desire to live. Negative experiences included hostility, indifference, exclusion, exposure, one way care and paternalistic control that engendered feelings of isolation, being burdensome, and being unsafe which lead to demands for discharge and further suicidal behaviours. The study also highlighted that care experiences made hospitalization a critical incident for living. While the views expressed by participants in this study were primarily positive this may have been influenced by the treatment / care context, which was a specialized facility with staff well trained in the care of the suicidal person (Samuelsson et al., 2000). A report commissioned by the Mental Health Commission (MHC) Ireland, that explored service users' experiences of mental health services, echoed similar concerns (Dunne, 2006). This report recommends that professionals demonstrate more open communication and interested engagement with patients (Dunne, 2006). This view is supported by others who are critical of custodial and defensive practices that preclude or contaminate engagement with the suicidal person (Cutcliffe et al., 2006).

Paternalistic practices advocate a one-way-care approach which fails to acknowledge and enact the mutuality of social connectedness and may reinforce feelings of inferiority and isolation. Bille-Brahe et al. (1999) emphasize the mutual nature of

social integration and support, particularly among men. This is viewed as a reciprocal rather than linear process, whereby there is a fit between what others perceive themselves to be providing in terms of social support and how the individual perceives and experiences this. Hence, the importance of negotiating expectations and boundaries is further endorsed. Another dimension of mutuality theory is that the individual not only needs to feel that he is the recipient of support but that he is also able to contribute in a meaningful way to social relationships, thereby helping others in addition to being helped. This suggests that people, and perhaps men in particular, are attracted to therapeutic activities that involve equality and reciprocity in relationship. Hence, attending to individual and gender related factors may be useful in advancing practice with the suicidal person, thereby addressing some of the criticisms outlined above and redressing some of the predominantly negative mental health practices outlined below.

In summary, it is interesting to note that both professionals and clients have highlighted similar concerns in relation to care of the suicidal person. However, despite efforts to address areas of concern over some considerable time, little has changed in terms of social and professional practice. This kind of impasse has rendered the suicidal person, and those associated with him, powerless to address their personal circumstances and seems to have overshadowed the issues underpinning such practices, thereby compromising patient autonomy and professional dignity.

4.5 Dominant Practices: Containment and Control

"This formulation of suicide as a concern of medicine did not just allow for the introduction of repressive technologies of containment and restraint, but was also productive in that it enabled the accumulation of knowledge and the development of theories as to causation, treatment and cure of suicidal states."

(Marsh, 2008, p127-128)

In the literature, common practices within mental health have been critiqued for the lack of empirical evidence supporting their use (Weiss, 2001), and for their counter-therapeutic effects (O'Donovan, 2007). Such practices have their historical origins in fears of mental illness and suicide-ality reflected in the growth of the asylum in the

eighteenth and nineteenth centuries. In a sort of circular fashion, suicide became established as a dangerous act, in terms of self-danger, its association with homicide, and its hereditary and contagion effects. This made suicide-ality a matter of public as well as individual safety, thereby legitimizing custodial practices reflected in observation, examination and classification, reinforcing the need for specialist practitioners to treat the suicidal person. Despite alternative perspectives, medical and psychiatric discourses remain strong and are reflected in wider society, for example, in media reports (Cullen, 2006), government documents and strategy (White, 1995), professional literature (O'Donovan, 2007), and the law (DoHC, 2001). Suicide is currently frequently represented as a tragic act associated with mental instability, and the suicidal person portrayed as distressed and driven by some internalized torment, perhaps complicated by biochemical and social factors. Mental health practitioners influenced by, and in turn influencing, prevailing social and professional discourses frequently draw upon this pathological version of suicide-ality, reinforcing the reality of sick patients and expert professionals and providing a rationale for professional interventions underpinned by control (Barker et al., 1999; Mac Gabhann, 2008). However, while there has been much critique of well established traditional attitudes and clinical practices, it seems that these have not being replaced by, but sit alongside, contemporary approaches. Hence, it is important to examine in more detail some dominant practices and critique their on-going use, which is done in this text relation to the exercise of power.

Power

The concept of power has been described in two key ways: as a possession or entity that defines one's status in hierarchical terms in relation to another, and as an active relational phenomenon or status differential that comes into play in relationship and is negotiated and constructed in momentary interactions (Inger & Inger, 1994). While the former understanding portrays a view of power as fixed, the latter perspective suggests that power can be understood as a network of social boundaries that enable or constrain social action. The latter is attractive in terms of opening possibilities to rebalance power differentials in everyday action and interaction with others. However, it must be acknowledged that power is experienced as very real to those who are disempowered, frequently rendering them unable to challenge hierarchical

structures. Hence, there is a need to challenge the practice of power misuse with, and if necessary for, those who are unable to do this themselves.

Roberts (2005, p.36), using a Foucaultian analysis, critiques the exercise of power within contemporary mental health. He argues that the misuse of power promotes panopticism, visibility and scrutiny, whereby the professional and patient become instruments of social and moral control. However, moving beyond such constraints can be viewed as risky, as it requires one to challenge some of the social conventions and cultural prescriptions within which the professional self is embedded (Inger & Inger, 1994; Hazelton, 1999). Some practices that exemplify the misuse of power in the mental health arena are briefly discussed below.

Labelling

Most descriptions of ill-health emphasize the pathology that sets the unwell apart from others, the well, with treatment focused on creating conditions for change toward the norm (Linehan, 1993), in order to enhance "reality adaptation" (Lazarus, 1983). This tradition relies heavily on accurate categorization of the individual in order to plan appropriate treatment, so there is a predominant focus on diagnosis. While diagnostic labelling is a convenient short-hand mechanism of communication among professionals, attention has been drawn to its productive power (Inger & Inger 1994; Roberts, 2005). This includes promoting pathologizing identities (Roberts, 2005), and exclusion of those who do not understand professional jargon (Inger & Inger, 1994), thereby establishing a power hierarchy between the professional, client and lay community which has been described as a political move to reinforce societal hierarchies (Aldridge, 1998). Stripping away personal identity and replacing it with a patient identity or subjectivity can be experienced as abusive as the professional assumes a superior status to another and labels him as if he has no control over this process. The health disciplines have been critiqued for their over-reliance on pathologizing labelling which fits information into pre-existing categories that represent dominant constructions of reality (Inger & Inger, 1994). Indeed, Webb (2002) likens his experience of being labelled to being made invisible, which he claims objectified him and further perpetuated his silence around suicide. When bound up in professional jargon and other forms of categorical thinking, interpretation

and explanation, practitioner creativity and spontaneity can also be constrained (Inger & Inger, 1994).

Some efforts have been made to redress the negative effects of labelling through language change. For example, Dunleavey (1992) refers to the psychiatrically distressed as opposed to the psychiatrically ill, suggesting that this distinction fosters a more responsible attitude in practitioners. Similarly, Isaacson and Rich (2001) describe DSH as a behaviour not an illness, however, they support the view that treatment must begin with a formal psychiatric evaluation. Hence, the limiting and potentially detrimental influence that diagnostic labelling may have on client experience and practitioner beliefs, suggests that mental health practitioners may need to more critically review the language associated with psychiatric / mental health services. It also suggests that the long-held tradition of relying on accurate diagnosis to direct response may need to be reviewed to enhance creative and individualized care (Moss, 1988; Barker et al., 1999).

Psychopharmacology

Treatment responses based on the bio-medical model rely heavily on medical interventions, primarily psychopharmacology, which has been viewed as another potential form of power misuse in relation to informed consent and physical restraint. While side-effects of medications are well known this information is frequently withheld from the patient in the fear that it will compromise compliance, while also compromising informed consent. The use of medication has also been criticized as a convenient way to control the person psychologically and physically due to its subduing effects.

Psychopharmacology has also been critiqued as an inadequate response to the distressed person and for its serious and enduring side-effects which directly affect the person in his daily living and impact his future life. Short-term medication regimes, while sometimes useful in helping the person gain a sense of control in his life, have been critiqued for being over-used, with lack of review of their effectiveness (Lakeman & Cutcliffe, 2009). Psychopharmacology is frequently a life-long regime, particularly in the case of serious mental illness and long-term negative effects

include intellectual impairment, abnormal motor functioning and shortened life expectancy among others.

Assessing Suicide Risk

"...suicide risk assessment may well be the most complex task that psychiatrists, psychologists and other mental health professionals face. If we are to confront this complexity, we will see that assessment and prediction are interwoven with understanding."

(Leenaars, 2004, p.93)

It has been suggested that a shift in clinical focus has taken place in relation to suicide-ality, from prediction in the 1960s and 1970s, whereby it was believed possible to identify individuals who would ultimately complete suicide or predict the future occurrence of completed suicide, to assessment in the 1980s and 1990s, whereby the intent was to assess potentially suicidal persons in a more holistic way (Leenaars, 2004). Indeed Bertolote et al. (2004) suggest that it may be impossible to predict suicide even among identified high risk groups of patients due to individual uniqueness in presentation, the complexity of suicide, and the low base rates of completed suicide. Battin (1994), noting the lack of absolute reliability and sensitivity of predictive measures, draws attention to the moral implications of inaccurate suicide assessment practices in promoting patient coercion. False positives may lead to unjustified constraining practices while false negatives may be misleading in terms of patient safety and support needs, raising questions about the justification of restrictive practices in both instances.

Assessment of the suicidal person has gained much attention in the literature, however, despite these shifts in assessment focus, in practice it continues to centre primarily on risk containment and multiple ways of enhancing this practice have been proposed. Some of these proposals challenge the approach to assessment as a task carried out on one person by another, promoting instead a view of assessment as collaborative process, thereby challenging the inherent power assumptions underpinning the former (Anderson, 1997). Key recommendations that enhance the assessment process include: combining clinical assessment based on clinical expertise and judgment with standardized psychometric tests and structured models (Anderson,

1997), and adopting a basic nomenclature to guide holistic assessment (Silverman et al., 2007a, 2007b). This means incorporating multiple aspects of the persons concerns and life, such as the nature of the suicidal act, medical lethality, intent and motivation, history of suicidality and previous attempts, current living circumstances, and risk and protective factors (Leenaars, 2004; Rudd, 2006; Silverman et al., 2007a, 2007b). Neglected areas of suicide assessment have also been highlighted, for example: making a clear distinction between acute and chronic risk, as most clinicians focus on acute risk and fail to address the needs of people who pose a continuing suicide risk (Rudd, 2006), and incorporating exploration of life stresses with the suicidal person which is frequently overlooked in favour of more recent precipitating events (Grad, 2005). It is also proposed that assessment of suicide risk be viewed as an on-going and complex interactional process, rather than an isolated interaction at initial contact, that is at best a *"…very inexact art"* (Anderson, 1997, p.98).

No-harm / No-suicide contracts

No-harm / no-suicide contracts are terms that are used interchangeably in the literature to describe a verbal or written agreement between a client and a health professional to refrain from self-destructive behaviours. They are intended to prevent self-harm or suicide (O'Donovan, 2007). While some benefits have been reported in the use of such contacts as a useful prevention strategy in the context of a good therapeutic relationship, there has been much critique of practitioner over-reliance on contracts as they are considered ineffective in preventing self-harm in a considerable number of cases (Weiss, 2001; O'Donovan, 2007). Interestingly, in contrast to no-harm contracts, harm-reduction programmes have been introduced that allow the person to harm themselves in a safer manner. These programmes are reported to work well for some individuals as an interim measure in self-harm reduction, particularly in the context of repeated DSH (Shaw, 2009). However, such practices have also been viewed with scepticism in view of the medico-legal risks associated with allowing patients to self-harm. Hence, the tension between prescriptive control and collaboration in this area remains high.

Physical Confinement

Multiple forms of physical confinement have been developed to ensure physical safety of the suicidal person; these have been strongly criticized over time as the

ultimate form of enforcing power over the suicidal individual (Szasz, 1970). Nevertheless the use of such practices continues and has been justified in terms of medico-legal responsibility and moral duty of care. Extended institutional confinement, whilst less readily available in today's restricted economic climate, has been criticized for its disruption to social networks, marginalization of the individual, stigmatizing and discriminatory connotation, and social consequences such as poverty, which frequently accompanies the hospitalization process (Maris et al., 2000). While extended incarceration is not always the norm for the suicidal person, other forms of containment are common. The terms special, close, formal, and continuous observation are used interchangeably in the literature to describe the practice of maintaining close physical proximity with the suicidal person. This is a common practice in mental health settings and is sometimes accompanied by practices such as removing potentially harmful objects and keeping the person in bedclothes (O'Donovan, 2007).

O'Donovan (2007) undertook a study in two acute psychiatric in-patient units in Ireland examining the strategies used by mental health nurses in working with self-harming populations. She found that in addition to the use of observation, confinement practices and threats of negative consequences for self-harm, nurses engaged in distraction strategies, such as physical activity with the patient, and used various therapeutic techniques to reduce stress and enhance personal coping skills and well-being. She also found that the practices used, the practitioner's motivations for their use, the way that decisions were made about their use, and practitioner understanding of and approach to therapeutic interaction varied within and across both settings. She concluded that responses to the self-harming person are frequently based on pragmatic considerations, favour a medical model of care, and are reactive rather than proactive (O'Donovan, 2007). She notes that her findings are similar to those in the UK where it is recognized that there is little therapeutic input in some settings, care is fragmented and there is a lack of collaborative decision-making among different professional disciplines (O'Donovan, 2007).

Recent studies suggest that there is no consistent evidence that high levels of confinement and restriction reduce the risk of self-harm or suicide, and may indeed increase this, as the practice becomes ineffective after a period of time (O'Donovan,

2007). Furthermore, these practices can be counterproductive as they serve to increase patient isolation (O'Donovan, 2007), and can be experienced as crude and dehumanizing (Jackson & Stevenson, 1998). Thus, they have been described as outdated historical and political constructions (Cutcliffe et al., 2006; Cutcliffe & Stevenson, 2007). Critics have challenged prioritization of the physical body over other dimensions of the self, and have advocated balancing emotional and physical safety, a more participatory stance on the part of the professional (Barker, et al., 1999; Barker, 2009), deeper in-presence interpersonal relationship with the patient to reconnect him with humanity, and a move from a cure to a recovery ethos (Cutcliffe & Stevenson, 2007). Furthermore, replacing close observation with structured activities has been shown to be beneficial in improving the quality of patient care, reducing rates of self-harm and absconding, and improving staff morale (Dodd & Bowles, 2001; O'Donovan, 2007). As discussed above, while some of these more contemporary interventions show promise further studies on their effectiveness are required, and the important issue of professional training in the use of such strategies invites attention (Weiss, 2001; O'Donovan 2007).

It is suggested that practices of confinement persist because of lack of critique of underpinning paternalistic and benevolent discourses, that reflect and are reflected in a wider political and social regulatory nexus, making the professional an instrument of suicide prevention by obstructing such acts (Althaus & Hegerl, 2003; Stevenson and Cutcliffe, 2006). Interestingly, Hazelton (1999) suggests that practitioners who are overly reliant on practices of containment and surveillance lose their ability to interact therapeutically with patients. These views draw attention to the challenges inherent in changing well-established practices regardless of their usefulness.

In summary, there has been much criticism, primarily in academic circles, of dominant divisive and controlling practices that support power misuse embedded in medical / psychiatric discourses. Nevertheless, containment of the person, psychologically and / or physically, has continued to be the mainstay mental health treatment in many countries, including Ireland, with alternatives such as psychotherapeutic and non-mental health interventions less accessible (Carr, 2007). While questions have been tentatively raised about the place of suicide-ality within mental health, the responsibility for the suicidal person has been firmly embedded

within this health sector. It could be argued, however, that shifting suicide-ality into another equally limited domain would simply shift the problem, rather than perturbing the underpinning beliefs, and indeed may well perpetuate the current partial response culture if underlying values go unchallenged. Furthermore, many important areas for development have been identified within the field that could redress much of the critique of current mental health care responses. This raises questions about why such practices are slow to change and what the future holds in terms of mental health care of the suicidal person.

4.6 Summary: The Enigma of Suicide

"…there is no simple answer to the enigma of suicide; to know that the end of each individual's universe is, like the universe itself, a gigantic jigsaw puzzle of a seemingly infinite number of pieces, many of which have dropped to the floor and have been swept under the cosmic rug."

(Shneidman, 2001, p.5)

This literature pre-view has highlighted that suicide-ality has been an issue of public and private concern for some time and with a growing recognition of its extent and impact, there has been a corresponding social and political drive to address the issue (Hawton, 2005). It also highlighted the complexity and challenges associated with responding to the suicidal person within the domain of mental health. This is in part due to inadequate professional preparation underpinned by socio-political discourses of pathology and prevention that restrict practice and mirror the suicidal person's experience. However, it also suggests that there is scope to redress many of the current criticisms associated with professional responses, such as, replacing confining and controlling practices, based on power misuse, with collaborative and caring practices that are viewed as more therapeutic and humane (Barker et al., 1999; Samuelsson, 2000). Responses to the suicidal person at social, professional and political levels are intertwined and impact the person's help-seeking pathway (Maris et al., 2000), hence the need to examine wider social discourses also.

The literature review has also supported the rationale for this study by highlighting that, while much is known in the field of suicidology, in many ways suicide-ality

remains an enigma (Shneidman, 2001), perhaps due to the lack of attention to the suicidal process and person (Webb, 2002; Leenaars, 2004). It has highlighted gaps in research to date in terms of methodology, focus and perspective. In particular it has highlighted the need to gain a more in-depth and emic understanding of and theoretical base for suicide-ality. It also drew attention to the importance of examining how the field of mental health, within which suicide-ality has been firmly located, can be informed in relation to enhanced understanding in this area.

The following two chapters describe the classic GT methodology in detail and outline how this approach was used to develop a substantive theory that enhances understanding of suicide-ality among young men and can be utilized to inform mental health knowledge and practice.

Chapter 5. Method-ology: Classic Grounded Theory

5.1 Introduction

This chapter will describe the methodology utilized in this study, classic Grounded Theory (GT), and situate it within the broader domain of knowledge generation. As there are a range of accounts on where GT is positioned philosophically and on what constitutes a GT study, the particular orientation adopted for this study will be articulated. This version of GT is associated with the work of sociologist Barney Glaser (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998, 2001, 2005). An overview will be provided of the discovery and evolution of GT, and current debates in the field of GT research will be explored. The researcher's position in relation to these debates will be outlined, which guided the study process and informed the approach taken in this study to theory generation, use of knowledge, and ethics. The central tenets of the methodology and the criteria used to assess study robustness will also be elaborated.

5.2 Knowledge Generation

"For as long as can be recalled, we argued over different ways of knowing. Gods, giants and even reasonable people cannot seem to agree about the nature of reality and how we can understand it."

(Moses & Knutsen, 2007, p.1)

There are multiple ways of generating knowledge and the purpose of a particular study determines how this can be best achieved and the applicable scope of findings. This is shaped by the problem being addressed, the conceptual framework within which this is embedded, and the intended product (Kvale, 1996; Marshall & Rossman, 2006). Distinctions have been drawn between research paradigms, which are usually denoted in terms of how they relate to the philosophical questions of ontology and epistemology. These are briefly discussed by way of elaborating the place of classic GT within the domain of the philosophy of science and establishing a rationale for the use of GT in this study.

Ways of Knowing

Ontology refers to assumptions about the nature of reality, epistemology refers to what one can know about this, or the relationship between the known and the knower, and methodology refers to how one can come to know this (Moses & Knutsen, 2007). Ontological and epistemological positions have been described in different ways (Crotty, 2003). Ontological perspectives can be described on a continuum between *positivism,* a belief in a true, external and observer-independent reality, and *constructivism,* a belief in multiple observer-determined realities (Moses & Knutsen, 2007). Epistemological paradigms can be described as moving between *objectivism and subjectivism.* Objectivism refers to the belief that knowledge can be gleaned by an unbiased observer and is usually associated with a positivist ontological position. Subjectivism suggests that knowledge can be gleaned through the subjective accounts of a phenomenon and is usually associated with a constructivist ontology (Kvale, 1992; 1996; May, 2001; Crotty, 2003; Moses & Knutsen, 2007). Methodological differences are defined primarily as quantitative and qualitative approaches. Quantitative approaches are concerned with analysis of numerical data whereas qualitative approaches are concerned with analysis of the spoken, written and represented word (Todd et al., 2004).

A *positivist* orientation is generally associated with a nomothetic approach and deductive and quantitative methodologies aimed at prediction and control. A nomothetic approach refers to the discovery of general laws and is concerned with analysis at the level of groups and populations where one can make only probabilistic claims about individuals. Deduction refers to the process of generating knowledge by starting with a general proposition which is used to illuminate observations through established rules of reasoning towards explanation of single events, thereby building on accepted claims in an attempt to increase predictive understanding of a phenomenon or cause and effect relationships.

A *constructivist* orientation is generally associated with an idiographic approach, and inductive and qualitative methodologies aimed at understanding and explaining phenomena. An idiographic approach refers to description of the particulars of a situation, derived from examination of specific cases, allowing one to make specific

statements about these individual cases. Induction refers to the process of generating knowledge through building on systematic observation and analysis in an attempt to produce descriptions and meanings or greater understanding of the relationship between a phenomenon and its context, history and subjective influence (Kvale, 1996; Willig, 2001; Myers, 2003).

Quantitative studies reduce phenomena to numbers for the purpose of measurement that identify cause and effect relationships, and is concerned with prediction and control. Hence quantitative studies are generally associated with a positivist ontology and objective epistemology. *Qualitative* studies seek to gain understanding of phenomena and are generally associated with a constructivist ontology and subjectivist epistemology (Smith, 2008). It has been suggested that recognition of the unique contribution of both approaches and acknowledgement of how these approaches can be used in harmony is evolving (Kvale, 1996; Todd et al., 2004). However, there is on-going debate about the meanings of these philosophical and methodological distinctions, which perhaps highlight nuances and preferences rather than representing distinct demarcations (Myers, 2003). It is also argued that approaches can vary across studies and can be combined in a responsible and creative manner (Kvale, 1996; Todd et al., 2004). These debates have been reflected in the GT literature as elaborated throughout this chapter.

GT was developed to take a middle ground between these philosophical and methodological divides. GT proposes that reality can be discovered, however, this reality is true only for a particular study, therefore the researcher seeks to explain reality made real in the substantive area rather than seeking a real world. The GT researcher enters the field without preconception of the study outcome and draws upon theoretical frameworks following, rather than prior to, analysis. Therefore, adherence to the methodology is advised to prevent data forcing, whereby the use of theory and self inform, rather than predetermine, the analyst's lens for understanding or way of knowing. GT is primarily an inductive method, however, as theory emerges, deduction facilitates delimiting the theory. GT can incorporate an emic perspective as appropriate to the study aim. However, as analysis is concerned with identifying patterns across data rather than engaging in-depth with individual accounts extensive use of raw data in the final write up of the theory is not advocated as it

cannot adequately capture a well densified category (Glaser, 2009). GT can be utilized with both qualitative and quantitative data (Glaser & Strauss, 1967; Glaser, 1978, 1998).

Positioning Grounded Theory: Challenges and debates in grounded theory - A paradoxical methodology

"The paradox of Grounded Theory is that the researcher has scrupulously generated, without forcing, grounded theory that fits, works and is relevant."

(Glaser, 1998, p.107)

Glaser (1998) describes a central paradox in conducting a GT study which is to systematically and carefully generate a parsimonious theory that has applicable scope and that is grounded in the data, while avoiding contamination with pre-supposition. According to Glaser (1998) it is possible to transcend this paradox through a disposition of "open-mindedness", which reduces the risk of analyst pre-conception and conjecture leading to theoretical fore-closure and theory forcing, while also conceptualizing the data in an informed manner. Theory generation also requires patience as the analyst waits for the theory to emerge (Glaser, 2008). However, debates relating to these issues abound within the GT literature leading to criticism of the original methodology as positivist and objectivist and describing it as a qualitative methodology. Such debate has centred on two key interlinked areas: ontological assumptions about the meaning of discoverable theory, and epistemological assumptions about the nature of the relationship between the researcher and data, particularly in relation to pre-existing and emergent, and internal and external knowledge.

Theory discovery is it palatable?

The first criticism is concerned with issues of ontology and the idea that theory can be discovered has lead to critique of GT methodology as *positivist*, which asserts that there exists an external and discernable reality. This perspective is in keeping with a view of knowledge as external, unquestionable and static (Myers, 2003; Moses & Knutsen, 2007). From this perspective the purpose of GT is to uncover a pre-existing reality through the identification of hidden patterns that can be formulated into a valid theory (Urquhart, 2002). Consistent with movement in qualitative research, it has

been argued that a positivist perspective is redundant as it is seen to misrepresent the aims of qualitative research, which emphasize the subjective, contextual, historical and constructed nature of reality. Thus, a *constructivist* ontology, which assumes that there are multiple realities, is privileged. This critique has led to proposals to revise GT by incorporating alternative philosophical lenses that replace GT's perceived positivist perspective with postmodern, constructivist and social constructionist lenses (Annels, 1997a; Strauss & Corbin, 1998; Charmez, 2000). This is reflected by Lomborg and Kirkevold (2003, p.190) who suggest that *"...postmodern and constructivist versions of the methodology with 'nonrealist' interpretations of truth and reality are now being advanced."*

The founders of GT have implicitly addressed this issue at a number of levels over time, making the strong argument that discovery of theory is not the same as uncovering truth (Glaser & Strauss, 1967; Glaser, 1992; 1998; 2002). Firstly, they emphasize that the purpose of GT is to develop a theory that is unique to each study and as such is not replicable, as different researchers may discover different theories in the same substantive area. They also emphasize that theory should be "modifiable" in light of new information; therefore, a grounded theory is not viewed as a finalised product and can be developed for depth and endurance rather than validity (Glaser & Strauss, 1967). Finally, they argue that a GT study is a substantive theory that makes sense of the area of interest and is useful in guiding action for those most concerned with and by the particular phenomenon, thereby privileging contextual and local knowledge generation that has "fit" and "relevance" (Glaser & Strauss, 1967). Hence, Glaser (2002) argues that applying a theoretical lens to the method, such as constructivism, does not represent a remodelled version of GT methodology; rather it represents one possible philosophical lens for understanding a component of data in a GT study. Therefore, application of theoretical frames / codes following, rather than preceding, theory development is advised (Glaser, 2002).

Controlling Bias: Is it Possible?

"...one should deliberately cultivate such reflections on personal experience. Generally we suppress them, or give them the status of mere opinions...rather than looking at them as springboards to systematic theorizing."

(Glaser & Strauss, 1967, p.252)

The second criticism of GT is concerned with the issue of epistemology and GT has been critiqued for supporting an objectivist researcher stance (Charmez, 2000), reflecting concerns about bias control which has been a central issue in scientific endeavour for some time (Chalmers, 1982). While there is little argument that GT inevitably involves interaction between the researcher and the world she is studying (Glaser & Strauss, 1967; Strauss & Corbin, 1998), how this interaction influences the emerging theory remains a matter of debate in the GT literature (Annels, 1997b). Consistent with a belief that GT was founded on positivist tradition, is that it assumes an objectivist researcher stance. This holds that the world can be known through non-biased and non-involved observation, assuming the researcher enters the field devoid of personal and professional knowledge and without a research agenda (Suddaby, 2006). These criticisms have been made on the basis of GT's perceived attempt to separate the researcher from self-knowledge and other-knowledge, particularly literature in the substantive area.

In relation to self-knowledge, two extreme suggestions for how to understand and manage this dilemma have been proposed in the world of research, each of which emerged from different ontological and epistemological positions. Some suggest *bracketing*, or closing off, prior knowledge to avoid researcher contamination of data, a position that reflects a positivist objective-observer approach. Others advocate that a *constructivist* epistemological position is adopted that explicitly acknowledges and incorporates researcher bias, through a process of *reflexivity* (Steier, 1993; Willig, 2001). The latter is consistent with evolving trends in qualitative research in recent years and consequently has dominated this debate as GT has been described as a qualitative method. However, this proposal has been refuted on the basis that the systematic analytic method transgresses dichotomies and researcher bias by viewing all information as data and subjecting it to the rigours of the constant comparative analytic method, thereby, incorporating but nevertheless controlling bias (Glaser & Strauss, 1967; Glaser, 1998).

Other authors have also suggested that, in GT, researcher bias is acknowledged, incorporated and relied upon to bring forth new data, whilst operating from a "not-knowing" position, making the interaction between researcher, researched and emerging theory a reflexive endeavour (Baker et al., 1992; Haig, 1995; McGhee et al.,

2007). Therefore, noting what is included and excluded, given primacy and subjugated, is essential throughout the study, making researcher bias a helpful source of feedback. Hence, Glaser (2001) argues that it is not necessary to make reflexivity an additional element in GT, as the methodology incorporates processes, practices and tools to facilitate reflection, transcending yet not eliminating researcher perspective. These processes and techniques include the use of unstructured interviewing, theoretical memoing, field noting, consultation and adherence to the method-ology. In short, Glaser (1998) insists that systematic abstraction of the data that forms conceptual realities is not the same as occupying a stance of non-involvement. The former represents a rigourous analytic process of comparing data with data, leading to the identification of latent patterns that can incorporate researcher perspective, whereas the latter implies the absence of researcher views, whereby one discovers independent, external and predetermined realities (Glaser & Strauss, 1967; Glaser, 2002). From this perspective researcher bias is acknowledged while also seen as tentative and only one source of data; it can be combined with other data to inform researcher theoretical sensitivity.

Heath (2006) coined the terms inductive and deductive theoretical sensitivity to differentiate between two key phases of the literature review. *Deductive* theoretical sensitivity refers to researcher sensitivity to important issues in the areas of investigation that are already known to her through her own knowledge and / or the literature. *Inductive* theoretical sensitivity refers to researcher sensitivity to emergent issues that become known from the data and subsequent identification and reading of relevant literature to inform and refine this, locating the emergent theory within the general body of knowledge in the field. Thus, the researcher informs herself about relevant information and concerns pertaining to her area of inquiry and emergent categories as the study progresses, whilst attempting to avoid forcing the theory (Glaser, 1998). This demarcation was deemed useful and influenced the literature review strategy used in this study, incorporating both a literature pre-view and literature re-view.

In addition to separating the researcher from her own knowledge, it has been proposed that GT also attempts to separate her from existing knowledge in the substantive literature (Charmez, 2000; Puddephatt, 2006). This criticism has arisen from the

recommendation that the researcher avoid theoretical overload early in her study to facilitate analyst open-mindedness and avoid theory forcing (Glaser & Strauss, 1967). Forced theory refers to theory generated by a researcher who is guided by preconceived ideas about what will emerge from the study or one who resorts to premature conjecture rather than being open and informed by the data, thereby testing rather than conceptualizing theory. However, the dictum "all is data" proposes that researcher knowledge, regardless of its source, be treated as another form of data that informs her theoretical sensitivity. Hence, this is subjected to the same analytic process as other forms of data.

To address these debated in this study a literature review strategy was established at the outset. This incorporated initially conducting a literature pre-view to inform the researcher about existing knowledge and contemporary debates in suicidology in order to enable her to: provide a rationale for the study; critically analyse her relationship with the theory, topic and research population, and distinguish between new and old information in the data. A literature re-view was conducted during and following data analysis in order to facilitate conceptualization of the data and enrich and stretch the substantive theory, demonstrating how literature can be utilized as another source of data as the study progresses. This involved re-visiting some aspects of the pre-viewed literature in the substantive area in more depth and engaging with additional literature related to emerging concepts. In this way, existing literature in the area of suicidology and related to the substantive theory was combined and used as a conceptual mirror upon which the substantive theory was reflected. In summary, the literature pre-view enhances deductive theoretical sensitivity by attuning the researcher to where the study is historically, socially and theoretically situated, whereas the literature re-view enhances inductive theoretical sensitivity, as it related more specifically to the emergent substantive theory. In this way researcher knowledge and pre-existing knowledge in the field and beyond are treated as data that inform theory development.

Regardless of the position that the GT researcher takes in relation to these debates and her preferred philosophical underpinnings, she is challenged to demonstrate to herself and others that the final product has been derived from the data and not constructed by the analyst from *a priori* assumptions based on personal and professional biases -

that is, there exists a logical connection between data and theory and that decision-making regarding ethical, methodological and technical concerns are accountable. Therefore, in the interest of transparency the debates surrounding these issues and the researcher's own position in relation to these is elaborated in this chapter and the process of theory generation is described in some detail in chapters seven, eight and nine.

What is Theory?

The term *theory* has distinct meanings across different fields of knowledge, disciplines and contexts. Tacit or informal theory refers to one's own understanding of a phenomenon which is developed over time and often cannot be articulated while drawn upon in practice (Berragan, 1998). Formal theory in social science usually refers to a structured and tested set of ideas or concepts derived from empirical study that aids explanation and understanding (Moses & Knutsen, 2007). Theories can be divided into different types that reflect their level of abstraction and applicable scope. *Grand theories* are those that are highly abstract and broad in their applicable scope, for example, theories that attempt to explain the nature of society. *Mid-range theories* are those that are less abstract and more limited in applicable scope, for example, theories that are focused on a specific aspect of social inquiry and are therefore more important to practice-oriented disciplines. *Practice theories* are those that are more concrete and have narrow applicable scope, for example, theories regarding a specific social practice (McKenna, 1997; Cutcliffe, 2000).

GT methodology was designed to foster the development of mid-range substantive and formal theory consisting of abstract renderings of specific social phenomena that are grounded in the data (Charmez, 2006). Substantive theory refers to theory that is relevant to a particular area of interest. Through further analysis this may be developed into a formal theory that is relevant to wider contexts (Glaser & Strauss, 1967; Glaser, 1998; Charmez, 2000), by generating more abstract concepts and specifying relationships between them to understand problems in multiple substantive areas (Charmez, 2006). Substantive theory is therefore developed for a specific area of social inquiry, while formal theory is developed for transferability to a wider area of social inquiry. Substantive theory can also be viewed as a practical theory as it aims to inform action in the area of interest (Glaser & Strauss, 1967). While such

theory guides practice it is not a practice theory as described above, which is derived directly from observation and analysis of practice which it then informs (Berragan, 1998; McKenna, 1999). The aim of this study was to develop a substantive theory relating to the phenomena of suicide-ality among young Irish men that specifically explained the processes in which they engaged to resolve their core concern, from which the core variable and theory emerged.

Rationale for GT Methodology

The previous chapters have demonstrated that there is an extensive, growing and broad knowledge base in suicidology. However, there are some consistently identified knowledge gaps in the field in general, and in relation to suicide-ality among young men in particular. For example, it is not clear how young men understand their suicidal process and selves and how this understanding can inform the mental health practitioner in responding to their needs (Maltsberger & Goldblatt, 1996; Ting et al., 2006; Cutcliffe & Stevenson, 2007). This study sought to address these gaps by exploring such issues directly with formerly suicidal young men who had been involved with the mental health services.

GT can be used with both quantitative and qualitative data. Qualitative approaches are suited to exploring the unknown and uncovering the unexpected in areas where little is understood about the phenomenon of interest. Furthermore, they are appropriate when an emic perspective is sought, as rich data can be gathered that enhances understanding from the perspective of those at the centre of the issue of concern (Kvale, 1996; Robson, 2002; Marshall & Rossman, 2006). Choosing the qualitative approach that fits a particular study requires consideration. For example, a deeper understanding of participants' experiences in relation to a particular event, situation or topic and the meaning they attach to these can be acquired using a phenomenological approach, which will capture rich descriptions of the phenomenon of interest that represent individual accounts (Smith, 2008). Therefore, while alternative qualitative approaches could well offer new and exciting insights in the field of suicidology, they do not advance the overall aim of this study to address a theoretical gap by generating new theory. GT seeks to develop a substantive theory that identifies and explains patterns underlying social phenomena (Glaser & Strauss, 1967), such as the processes in which suicidal young men engage to resolve their

concerns. While GT is utilizes qualitative data it seeks to integrate multiple indices of data from different participants rather than focusing in-depth on the lived experience, socio-cultural context, or meaning-making system of individuals, although these issues undoubtedly emerge as important components of the whole that the substantive theory represents. This means that participant quotations serve as illustrations of patterns rather than representing an in-depth individual perspective; therefore, quotes used in this text are not connected to individual participants nor are they intended to fully capture a particular concept.

GT is specifically designed for theory building that is comprehendible and usable to those most concerned with the phenomenon in question and can therefore guide practice (Glaser & Strauss, 1967; Glaser, 1992). These issues are relevant to research in suicide-ality among young men where the subjective perspective is noticeably absent. Yet this is crucial in order to gain a better understanding of what is relevant to them in terms of having their needs met by professionals, thereby informing mental health practice in new and insightful ways and contributing to suicidology knowledge. Therefore, exploring how the theory fits with those in the substantive area ensures utility rather than confirming accurate representation of participant accounts, as it is not expected that an individual will recognize his personal data in the substantive theory, which represents conceptualization across data indices (Glaser, 1998). Hence, the researcher discussed the theory retrospectively with a young man who was both a study participant and mental health practitioner, with an independent ex-service user, and with a mental health professional in a local service, which served to assess theory robustness rather than verify the theory.

In summary, GT was viewed as the most appropriate way to conduct this study for two key reasons as fitting with the purpose and product of GT, namely to address a theoretical gap in the field and to enhance practice. Firstly, given the dearth of research that theoretically explains suicide-ality from emic perspectives this study aimed to identify the core concern of suicidal young men in Ireland and to generate a substantive theory explaining the processes in which they engaged to resolve this concern. Secondly, this theory is intended to inform professional knowledge and practice in relation to meaningful responses to the suicidal person within the domain of mental health. Given the unique challenges associated with studying men in

general, and intimate life transitions in particular (Begley et al., 2004), one-to-one, in-depth interviewing was used as the main source of data collection. This provided scope to unpack participants unique stories (Kvale, 1996), thereby delimiting categories as the study progressed (Glaser & Strauss, 1967). Thus, the methodology chosen for this study was GT utilizing qualitative data based on subjective accounts of participants.

Summary

Knowledge can be generated in different ways depending on the purpose of a study. Debate regarding knowledge generation abounds in the research literature and it has been proposed that GT occupies a middle ground position in relation to proposed dichotomies. There are a number of challenges associated with conducting a GT study that the researcher must consider. These include: the value placed on data, including researcher preference and existing literature; simultaneously sustaining engagement with the data and conceptualizing this in a systematic manner, or holding an observing *and* participating position; and, developing a theory that is contextual, practical and robust while also informed by multiple sources of data. This has led some authors to consider the methodology as paradoxical (Glaser, 1998; Urquhart, 2002), nevertheless, it is simultaneously systematic and conceptual, and theory is researcher informed while not led.

5.3 Methodological Framework: Classic Grounded Theory

"Grounded Theory does not provide the researcher with a series of steps, which if followed correctly, will take him or her from the formulation of the research question through data collection to analysis and, finally, to the production of a research report. Instead Grounded Theory encourages the researcher to continuously revisit earlier stages of the research and, if necessary, to change direction."

(Willig, 2001, p. 36)

GT method is itself a grounded theory as it was discovered by Glaser and Strauss in the course of their collaborative research on death and dying in hospital settings in the US during the 1960s. They subsequently set about describing in detail the processes and procedures in which they engaged to develop their theory, *awareness of dying*

(Glaser & Strauss, 1965), giving rise to a systematic method for theory development in social science (Glaser & Strauss, 1967).

The Foundations and Evolution of GT

"The principle point to keep clear is the purpose of the research, so that rules of evidence do not hinder discovery of theory".

(Glaser & Strauss, 1967, p.51)

Whilst acknowledging the importance of verifying theory, sociologists Glaser and Strauss (1967), devised a methodology for theory generation through systematic analysis in social research, which they called GT. Theory is grounded in the data or developed from analytic integration of data rather than by *"...logical deduction from* a priori *assumptions"* (Annels, 1997a, p.126). As GT was designed to facilitate the process of theory generation that informs social action, its purpose is primarily to generate substantive theory in the area of interest that is not contextually limited, which, on further analysis, can be developed to a formal, or more transferable theory (Glaser, 1998). It is advocated that GT challenged existing dichotomised research boundaries providing a revolutionary alternative approach to re-balance the then emphasis on hypothesis and theory testing (Charmez, 2000). GT also addressed the positivist claim that qualitative research was unscientific and anecdotal by devising a systematic analytic method that could be used with both quantitative and qualitative data and a method that incorporates both inductive and deductive processes (Tavakol et al., 2006). Furthermore, it challenged the existing arbitrary division between theory and research by allowing the researcher to move from data to theory which in turn is useful and effective in guiding action (Glaser & Strauss, 1967; Willig, 2001).

While not initially explicated by the originators, the philosophical underpinnings of GT have been debated within GT literature. Glaser and Strauss came from different research traditions, Glaser from a quantitative background at Columbia University, and Strauss from a qualitative background at Chicago University. It has been proposed that GT has been influenced by both schools (Glaser, 2005; 2008). For example, the Chicago school was immersed in Symbolic Interactionism (SI), which in turn was influenced by Pragmatism (Tavakol et al., 2006; Urquhart, 2002). Briefly, SI assumes that: meaning is negotiated and interpreted through human interaction and

mediated through a shared system of communication, language or symbols, and meaning and action are inextricably linked and mutually influencing. From this perspective, reality, including theory, is socially constructed and is historically and contextually bound (Tavakol et al., 2006; Urquhart, 2002). GT reflects this approach in its view of theory as unfinished and modifiable, and emerging from data that is related to the substantive area under study. *Pragmatism* asserts that things are real in their consequences rather than their inherent truth value, therefore, truth is a matter of human utility. GT is pragmatic in its purpose as the robustness of the emergent theory is judged on the basis of its explanatory power and applicable scope. From this perspective, a GT study can be described as a 'practical inquiry' that re-informs practice, thereby bridging the theory-practice gap (Stevenson, 2005).

While Glaser agrees that GT resembles some core assumptions in SI, he identifies some key social science principles and practices, derived from mathematics, as the primary influence on the foundations of GT and the development of the Constant Comparison Analytic Method (CCAM), in particular the *Concept Indicator Model* (CIM) developed by Lazarsfeld (Glaser, 2005; 2008). According to Glaser (2005), three central and inter-related ideas associated with this model have been incorporated into GT theory development: the index formation model, interchangability of indices, and core variable analysis (Glaser, 2005). Briefly, the *index formation model* refers to the accumulation and integration of indicators from the data to generate concepts; this is fundamental to the inductive theory building process in GT. *Interchangability of indices* refers to analysis of the relationship among concepts until reaching theoretical saturation; this enhances the deductive theory building process in GT by delimiting the theory. Finally, *core variable analysis* refers to identification of a core variable within the data which is related to all other categories. The core variable explains much of what is "going on" and how the main concern of participants in the substantive area is resolved, leading to theory generation (Glaser, 2005). The centrality of these analytic processes can be clearly seen in the CCAM that is one of the hallmarks of GT.

Glaser and Strauss (1967) advocated that GT not be underpinned by a single philosophical frame, nevertheless, they outlined some key ideas that underpin GT. They viewed *research as process* emphasizing the concurrent nature of data gathering

and analysis and the recursive influence between data and researcher. They viewed *theory as process* that is emergent and modifiable. They valued multiple lenses for interpretation, hence, the application of theoretical frameworks following, rather than preceding, theory development. They emphasized the importance of *fit, relevance* and *workability* of the research product, stressing the importance of practical applicability. Finally, they stressed the need for the researcher to enter the field with and to sustain a disposition of *open-mindedness* in order to facilitate theory evolution from data. From this perspective, GT can be viewed as both a methodology and a method as it provides a beginning frame from which the researcher can position herself and a systematic method for conducting a study.

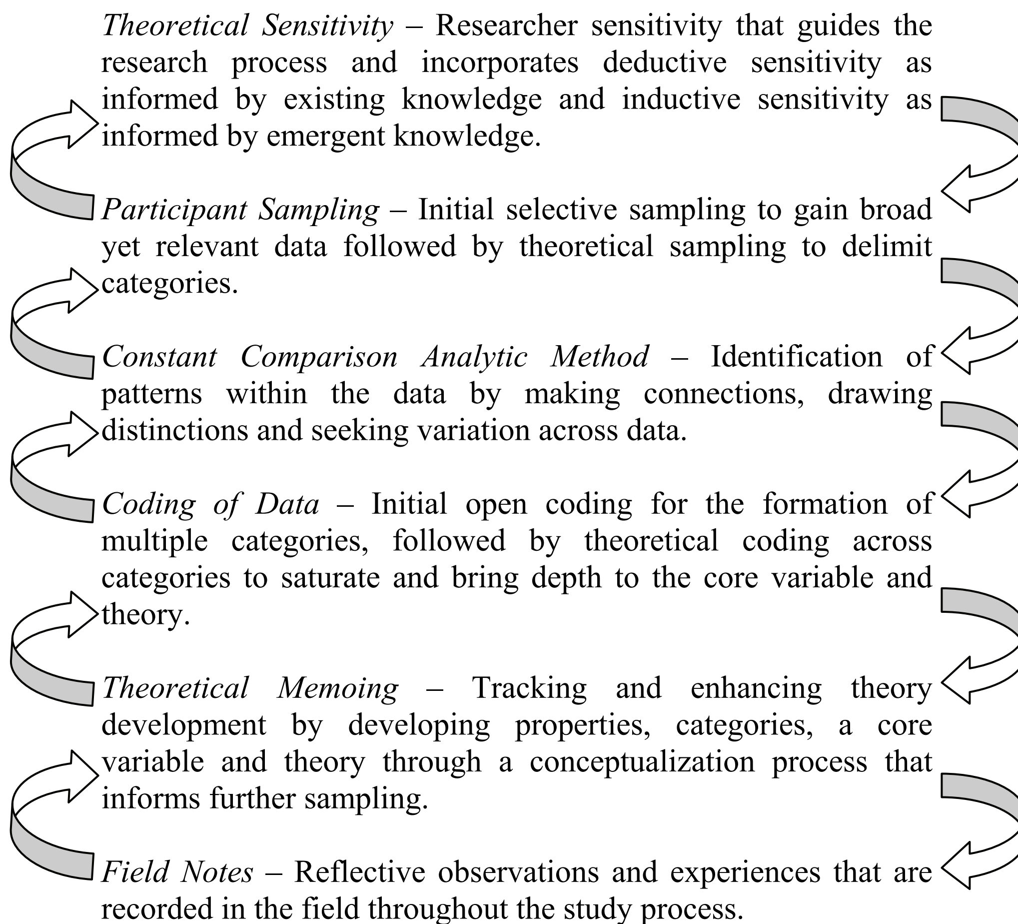
Over time the originators emphasized different aspects of the analytic method reflecting different views about the nature of the relationship between researcher and data. Glaser developed the emergent and creative process of theory evolution, advocating scanning across data in order to identify key concepts and latent patterns (Glaser, 1992; 2005). Strauss elaborated the systematic aspect of data management and analysis, advocating micro-analysis of every piece of data for possible meaning (Strauss & Corbin, 1998). Glaser (1992) criticized this approach as overly analytical whereby the analyst becomes engrossed in the minutiae and loses sight of the bigger picture. It can also create data overload whereby she becomes immersed in description rather than conceptualization. He continued to emphasize the importance of analytic conceptualization in theory generation, while stressing the central tension in GT studies between existing and emergent, and internal and external knowledge (Glaser, 1998; 2001).

Despite their different emphasis, both Glaser and Strauss continued to promote core theory development processes, for example, analyst theoretical sensitivity and close engagement with the data (Glaser, 1992; 1998; Strauss & Corbin, 1998). However, the split between the founders has been reflected in debates among GT researchers about how best to define its origins, purpose and product (Charmez, 2000; Glaser, 2002). The critique of GT is its perceived underlying positivist ontological assumption and objective epistemological assumption has led to proposals for new versions of GT that reflect a shift from modernist to postmodernist assumptions in qualitative research (Annels, 1997b; Charmez, 2000). However, Glaser has continued

to assert that truth and theory is not the same thing and that observer bias can be controlled. Thus, he advocates adherence to, rather than revisioning of, the methodology as the way to address the inherent challenges in conducting a GT study (Glaser, 2002). It is Glaser's methodology that primarily influenced this study as it adheres to the original systematic procedures of GT while encouraging researcher creativity and conceptualization (Glaser, 1998; 2001). Strauss and Corbin's (1998) highly structured and detailed coding method risks over-immersion in the data and can be said to reflect a positivist yearning for accurate and verifiable truths. Charmez's (2000) constructivist approach espouses a pre-determined lens for interpretation, which conflicts with the GT principles of open-mindedness and use of multiple lenses for conceptualization.

Key Tenets of GT: Analytic methods, processes and tools

Diagram 5.1: GT Processes, Methods & Tools



In GT, data collection and analysis are concurrent activities that recursively inform, clarify and critique each other throughout the inquiry. A range of interconnected analytic methods, processes and tools are utilized to facilitate theory development and to address some of the challenges inherent in the methodology as discussed above. These include the process of systematically developing theory by maintaining theoretical sensitivity, through the use of the CCAM. This process in turn is facilitated by frameworks for sampling and coding, and the use of recording and reflection tools such as theoretical memos and field notes. The reflexivity between the core processes and procedures of GT is demonstrated in diagram 5.1 above, and each is discussed in more detail below.

Theory Development: Theoretical pacing

"By far the most exciting use of grounded theory over the last ten years is its legitimating of concept generation. The researcher is empowered to discover and generate new categories and properties, instead of being forced to use received concepts…It is academic freedom to the max."

(Glaser, 1998, p.133)

Glaser and Strauss (1967, p.43) emphasized theory as process or *"...theory as an ever-developing entity, not as a perfected product..."*; a momentary product that is modifiable through further analysis. Theory emerges from an on-going process of induction and deduction, constant comparison of data with data through an underlying joint operation of data gathering, coding and analysis. Therefore, while theory is viewed as partial, evolving and temporary, its development takes place systematically through the complex interplay of GT practices and procedures that together enhance theoretical robustness and methodological rigour. It is developed carefully; therefore, theoretical pacing is important so that theoretical closure does not occur prematurely (Jeon, 2004).

Theoretical Sensitivity

"[Theoretical sensitivity] involves his [the researcher's] own personal and temperamental best ability to have theoretical insight into his area of research, combined with an ability to make something of his insights."

(Glaser & Strauss, 1967, p.46)

Theoretical sensitivity refers to the researcher's relationship with the area of inquiry, specifically to how she sensitises herself to approach the study and analyzes and seeks further data in order to develop theory and progress the research. Theoretical sensitivity is informed by multiple sources of information including pre-existing literature, personal and professional knowledge and emerging ideas. It is also informed by the interactive process of data collection, coding, analysis and conceptualization, which in turn, informs theoretical sampling (Glaser & Strauss, 1967).

The researcher's relationship with the study will evolve as she is exposed to data through the conceptualization and theory formulation processes. Thus, theoretical sensitivity facilitates movement from a descriptive to an analytic level, which in turn informs her re-engagement with the research study until saturation is reached. Theoretical saturation refers to the process whereby no new information emerges from the data (Jeon, 2004). This is not the same as repetition of events, stories or patterns but refers to conceptualization of comparisons of indices which yield different properties of the pattern until no new properties of that pattern emerge (Glaser, 2001; Charmez, 2006). As Glaser and Strauss (1967) suggested, theory can always be revisited and reconceptualized to develop a richer theory, therefore, *"The analyst also realizes that his theory as process can still be developed further, but that it is now sufficiently formulated for his current work to be closed and published."* (Glaser & Strauss, 1967, p.225). From this perspective theoretical saturation can be viewed as a temporary rather than permanent place or *"...a pause in the never-ending process of generating theory"* that is sufficiently formulated for the researcher's current project (Glaser & Strauss, 1967, p.40). However, it should be marked as relevant and subjected to diversity, stretching and integration as far as possible and the analyst should be satisfied regarding the empirical limits of the data (Glaser & Strauss, 1967). Therefore, saturation can be described as 'enough for now', where the theory is developed as far as possible in a particular context at a particular moment in time, but nevertheless meets the core GT criteria for theoretical robustness, as elaborated below.

The Constant Comparative Analytic Method (CCAM)

"...dependent on the skills and sensitivities of the analyst the constant comparative method is not designed (as methods of quantitative analysis are) to guarantee that two analysts working independently with the same data will achieve the same results; it is designed to allow with discipline, for some of the vagueness and flexibility that aid the creative generation of theory"

(Glaser & Strauss, 1967, p.103)

The method of analysis employed in a study depends upon the status of the material as determined by the research goal (Kvale, 1996). Hence, some selective interpretation occurs throughout the data collection and analysis process, as informed by researcher theoretical sensitivity. However, in order to retain rigour, a systematic method of analysis is necessary, which in GT is known as the Constant Comparative Analytic Method (CCAM) (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Glaser, 2005).

Comparative analysis is a general method that has been used in social research for some time. It is primarily used for: checking the accuracy of evidence or factual accuracy, empirical generalisation and the generalisability of a fact across contexts, concept specification or bringing out the distinctive element or nature of a specific case, and testing / verifying or modifying existing or emerging theory. However, according to Glaser and Strauss (1967) theory verification, in terms of accuracy, is not an issue in GT as the analyst yearns to add breadth and depth to categories rather than confirm them. Therefore, the objective of comparative analysis in GT is to compare and integrate data gathered from multiple sources *"…in such a way that all instances of variation are captured by the emerging theory"* (Willig, 2001, p.34). Hence, building-up and breaking-down categories is a continuous activity undertaken to add depth and density to the emerging theory.

Glaser and Strauss (1967, p.105) describe four interrelated stages in this process *"(1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory"*. Therefore, the inquiry focus evolves with the emergence of new categories, which in turn influences

further data collection and analysis, until a more comprehensive and integrated theory is elaborated, highlighting the interrelatedness of inductive and deductive processes. Furthermore, as evident from the above quote, the method was designed to incorporate both unique analyst creativity and systematic analytic rigour that is enhanced by the ever increasing levels of conceptual abstraction built into the coding process.

The Conceptualization Process

Glaser and Strauss (1967, p.111) describe the two major requirements of theory as: "*(1) parsimony of variables and formulations, and (2) scope in the applicability of the theory to a wide range of situations, while keeping a close correspondence of theory and data*". Therefore, the theory should provide a concise yet dense statement of the matters studied which gets to the heart of the matter, and is presented in a way that others in the field can understand and use. In this way the conceptualization processes are irretrievably interlinked, interdependent and incorporate different levels of abstraction (Glaser & Strauss, 1967).

Level 1: Categories and Their Properties

This level involves creating conceptual categories and defining their properties. These categories are indicated by the data but do not only reflect the data itself, therefore, they vary in degree of conceptual abstraction.

Level 2: Propositions and Core Variable

This level incorporates generalized relations or propositions among categories and between categories and hypotheses. It represents overriding and integrated conceptualizations leading to a core variable.

Level 3: Substantive and Formal Theory

The substantive theory draws together and explains the core variable that is both analytic, or conceptualized, and sensitizing, or meaningful, within the substantive area. While it was not the aim of this study to develop a formal theory this could be done through further theoretical sampling and data analysis.

Sampling: Selective and theoretical

The technique of *selective sampling* identifies sources that are likely to inform the beginning research questions in a broad yet relevant manner. The researcher initiates the sampling process by interviewing significant individuals (Baker et al., 1992), or those who are knowledgeable about the research topic (Morse, 1996). For example, in this study selective sampling involved one-to-one interviews with young men who were formerly suicidal and who had engaged with mental health services. This initial phase of the inquiry provided rich material to direct forward movement through *theoretical sampling*. Theoretical sampling refers to seeking precise information *"…to develop our emerging categories and to make them more definitive and useful"* (Charmez, 2000, p.519). Thus, theoretical sampling is primarily concerned with theoretical refinement and ultimately saturation, rather than extension of categories. Theoretical sampling refers to sampling ideas rather than sampling specific population groups (Glaser & Strauss, 1967; Willig, 2001). In this study, theoretical sampling involved further face-to-face discussion with young men about emerging categories wherein variation was also sought, which refers to seeking out differences within a pattern, not in individuals.

Together the practices of selective and theoretical sampling provide scope for both open and specific data to be sourced, ensure robustness in theorizing by demanding that the researcher complete the comparative process until sound concepts emerge, and prevent premature saturation, while the researcher remains focused on her research area. This sampling framework promotes the CCAM as a range of sources and perspectives are identified and integrated (Glaser, 1998; Charmez, 2000).

Coding: Open, theoretical and selective

"The result of grounded theory is not a reporting of facts but a set of probability statements about the relationship between concepts, or an integrated set of conceptual hypotheses developed from empirical data."

(Glaser, 1998, p.2)

Coding refers to the fundamental process by which categories are identified, moving from descriptive labelling to theoretical categorisation. It starts the chain of theory development, which begins to emerge at an early stage in the inquiry, rather than

before the inquiry or at the end of the study (Charmez, 2000). There are three main types of coding: open, theoretical and selective coding. *Open coding* refers to the scanning of the data for anything possible to emerge, leading to formulation of descriptive labels. *Theoretical coding* refers to the process of yielding conceptual relationships across categories and their properties as they emerge. S*elective coding* refers to coding data that relate to the core variable (Glaser & Strauss, 1967; Glaser, 1992). Selective coding thereby partially lowers the conceptual level of the study while it raises the conceptual level of the selective codes (Glaser, 1998), further demonstrating the iterative dance towards saturation between inductive and deductive processes (Kelsey, 2003).

The three basic elements of GT theory development include building *categories*, or describing key incidents in the data, outlining their *properties*, or the characteristics of these categories, and formulating *propositions / hypotheses* that explain the relationship between categories. These elements combine in an interactive process to generate a *core variable*, sometimes referred to as *a core category*, which accounts for most of the activity in the substantive area and explains how participants resolve their core concern. The labelling of categories incorporates both descriptive in vivo concepts directly taken from the data and in vitro concepts constructed by the analyst; the latter tending to explain the processes being described in the former (Glaser & Strauss, 1967). Categorization, according to Glaser (1998), accounts for most of the activity in a substantive area, thus, the evolving core variable attempts to integrate new data to bring completeness to existing categories. Glaser (1998) advises against basing categories on a single incident, instead suggesting that the researcher find patterns that connect across incidents, and that she seek to saturate categories by continued exploration until no new data is emerging.

Propositions *"…indicate generalized relationships between a category and its concepts and between discrete categories"* (Pandit, 1996, p.2), requiring a higher level of conceptualization than the generation of categories. It is from refining and elaborating evolving propositions that the researcher formulates her final theory. The conceptualization process highlights the contrast between GT and Qualitative Data Analysis (QDA), which seeks accurate description and participant representation (Glaser, 2002).

Integration, in this multi-level conceptual process, is aided by the simultaneous engagement in coding and reflection on this process. This is facilitated by writing theoretical memos and making field notes as described below. The coding process incorporates theoretical sensitivity as the researcher decides how categories may be worked together, ensuring fit between properties, categories, propositions and new data. Thus, coding is an interactive process between the researcher and the data, giving scope for transformative learning at every stage in the process (Glaser, 1998).

Recording and Reflecting: Field Notes and Theoretical Memos

A range of data is gathered during the inquiry process. Glaser (1998) refers to these as: *baseline data,* descriptions of participants' actions, *interpreted data*, meaning given by participants to these descriptions, *properline data*, material given by participants based on what they think the researcher expects to hear, *vague data*, incoherent material such as mumbling, and *conceptual data*, taken-for-granted discourses and language, for example, professional jargon. In addition to data directly provided by study participants, a range of other technical and non-technical data is incorporated into the GT study through the constant comparative method (Glaser & Strauss, 1967). Data need to be organised in a way that facilitates conceptualisation in a systematic manner and two key GT tools that assist with this process are writing field notes and theoretical memos. These activities are in a continual process of balance-change depending on the nature of the data, the stage of theory development, and analyst "mood" based on her personal sensitivity. The task of the analyst is *"...to take apart the story within his data"*, fracturing the whole to identify significant parts, and then integrating the parts to form a coherent new explanatory whole (Glaser & Strauss, 1967, p.108).

According to Glaser (1998, p.107) *"...when doing grounded theory there is no need for 'complete' recording of the interviews as one would want in descriptive completeness"*. Instead he suggests that *field notes* be promptly recorded following the researcher's interaction with the data. He argues that theoretical completeness requires the meaningful mix between data and researcher observations. Similarly, Rafuls and Moon (1996, p.78) suggest that in GT the emphasis is on *"...depth of conceptualizations rather than on description"*, therefore, supportive documentation should be kept to minimum. *Theoretical Memos* trace the elaboration of properties,

categories, core variable and theory (Willig, 2001). According to Charmez (2000), memos keep the researcher focused on the analysis, involved in the research, and help her in viewing the data in new ways. Therefore, memo writing extends the interactive process between the researcher and the data to a deeper and richer level of engagement.

In this study these analytic processes, practices and tools helped to refine and integrate patterns relating to the core variable, *re-vitalizing worthiness*, which describes the process in which the young men in this study engaged to transcend suicidality.

Methodological Rigour and Theoretical Robustness

Criteria for evaluating the scientific status of a study hold different meanings in different research paradigms, depending on the claims being made regarding the scope of the theory. Validity and reliability, relating to accuracy and repeatability respectively, and supporting the aim of empirical generalization, have become important research evaluative cornerstones as measured through verifiability and / or falsifiability practices. While these approaches offer ways of critiquing theory, one through proof of the proposed concepts correspondence to the real world and one through proof of absence of alternative plausible explanations that falsify the theory, both *"...share an implicit understanding that there is a Real World filled with naturally existing patterns that can reveal themselves to the disinterested observer"* (Moses & Knutsen, 2007, p.47). These practices have been accepted within the positivistic domain of thought, which seeks to describe a set of verifiable correlations that are logically and systematically related to each other. However, they have been rejected within the constructivist domain, which seeks to capture and understand meaning from a local perspective that cannot be empirically generalised or proved in the same way. Nevertheless, the importance of rigour should not be under-estimated in qualitative research (Willig, 2001). Terms such as credibility, plausibility and trustworthiness are used instead to denote theoretical robustness and methodological rigour, ensuring that the data are reflected in the findings and are reported in a way that is respectful of participants' views. Therefore, while qualitative research is not generalisable in a probabilistic sense the findings may be theoretically generalisable or transferable to wider situations (Kvale, 1996). According to Smith (2008),

theoretical generalisability is possible when links are made between the study findings, the reader's experience and the extant literature, and the robustness of the study is judged on the light it sheds on the broader context.

The aim of GT is not to produce an accurate and universal truth but a theory that makes sense, both of and in, the substantive area under study and that is useful to those concerned with that phenomenon (Glaser & Strauss, 1967), hence the analyst aims to demonstrate completeness, depth and scope (Glaser, 2005). The criteria outlined by Glaser and Strauss (1967) provide measures for ensuring theoretical robustness, while adherence to the comprehensive processes and procedures within the methodology provide for methodological rigour.

Relevance, Fit, Workability, Modifiability, Parsimony, Scope and Grab

Some key interlinked criteria for theoretical robustness have been outlined in the GT literature: relevance, fit, workability, modifiability, parsimony, scope and grab (Glaser & Strauss, 1967; Glaser, 1998). *Relevant* theory informs the study situation by providing explanations that make sense of and to the substantive area. *Fit* of theory can be understood as theory that is substantively congruent, or fitting the study phenomenon. W*orkability* means that the theory assists the everyday practice of those involved in the substantive area, while *modifiability* refers to the unfinalised nature of theory, which can be revised with new information. *Parsimony* is based on the premise that theory should identify and succinctly describe central processes within the phenomenon that address the core concern of participants in the substantive area. *Scope in applicability* refers to how useful the theory is to those in the substantive area and beyond, highlighting that the purpose of a GT study is to inform everyday practice and knowledge. Additionally a good GT study should demonstrate conceptualization, which means that the concepts that are generated are time, place and person independent. Thus, the analyst shows that she has moved beyond the raw data and abstracted concepts from this which are context free, as described in the conceptualization process. Finally, the theory should have *enduring grab* which means that it should be attractive to and memorable for those who hear about it (Glaser, 2001).

Hence, robustness of findings can be ascertained by examining if the theory was derived from the data, subjected to theoretical elaboration, judged as adequate and relevant to the study context, committed to by the researcher based on her critical engagement with the data and the research process, and experienced as novel and fitting by others in the field (Glaser, 1998). These criteria are revisited in chapter eleven, which assesses the substantive theory generated in this study using these GT measures.

5.4 Ethical Framework: Ethics as process and processing ethics

"The problem with qualitative research is that, both for the so-called researchers and either co-researchers or respondents, they often do not know in advance the complexity and depth of issues that are going to come up and their experiential implications for them...As soon as people start sharing their lives, one does not always know what the full implications of that are."

(Redwood & Todres, 2006, p.2)

Ethical Positioning

Ethics is traditionally a branch of philosophy that deals with moral problems and moral judgements in relation to *"...evaluation of human action"* as right or wrong (Koocher & Keith-Speigel, 1998, p7). This judgement will depend upon one's perspective on a moral principle or ethical guideline, with violation of ethical standards occurring through acts of omission or commission based on such interpretations (Koocher & Keith-Speigel, 1998). Whilst one's ethical position is influenced by one's personal underlying moral values, ethics is not simply defined by an individual. Socially constructed and sanctioned standards influence how values are shaped and the scope they allow for making judgements, thus, ethics is an evolving phenomenon (Navran, 2004).

In this study the author draws a distinction between rule or procedural ethics and process ethics (Redwood & Todres, 2006). *Procedural ethics* tend to regard ethical principles as universally understood concepts, ethical codes as providing answers to ethical problems, and ethical approval and decision-making as a task. *Process ethics* view ethical principles as interpretative, ethical codes as guiding ethical sensitivity

and imagination rather than providing directives for action, and ethical decision-making as a continuous and mutually negotiated process with ethical issues revisited throughout the inquiry process (Ramcharain & Cutliffe, 2001; Redwood & Todres, 2006). This positioning emphasizes: the temporal and contextual nature of ethics (McCarthy, 2005), the multiple meanings of ethical principles (O'Neill, 2002), the complexity of responsible ethical decision-making (Stewart & Amundson, 1995), ethicality as being (Anderson, 1994; Inger & Inger, 1994), and the unpredictability of human interaction, hence the difficulty in predicting all eventualities in the research endeavour (Redwood & Todres, 2006). Process ethics is fitting for studies with an emergent design and is coherent with GT as the process evolves over time. In viewing ethics as process, it is important to articulate explicitly the moral values or principles influencing a study so that one's interpretation of the relationship between research participants, research audience and researcher is transparent and open to scrutiny, promoting ethical rigour.

Ethical Values / Principles

"The use of persuasion, language, recourse to social control, and the like are power issues that are of major concern when considering the question of doing no harm."

(Inger & Inger, 1994, p.40)

Ethics codes date back to the Hippocratic Oath, the first profession-generated code of ethics, written about 400 B.C. Whilst described in different ways within moral philosophy (Bond, 1993) and professional practice (Beauchamp & Childress, 1989; Robson, 2002), a number of core ethical values and principles are regarded as fundamental to guide good research practice. *Non-malfeasance* assumes that perceived harm be avoided by ensuring that adequate care is taken to protect others. *Beneficence* assumes that one not only prevent harm but also aspire to promote benefit. *Autonomy* assumes that respect, or esteem be felt and shown toward others, based on one's perceived right to self-determination. *Justice* assumes that one act in an equitable, impartial and unprejudiced manner. Additionally professional values are encouraged, such as, *fidelity,* which means being faithful to promises made and honouring the trust put in one as a professional practitioner, and *self-respect,* meaning one fosters self-care and self-knowledge and works within one's scope of practice. Together these ethical and professional values give rise to some well established and

accepted research practices, such as, safeguarding participant privacy and data confidentiality, ensuring participant informed consent, and analyzing potential risks in conducting the study (Beauchamp & Childress, 1989; Bond, 1993; Koocher & Keith-Speigel, 1998; Robson, 2002). Thus, the core ethical principles that guided the researcher in conducting this study were drawn from several sources and were used as anchor points for exploring the ethical issues anticipated and encountered in the conduct of this study, for participants, researcher, and the research context, as described in the next chapter.

5.5 Summary: Grounded Re-Positioning

In this chapter the researchers gave an overview of different domains of knowledge generation and how GT methodology is situated in relation to these. Challenges and debates in the field of GT, and the researcher's positioning regarding these, which has shaped her engagement with the research process and her ethical stance is discussed. Some of the key principles and practices that underpin the methodology and the rationale for the choice of methodology were also elaborated.

There is a range of research paradigms from which to choose and this decision is determined by the purpose of the study. Each paradigm is generally underpinned by different ontological and epistemological assumptions (Kvale, 1996). GT was designed to take a middle ground positioning that transcends these dichotomies, while also advocating a beginning position for the researcher (Glaser & Strauss, 1967). Critical debate in the GT field has centred on two main areas, namely that GT is underpinned by a positivist ontology and objectivist epistemology. This has led to examination of the nature of the discovered theory and the relationship between the researcher and pre-existing self and other knowledge, particularly in relation to researcher bias and the substantive literature. Hence, the proposal to develop new versions of GT that reflect developments in the wider domain of qualitative research (Annels, 1997a; Charmez, 2000). This move has been refuted by Glaser as misrepresenting the intended purpose and product of GT (Glaser, 2005).

GT evolved from the collaborative work of sociologists Glaser and Strauss (1967) and provides the researcher with an orientation and general and systematic method for

theory generation in social science. It incorporates some of the central tenets of SI with its emphasis on theory and research as process, pragmatism, which privileges theory utility, and CIM, which provides the foundations for the development of the CCAM. GT established a range of interlinked processes and practices for theory generation including researcher theoretical sensitivity, a systematic analytic method, sampling and coding methods, recording and reflection tools, and criteria for theory robustness, which together promote study rigour. GT has evolved over time with the originators emphasizing different aspects of the analytic process and structure (Glaser, 1978, 1998, 2005).

A GT study identifies underlying processes in the substantive area that are conceptualized in the core variable, and the theory generated is grounded in the data (Glaser, 1998). In this study such processes were concerned with the young men's core concern in relation to suicide-ality and how they resolved this, thereby enhancing theoretical knowledge in the suicidology field. GT is a practical methodology as it aims to develop substantive theory that enhances everyday practice (Glaser & Strauss, 1967). Given the lack of practical guidance for professionals working with the suicidal person this methodology was fitting for advancing this study goal. Study robustness in GT involves measuring the theory against a range of criteria for theoretical soundness and examining the level of researcher adherence to the methodology (Glaser, 2002). This study was conducted using a classic GT methodology as described by Glaser. This approach enhances researcher creativity, offers a sound framework for researcher orientation, and provides a systematic study method (Glaser, 1978).

In this study researcher knowledge was viewed as a way to enhance theoretical sensitivity and was subjected to the rigours of the constant comparative method. The literature review strategy employed entailed accessing and incorporating relevant literature at different stages of the study as guided by and informing researcher sensitivity (Heath, 2006). Therefore, a literature pre-view was conducted to prepare for engagement with the study and a literature re-view was completed to situate the substantive theory in the wider knowledge domain. The ethical framework utilized views ethics as process (Ramcharin & Cutcliffe, 2001). This approach recognizes the continuous meaning-making and negotiation processes that occur among those

involved in the inquiry system and appreciates the fluidity of the ethical frameworks (Stewart & Amundson, 1995) and principles (O'Neill, 2002). This means that unanticipated philosophical, ethical and methodological issues were incorporated into the study design, procedures and process as the study unfolded. The next chapter outlines the specific design and procedures that reflect how classic GT was operationalized in this study.

Chapter 6. Design and Procedures: GT in Action

6.1 Introduction

This chapter will outline how GT was utilized in this particular study, setting the scene for mapping the development of the substantive theory as elaborated in the following three chapters. The researcher will describe the specific design and procedures followed, give an overview of theory development and discuss the ethical and methodological considerations relevant to conducting the study, some of which necessitated procedural changes as the study progressed.

6.2 Design & Procedures

This study was conducted over a three-year period. It involved gaining ethical approval from two research ethics committees and negotiating access and recruitment procedures with one participating site over this time.

Aims and Objectives

It was anticipated that this study would add to the field of suicidology by enhancing theoretical understanding of suicide-ality among young men, however, the specific focus of the theory was not known at the outset. The study was designed with a twofold purpose: to develop a substantive theory, and to utilize this theory to inform professional knowledge and practice in the area of mental health. It involved interviewing seventeen young men, aged 16-34 years of age, who form the highest risk group for completed suicide in Ireland. Interviews explored their perspectives on the suicidal process, their views about helpful and unhelpful responses and services, and their ideas about they were facilitated to address their concerns. Hence, the study provided insights into how the phenomena of suicide-ality is understood by young men in contemporary society and how they view professional help. As the substantive theory that emerged relates specifically to how these young men transcended suicide-ality it provides an overall framework and concept-based model for understanding how professionals can meaningfully engage with suicidal men to facilitate this process, conceptualized as *re-vitalizing worthiness*.

Inclusion and Exclusion Criteria

Given the specific area under study inclusion criteria were drawn up and those who did not meet these criteria were not invited to participate in the study. Inclusion criteria included:

- Male
- Aged 16-34 years
- A history of suicidality and involvement with mental health services
- Willing and able to participate in the study
- Agreeable to research protocols and processes
- Able to speak and understand the English language

Approval and Permission

Gaining access to the target population was negotiated at a number of levels. Recruitment through a clinical site was agreed with service managers and staff working directly with clients through the provision of written and oral information about the study and negotiation of local arrangements. Procedures for recruitment, conducting interviews, participant and researcher safety, and liaison between interviewer and clinicians were agreed and reviewed throughout the duration of the study in order to make appropriate adjustments. Poster invitations were also circulated to other services, which were displayed with the permission of service managers. Ethical approval for the study overall was granted by the Research Ethics Committee at Dublin City University and ethical approval for access to the clinical site was granted by the ethics committee in the area where the service was located.

Participant Recruitment

Two key sampling strategies were used to recruit participants for the study, through direct individual invitation by practitioners in the participating site and poster invitation (Appendix 1). Invitation made through personal contact by clinicians yielded eleven participants, while poster invitation yielded an additional six participants involved in health services outside the designated site. All participants were provided with the same information and afforded the same levels of personal and professional support. Detailed information was provided about the nature,

purpose of and procedures for the study and potential participants were asked to complete a consent form prior to interview (Appendices 2a and 2b).

The clinical site that assisted with recruitment was a crisis liaison psychiatric nursing service that responded to requests from a number of general hospitals to see patients admitted to hospital following a suicide attempt. The hospitals in question covered a large catchment area in the southern region of Ireland servicing rural and urban areas. The liaison nurse met with the patient within 24 hours of admission and offered him short-term (up to 6 weeks) follow-up support following discharge. The nurse also facilitated referral to other support services, for example, for specific presenting problems such as substance misuse, or for more generalised and longer term psychological and / or psychiatric intervention. The three nurses on this team worked with a number of men fitting the criteria for the study and informed them about the study. The contact details of those who expressed an interest in participating were forwarded to the researcher, who subsequently contacted each potential participant in person to impart additional information, answer queries about the study, and arrange an interview. Those who responded to the poster invitation were from different locations across the country. They contacted the researcher directly and the same procedures were followed. A total of seventeen one-to-one interviews were conducted over an eighteen month period, from February 2008 until August 2009. A follow up interview was conducted with one interviewee to discuss the substantive theory and others will receive information on this, as agreed at the time of initial interview.

The Sample: Who are we?

All of the men interviewed for the study met the inclusion criteria. Some broad aspects of participant profile are discussed below by way of introducing study participants, while some of the issues raised in terms of participant profile are discussed in more depth later. Whilst this is a small sample some comparisons are drawn between the participant profile in this study and national and international suicide-ality trends.

Interviewees came from a variety of geographical locations across the Republic of Ireland, including rural areas, small towns, and cities, and their life experiences and

living circumstances were varied. They came from a range of socioeconomic backgrounds, from working class to middle class, had different levels of educational attainment from primary to third level, and had a range of work experiences from casual to professional, as summarised in appendix 3. Briefly, one left school at primary school level, one left school without any significant secondary level education, four left school with some secondary level education but not with final examinations, two left having completed secondary level education, five were attending third level education on a full time basis (one as mature student), and four had completed third level education. Work experience also varied with three participants in professional work, one in semi-professional work, one in skilled work, two in manual work, and four unemployed, two of whom were in receipt of disability allowance due to mental health problems and two of whom were in receipt of unemployment benefit. The age of participants ranged from 19-34 years, with a mean age of 25 years. Six participants were in the 15-24 year age range, and eleven were in the 25-34 age group, which together form the highest risk groups for completed suicide in Ireland. Participants demonstrated awareness of these trends, having gleaned this information from media reports. However, having this information did not impact their help-seeking attitudes and behaviours, which seemed to be more influenced by stigma and fear about mental health and suicide-ality, as discussed in later chapters. Participants' experiences of mental health services also varied in terms of: treatment settings (in-patient, out-patient day care and community services); treatment orientation (psychiatric evaluation and biomedical intervention, supportive counselling, specialist programmes); treatment personnel (psychiatrist, psychologist, mental health nurse, social worker, multidisciplinary team approach); duration of contact with mental health services (four weeks to seventeen years); and satisfaction with services (poor to highly satisfactory).

The participant profiles are interesting in terms of the varied backgrounds of individuals, as this picture is not consistent with national trends. For example, it has been suggested in other Irish studies that suicidality is higher among marginalized men who come from lower socio-economic backgrounds and are generally uneducated and unemployed or engaged in manual work (Cleary, 2005a, 2005b). This difference might well be explained by the wide recruitment strategy used, which reached people from different regions and through different sources. It is noteworthy

that most participants were not in stable relationships at the time of interview, and the three young men with children had erratic contact with their ex-partners and children. This is consistent with the findings from general statistics, which suggest that social isolation and not being involved in a stable intimate relationship can be risk factors for suicide-ality among males (Hawton, 2005; Qin et al., 2005). Furthermore, a number of participants reported having had relationship difficulties or break-down of significant relationships that contributed to their suicidal ideation and behaviours. It has been suggested that men seem to be more adversely affected by relationship break-down in terms of suicidality. This can be interpreted as a gendered disposition to self-blame when intimate relationships do not evolve as anticipated, or may result from the fact that men are more likely to isolate themselves following a relationship breakup (IAS, 2008). This picture is consistent with another Irish study that identified a link between isolation and suicidality among young males (Cleary, 2005a). However, given the duration and negative consequences of suicidality, it could be hypothesized that this in itself prevented the young men from engaging in, and / or impacted negatively, their capacity to sustain intimate relationships. Mehlum (2005) suggests that traumatic exposure, which many of the young men had in their lives and in their suicidal process, impacts one's ability to form and maintain stable interpersonal relationships.

Precise definitions in relation to the level of suicidality experienced by participants is problematic due to the lack of consensus regarding common terminology, the interchangability of terminology across contexts, and the subjective nature of labelling, as discussed in the literature pre-view. However, initial selection of some potential participants was made by experienced mental health nurses working specifically in the area of post-suicide crisis management (n=11), who assessed the young men as suicidal. Self-selected participants (n=6) were asked to provide details of their suicidal experiences to the researcher. The duration of participant suicidality ranged from two to nineteen years and levels of suicidality over time varied. There was a significant difference in terms of the number of suicide attempts made by individuals, ranging from none to twenty. In this study sample, eight participants made a single suicide attempt, seven made more than one attempt, and two did not attempt suicide. The two participants who reported that they had not made a suicide attempt were engaged with services due to psychiatric / psychological problems that

spanned extended periods of their lives. One described himself as consumed with thoughts of suicide to the extent that his life was put on hold at times, while the other young man was suicidal over a two year period. Close examination of the data from those who had and those who had not attempted suicide did not reveal any significant differences in relation to their recovery process. Hence, data from both sets of interviews was included in the overall analysis despite the theoretical distinction made between those who have suicidal ideation and those who attempt suicide (Beautrais, 2001). Thirteen participants became involved with mental health / psychiatric services directly following a suicide attempt. These factors are important in terms of the emergent theory, which specifically relates to overcoming suicidality, and does not attempt to explain continued suicidality or completed suicide. Finally, while some of the young men were diagnosed with psychiatric illnesses such as borderline personality disorder (BPD), post-traumatic stress disorder (PTSD), depression and schizophrenia, some had not received a psychiatric diagnosis. This is inconsistent with the view that most suicidal people are mentally unwell (Kelleher, 1996), but fitting with findings from another Irish study where diagnosis of psychiatric illness was not necessarily associated with suicidality among young men (Cleary, 2005a).

In summary, it can be seen that participants came from diverse socio-demographic backgrounds and encountered unique personal and life events that impacted their suicidality. In short the suicidal young man could be anybody, from any location or background with or without a psychiatric history.

Data Management

Interviews were tape recorded, with the consent of participants, and in the case of one participant who did not wish to have the interview recorded, notes were taken during interview. Data were stored in a password protected computer data storage system. Only the researcher and her supervisors had access to the data; this was part of the in-built consultation process within the study. Participant data did not contain any identifying information about individuals or organizations, therefore anonymity of participants and services and confidentiality of data were safeguarded. In line with ethical approvals raw data will be disposed of safely five years after completion of the study. Findings and recommendations are being disseminated through conference

presentations, paper publications and research reports to relevant bodies, such as mental health service users, practitioners and providers.

While information about data management was made available to participants, many sought specific reassurances regarding personal anonymity and data confidentiality prior to and following interview. This can be interpreted as a heightened level of concern regarding the sensitive material that was shared on a taboo subject and perhaps reflects a central issue in suicidality concerning concealment of the suicidal self and fear of exposure. It was important, therefore, to allow adequate time to discuss participants' concerns at all points of contact.

6.3 Building the Theory

The procedures followed for data gathering and analysis in this study were consistent with the guidelines established for conducting a classic GT study, incorporating selective and theoretical sampling. Selective sampling meant that engaging with the first-hand personal accounts of young men who experienced suicidality and had involvement with mental health services was considered appropriate to gain a beginning understanding of the phenomenon of male suicide-ality in contemporary Ireland. This involved four one-to-one interviews with young men recruited through the participating clinical site. Interviewees were invited to share issues that seemed important to them in relation to their suicidality, giving rise to elaboration of the core concern. This initial phase of the inquiry provided rich data to direct forward movement through to theoretical sampling. Theoretical sampling involved further face-to-face interviews with men within the substantive group. Selective sampling identified the core concern of participants in the substantive area and the processes in which they engaged to resolve this, while theoretical sampling progressively explored in more depth such processes, giving rise to the core variable.

Most interviews were tape-recorded to enhance researcher presence at interview which can be compromised by note-taking. Recordings were then listened to and six were transcribed for supervision / consultation purposes. Theory building involved a number of procedures, including: gathering data to inform the substantive area, reviewing interview data in detail, coding, comparing and clustering data, and

developing tentative hypothesis / conceptual explanations about connections between and across emergent categories. A number of categories and their properties were identified which led to the building of a significant volume of theoretical memos. Through further analysis, these categories were collapsed, leading to the building of a hypothesis about the relationship between categories, which is captured in the core concern, core variable and substantive theory.

Field notes were maintained throughout the process of data collection and analysis. Appendix 4a provides a sample of a field note relating to interview number two. Theoretical memos were recorded and updated throughout the inquiry process and appendix 4b provides a sample of a memo related to the property *soothing the pain*, which is incorporated into the minor category *dancing with death*, which is further incorporated into the more mature category *concealing the dark side*, and then incorporated into the sub-core variable *confronting a crisis of destiny*. Selectivity in recording field notes and memos is *"...controlled by the emerging theory as coding, constant comparison, analysing and theoretical sampling constantly correct the theory"* (Glaser, 1998, p.110). Additional techniques used to enhance this process involved re-reading field notes, re-listening to recorded interviews, adding to memos for theory building on the basis of new insights, and consultation with colleagues about the seen and unseen in the data (Glaser & Strauss, 1967; Glaser, 1978). These measures enhanced the possibility that the propositions from which the final conclusions were drawn meet stringent criteria for theoretical robustness.

Evolution of the Research Process

Given the emphasis on research as process in GT it is acknowledged that all aspects of the study evolve as the study progresses, including the research question (Willig, 2001). However, in order to focus the researcher on her area of interest, it is useful to declare explicitly the area of interest and / or a beginning research question at the outset. Thus, a beginning research question was formulated, *"What are the core concerns of suicidal young men in contemporary Ireland?"* This initial question supported the open nature of the unstructured interviews in the early phase of the study. As categories emerged they were conceptualized in the core concern, *negotiating a dialectic of destiny*. On the basis of this development the research

question was reformulated as *"How is these young men's conflict with living and dying resolved?"* The latter question helped to focus the interviews in the latter phase of the study specifically on the processes by which, or how, the young men resolved their dialectic of destiny. Exploration of the patterns inherent in this process led to articulation of the core variable, *re-vitalizing worthiness*, which describes the process of transcending suicidality.

Interviewing

Within this study, interviewing was the main form of data gathering; therefore, it is important to explicate how the interview process was understood. Interviews have both advantages and disadvantages. Interviewing is an interpersonal endeavour therefore a good alliance needs to be established between the researcher and interviewee in a relatively short amount of time. This is important so that the interviewee feels safe and comfortable enough to share personal and sometimes painful information with a relative stranger. Part of creating a safe conversational context is ensuring that boundaries around the interview process and content are clear, with the interviewee controlling the nature and depth of information shared and what is withheld. This means that the researcher must trust in the process and accept that the data will be useful and that key patterns will emerge through the conceptualization process (Glaser, 2008). The interview yields large quantities of data in a short time, and the opportunity is afforded the researcher to check the meaning of data with the interviewee. In this study permission was sought from participants to re-contact them should any further questions arise regarding their data or the study in general; all agreed to this arrangement and one was re-contacted to discuss the theory, while others who requested information will be provided with a summary of the findings as agreed at interview.

Interviews can be structured, semi-structured or unstructured. Structured interviews allow the researcher to take control of and determine the focus of the interview. They provide greater reliability as the format is consistent across interviews and are usually short as there is minimal digression from the topic. However, there are a number of disadvantages to the structured interview, including: restricted opportunities for unravelling complex and ambiguous issues; greater risk of missing out on novel and important aspects of the topic (Smith, 2008); and excessive topic control on the part

of the interviewer that may constrain the participant (Cutcliffe, 2000). The unstructured interview is usually more time consuming and more complex to analyse than the structured interview and the researcher has less control over the interview process. In the unstructured interview, the interview schedule serves as a guide for the interviewer, allowing her flexibility to probe interesting areas in more detail, establish rapport with the interviewee, and follow the interviewee's interests and concerns thereby obtaining richer data (Smith, 2008). In this study the initial interviews were unstructured and as key categories emerged interview questions became more focused.

The interview process can be experienced in different ways by participants; for some it can be an emotionally charged and distressing event while for others it can be a validating and therapeutic experience (Munhall, 1991). The researcher allowed time at the end of each interview for de-briefing with the participant and exploring their experience of the interview process and content. None of the participants expressed any concerns about the interview per se, indicating that, while some unanticipated issues emerged in the discussion, they had been psychologically prepared for the interview. This may be in part due to their own preparation for talking about personal issues and events, and in part to the level of pre-interview contact between researcher and participant where potential areas for discussion were identified. All contact was therefore viewed as a dialogic exchange holding transformative possibilities for all parties (Anderson & Goolishian, 1992). Information sharing can be viewed as performative of self at a moment in time as well as representative of a particular event, and can be presented differently in different contexts (McNamee & Gergen, 1992, 1999). Therefore, the researcher was concerned with the reality inherent in emergent patterns and the consequences these might hold for analysis and further inquiry, rather than the accuracy of participant accounts.

Kvale (1996) suggests that the quality of an interview determines the quality of the data. He proposes a number of criteria for measuring quality: short interviewer questions; long, rich, specific and relevant interviewee responses; follow-up meaning clarification; interpretation throughout the interview; and, verification of researcher interpretations. These criteria served as guidelines for analysing the quality of

interviews in addition to monitoring essential qualities such as openness and sensitivity.

In summary, interviewing, while challenging, can provide a rich source of data gathering. Unstructured interviewing reduces researcher control over the interview content and process while offering opportunities for the unexpected to emerge, which is fitting with the aims of a GT study.

Methodological and Technical Considerations

Given the nature of this particular study, research with young men who were formerly suicidal, some reflective work was completed in advance of meeting participants in order to anticipate challenges and barriers to the study, leading to the development of practical study procedures and safety protocols. However, while some issues were anticipated in advance of the study, the unexpected also emerged as the study unfolded, posing some methodological considerations which translated into changes in specific technical procedures. Hence, on-going reflection and review of protocols and procedures was necessary. The issue of stigma has been discussed in the literature pre-view, however, the manner in which it became operationalized within the study was not fully appreciated until the study was underway. It impacted recruitment and raised concerns about data management. It was also a central issue for participants in relation to their process of overcoming suicidality, as detailed in the following chapters.

The nature of the study also required consideration of some specific gender and topic related issues. For example, engaging with participants in a way that respected anxieties about emotional transparency (Whitehead, 2002), by ensuring readiness to participate, confidentiality of data, and debriefing space. Acknowledging the importance of mutuality in social relationships was also important (Bille-Brahe et al., 1999), by informing participants that others were more likely to benefit directly from the study findings than themselves as they were already involved with health services, although the potential for therapeutic benefit derived from participation cannot be overlooked. Anticipating potentially low response and attendance rates was addressed by recruiting widely, through different modes of communication, and sending reminder messages about interview appointments (Begley et al., 2004).

Finally, safety was promoted by reviewing protocols and procedures in relation to each participant depending on how they were recruited and the issues that they presented before and during interview.

6.4 Ethical Considerations: Ensuring Safety in a Risk Context?

"Health care providers must tread a fine line between appropriately protecting vulnerable populations and paternalistic decision making supposedly made in the patient's best interest."

(Raudonis, 1992, p.242)

In order to ensure that all persons engaged with this study were treated with dignity and respect at all times, given the nature of the inquiry topic and population, a number of ethical concerns were identified that had the potential for social, emotional and psychological harm. Specific areas that warranted consideration centred on the sensitive nature of the inquiry topic and the vulnerable, age and gender specific nature of participants. These issues together with consideration of power relations, could have influenced the researcher in her engagement with the topic and participants.

The ethical and professional principles outlined in the previous chapter guided the researcher in anticipating ethical challenges in conducting this study, and a participant risk-benefit analysis was conducted. Within this study three potential participant risks that were identified included stigmatisation, traumatisation and exploitation, while the researcher-participant relationship also warranted consideration at different levels. Potential non-participant risks centred on researcher physical and psychological safety (Etherington, 1996), and contextual awareness (Robson, 2002). These interlinked issues and the management strategies developed to minimise them are discussed below. The possibility of emergent ethically significant moments throughout the study was also considered (Redwood & Todres, 2006).

Participant Considerations

A number of participant-related issues were considered prior to the study as described below.

Sensitivity and Vulnerability

The topic under study could be considered sensitive as it is emotionally charged and surrounded with social stigma (Renzetti & Lee, 1993), while the target population comprised suicidal young men who could be considered vulnerable as they could have been psychologically distressed at the time of interview (Rouf, 2004). However, it is important to note that sensitivity refers to the social status of a topic rather than the topic per se (Renzetti & Lee, 1993), and vulnerability remains a vague concept (Rouf, 2004). Indeed, as this study unfolded, both concepts underwent significant re-visioning due to social pressure and political strategizing associated with the issue of suicide-ality in Ireland. For example, a public awareness campaign was launched that sought to de-stigmatise mental ill-health and suicide (NOSP, 2007).

Stigmatisation

Stigmatisation refers to exposure of the person to a situation that could be experienced by him as negatively biased or judgemental. Within this study, the screening practices used to recruit participants could have led to a risk of stigmatisation. The site clinician identified potential participants who met the study criteria and provided them with information about the study. However, it is unclear to what extent they or others, professionals and social contacts, engaged in assessing their readiness and willingness to discuss personal and potentially distressing life events and consequently influenced their decision to participate, thereby privileging the expertise of others over individual autonomy. Furthermore, if the person were deemed to be at risk of suicide or self-harm during the interview process, he would be informed about this view and be advised to seek professional help. This could be viewed as stigmatizing if the young man did not perceive himself in this way, did not wish to be informed about this view of his mental status, or did not wish to be involved with health professionals at that point in time. Therefore, fairness to all concerned and sensitivity to distress, should this arise, needed to be considered.

It is widely accepted that every individual has a right to privacy (Beauchamp & Childress, 1989), therefore, a further risk of stigmatisation could occur if the study participants were identifiable or the data they provided was recognisable as belonging to them. Hence, it was important to ensure confidentiality of data and anonymity of participants and to inform participants about these measures and their limits. For

example, the legal and ethical limits of confidentiality, such as court subpoena, a freedom of information request, or reporting required explanation.

Traumatisation

Traumatisation refers to increased distress directly related to engagement in the research process. Within this study, traumatisation could have occurred through the recall of distressing and painful material leading to reactions such as increased anxiety and / or suicidality. This issue was addressed in the safety protocol by offering to terminate the interview, providing debriefing, and providing follow-up counselling where necessary. However, it is important to acknowledge that participants can derive therapeutic benefit by participating in a study that gives voice to troubling and predominantly silent and private issues. Therefore, it was important not to assume that distress was an abnormal response and to be prepared to discuss this with participants in the event of this arising.

Exploitation

Exploitation refers to putting the needs of the research above those of participants and treating them in a manner that does not consider their wishes; this can happen in the event of role confusion and / or conflict of interest. Hence, the multiple roles of the researcher, as clinician, researcher and PhD candidate, warranted some consideration. Participants might have felt exploited if they were pressurised to elaborate issues that they did not wish to discuss, if information was misused, or misconstrued through the enactment of personal / professional biases. Therefore, it was important to emphasize to participants that they retained overall control in communication with the researcher regarding the nature and level of material shared. They were advised that should they feel coerced into disclosing information that they did not wish to share, or engaging in activities that had not been explicitly negotiated with them, they should seek clarification and / or terminate the interview. The use of data in the dissemination process was explained and will be adhered to throughout reporting, and the researcher closely monitored the interview process for researcher bias. For example, the researcher's bias toward collaborative care might lead her to be critical of care perceived as paternalistic, regardless of how this was viewed by the participant, thereby inadvertently compromising the participants' perspective.

Risk-Benefit Ratio

Ethical issues in terms of *risk-benefit ratio* are concerned with judging the potential benefits, either to an individual or to society, against the possibility of harm to the individual or another party (Long & Johnson, 2007). It is noteworthy that current statistics suggest an inherent level of risk of suicide and self-harm associated with the target participant population, particularly if they did not avail of professional intervention. Therefore, it was envisaged that being involved in the study may not increase, and might serve to decrease, this risk for some participants through the provision of information about support systems and the empowerment of participation in itself. Furthermore, the potential benefits to participants, the wider clinical population and society at large, in conducting this study by taking action to alleviate the distress associated with the critical issue of suicide-ality were deemed to outweigh the risks associated with not engaging with this group and topic.

Researcher-Participant Relationship

The researcher-participant relationship warranted some consideration in terms of the gender and age differential between the researcher and participants, as the researcher was female and older than the participant group. While this may be disadvantageous in terms of similarity, it has been noted that most distressed young men are more likely to confide in females, particularly their mothers, than any other person in their lives (Begley et al., 2004). Therefore, this age and gender difference might have been experienced as comforting to participants. This issue was explored with participants during the research process and was viewed positively by them.

Inger and Inger (1994) emphasize the potential for misuse of power in human interaction, suggesting that the way power unfolds depends on how power differentials are perceived and processed by all concerned. Within the research domain, power may be misconstrued as belonging with the researcher and may be enacted in this way, leading to hierarchical practices with participants (Downey et al., 2007). Consequently, the more covert shifting power differential may be ignored to the determent of both researcher and participant. It is useful therefore to reflect on how the power differential in relationships among the key players might be reflected in research practices. It was anticipated that the relational stance of both researcher and participant, as influenced by the values and assumptions held by both, would

influence the researcher-participant relationship, whereby the researcher and participant could both make and take different positions as negotiated, explicitly or implicitly (Anderson & Goolishian, 1992, 1999). This was also monitored closely in the interviews, with specific attention paid to moments of discomfort that might signal power imbalance. Furthermore, as initial procedures were drawn up by the researcher without participant input, close review was necessary with participants throughout the study process.

Summary

Participant considerations associated with the conduct of this study included: stigmatisation, or exposure of participants to a situation experienced by them as negatively biased or judgemental; traumatisation, or increased distress directly related to engagement in the research process; and, exploitation, or putting the needs of the research above those of the participant. A risk-benefit ratio analysis was also conducted to balance potential risks and benefits to individuals and society. Risk management procedures were established to address potential participant risks. Briefly, this meant ensuring that adequate information was made available to participants about the nature and purpose of and procedures for the study, the potential risks to them, and the safety protocols that had been established to address emerging concerns. It meant providing space prior to, during and following the interview to discuss the process with participants so that they could voice their concerns and make suggestions; this promoted informed choice about their involvement in the study throughout the evolving process. It also required liaising closely with other members of the inquiry system so that emerging concerns could be addressed quickly and safely, and safely storing, retrieving and reporting on data throughout the study.

Researcher Considerations

"Researchers working in the domain of vulnerable consumers need to be aware that feelings of vulnerability may be reflected back to the researcher."

(Downey et al., 2007, p.734)

It has been acknowledged above that when exploring a sensitive and private topic and / or conducting an inquiry with vulnerable people there exists a risk of intrusion,

exposure and over-disclosure on the part of the researched, which can also be experienced by the researcher (Downey et al., 2007). According to Downey et al. (2007), researcher risks are underestimated due to the assumption that power resides with the researcher, and consequently there is a failure to acknowledge the shifting power differential and boundaries in the two-way vulnerability between researcher and researched. Johnson and Macleod Clarke (2003) identified a number of contributing factors to researcher experiences of distress. These included role conflict, lack of training and confidentiality concerns. Therefore, in addition to ensuring physical safety of the researcher, it is important to consider issues that might increase the risk of “psychological overload” and “responsibility anxiety” (Etherington, 1996) associated with the research topic, population and process.

Physical Safety

Within this study the issue of *physical safety* was important given the nature of the study. The researcher was meeting with young men who had a history of self-harm, some of whom might also have engaged in other-directed violence (Aldridge, 1998). These factors led to the development of a safety protocol for the researcher, which indirectly provided additional safety for the participant through researcher comfort with the interviewing arrangements. This meant arranging interviews in a safe location and informing another person about interview arrangements.

Psychological Overload and Responsibility Anxiety

The researcher can experience *psychological overload* through the intense listening to traumatic stories of participants. This was a potential risk in this study as participants were being invited to discuss their suicidality which might also have involved disclosure of distressing life events. However, intense engagement with the participant is necessary in order to hear fully their story, respond empathetically, and re-visit the pertinent detail of these stories for in-depth analysis. *Responsibility anxiety* refers to the researcher taking on responsibility and perhaps attempting to resolve participant distress. This is more likely to occur if the researcher holds the dual role of clinician and researcher, as was the case in this study (Etherington, 1996). Both psychological overload and responsibility anxiety can lead to symptoms such as restlessness, sleep disturbance, and over-enmeshment with or disengagement from the

study (Downey et al., 2007). Therefore, the researcher monitored herself closely for such signals as the study progressed.

Similarities between the research and therapeutic interview have been noted in terms of: interviewer skill (Rafuls & Moon, 1996); researcher empathy and emotional transference (Cutcliffe, 2003); researcher authenticity and reflexivity; and creating a trusting and safe context (Redwood & Todres, 2006), which facilitates the clinical researcher to move smoothly between both domains. However, Etherington (1996) emphasizes that these are different contexts and advises putting aside the clinician part of oneself as a way of ensuring safe and appropriate research boundaries. The researcher agrees with her to the extent that the contexts for both clinical and research interviews differ, which changes the rules for engagement with the other. For example, time constraints do not permit the gradual building of a trusting relationship; instead this must be created in a short encounter. However, rather than bracketing off aspects of the self to enter the researcher role, a more realistic and achievable goal might be to attend reflexively to and manage responsibly potential areas of role confusion. Therefore, researcher self-care was monitored throughout the study through formal and informal consultation and supervision. For example, the researcher used consultation and wrote extensive field notes to attend to these boundary issues, particularly when she experienced an encounter as emotionally 'heavy' or felt uneasy about the interview process.

Summary

In summary, a range of issues impacts the researcher over the course of a study, which ultimately influence how she engages with the study and those involved in this. Therefore, it is important to attend to these to safeguard all concerned. In this study, potential researcher risks included physical and psychological safety that necessitated self-care and use of support systems.

Contextual Considerations: Contextual Sensitivity

Contextual considerations refer to how one attends to issues related to the wider context within which the study is taking place, and can be described as *contextual sensitivity*. It has been proposed that the researcher needs to be contextually aware in relation to: entering a domain that may have many competing agendas, which may or

may not include the research study (Robson, 2002); having multiple research audiences and possibilities for utility of the text produced (Redwood and Todres, 2006); utilizing contextual knowledge and experiential alertness to position oneself as the study process unfolds (Kirby, 2007); and taking responsibility for the influence of the research (Stevenson, 2005). Each person associated with the study had his / her own priorities and agendas and it was important that the research was not contaminated or overly limited by these. Therefore, potential conflict of interest and / or misuse of data required close examination, monitoring and negotiation. Contextual issues also involved balancing respect for local knowledge with the collaborating clinical partner while ensuring that participants were treated in a fair and respectful manner in terms of recruitment. It was also important to ensure that the integrity of collaborators was safeguarded in all communications with and about them, and that relevant others received recognition for their contribution to the study. In summary, contextual considerations included being aware of issues within the wider research context such as competing interests and agendas, and negotiating these as required (Robson, 2002).

Summary

In summary, an ethics as process perspective espouses the ideas that there are multiple and evolving meanings inherent in any ethical principle, and that the relationship between the researcher, the researched, the data and the study process are continuously negotiated between persons, rather than being determined by the pre-ordained status of those persons and static ethical principles (Ramcharin & Cutcliffe, 2001; O'Neill, 2002). This in turn means that privileged principles and commitments provide a broad guide for the researcher around which she can explore the affordances and constraints associated with decision-making, rather than providing a blueprint for action (Stewart & Amundson, 1995). Given the complexity of the ethical considerations outlined for this study, it was imperative that the researcher be sensitive to the interests of multiple parties in this process, and that emergent and unanticipated dilemmas be attended to and managed throughout the course of the study (Redwood & Todres, 2006).

6.5 Summary: Negotiating Movement

This GT study was conducted over a three year period and involved interviewing seventeen men from different socio-economic backgrounds. Participants had experienced different levels of suicidality over time and had different experiences of mental health services in terms of duration, nature of contact, and perceived quality of service provision.

A number of interrelated philosophical, ethical and methodological challenges were identified prior to and during the study. Philosophical challenges centred on examining the researchers assumptions about suicide-ality and the suicidal person. These were identified through personal and relational reflexivity, enhanced by the use of field notes and theoretical memos as the study progressed. Potential participant, researcher and contextual ethical considerations were identified, which centred on balancing values that promoted a safe research context with the research agenda. Within this study, specific considerations concerned the sensitive nature of the inquiry topic, and the vulnerable, age and gender-specific nature of the sample (Renzetti & Lee, 1993; Rouf, 2004). These interlinked issues required the development of management strategies to minimise the possibility of their emergence and attend to them when necessary. Technical and methodological issues centred on enacting espoused ethical values in all research practices in a congruent manner to promote study integrity and methodological coherence. This meant that research procedures and protocols were treated as tentative, were reviewed for unique participant and context fit, and were revised as deemed necessary in light of emergent concerns and insights.

Having provided the methodological, philosophical and ethical context for this study the following three chapters describe the emergent theory, *re-vitalizing worthiness in transcending suicidality*, in detail. Throughout this discussion links will be made with the literature as outlined in the literature pre-view and beyond to elaborate some of the emergent concepts.

Chapter 7. The Theory: Re-Vitalizing Worthiness In Transcending Suicidality

"To be or not to be; that is the question
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take arms against a sea of troubles,
And by opposing end them. To die; to sleep;
No more; and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to, 'tis a consummation
Devoutly to be wish'd. To die; to sleep…"

(Shakespeare, Hamlet, Act 3 scene 1)

7.1 Introduction

This study was concerned with gaining a better understanding of the phenomena of suicide-ality among young men in contemporary Ireland in the context of a significant rise in completed and attempted suicide in recent decades among this group. Given the dearth of theory in this specific area, the aim of the study was to develop a substantive theory that would explain a key aspect of suicide-ality that could be utilized to inform professional practice in the domain of mental health. GT, while acknowledging the unique nature of individual accounts, asserts that latent patterns exist within social and psychological phenomena that can be identified, conceptualized and theorized across data indicators (Glaser & Strauss, 1967). However, at the outset of a study it is often not clear to what such patterns will specifically relate, as the outcome is unknown. Therefore, GT identifies the core concern of those most affected by or at the centre of the area of study. When this has been established, the researcher seeks to identify the processes in which participants engage to resolve this concern, which is captured in the core variable.

The procedures followed for data gathering and analysis were consistent with the guidelines established for conducting a classic GT study, as outlined in chapters five

and six. Seventeen participants took part in one-to-one interviews and the data were analyzed until a point of theoretical saturation was reached, leading to the emergence of a substantive theory *Re-vitalizing Worthiness in Transcending Suicidality*. The core variable, *re-vitalizing worthiness,* captures the psychosocial processes in which the young men engaged to resolve their core concern, *negotiating a dialectic of destiny*, which refers to the young men's perpetual working out of their relationship with living and dying and their place in the world. When transcending suicidality this destiny negotiation process focused primarily on how they would regain a sense of worthiness to be, in order to establish new viable and rewarding identities and lives.

To contextualize the theory this chapter will elaborate the core concern, core variable and theory, and briefly discuss the connection between substantive categories incorporated into the theory and literature in the field of suicidology and beyond. It will introduce the two sub-core variables, *confronting a crisis of destiny* and *earning a life*, incorporated into the core variable. The sub-core variables describe the process of re-vitalizing worthiness which entails identity re-configuration and is enhanced by epiphanies. In the interest of transparency, the connection between data and theory is clearly explicated in this and the following two chapters.

In keeping with the classic GT methodology, the researcher refrained from accessing the body of knowledge that related specifically to the emergent theory until the theory was well developed. Consequently, the following chapters incorporate literature not included in the initial literature pre-view. This illustrates further refinement of the emergent theory and places it in the wider knowledge domain. This discussion is interspersed with participant quotes italicized outside the main text. As patterns are conceptualized across the data, quotes are used to illustrate patterns and to enliven the discussion rather than representing individual accounts; hence, they are not linked to individual participants.

7.2 Theory Development

Data gathering and analysis in GT is a cyclical process, however, for the purpose of clarity this is described in two distinct yet interlinked phases that spanned selective and theoretical sampling. Phase one was concerned with identification of the core concern of participants, *negotiating a dialectic of destiny,* which emerged in the first

four interviews. Phase two focused on identifying the key process in which participants engaged to resolve this concern. Thus, the core concern provided a conceptual framework for theory development and a focus for further interviews. Phase two involved analysis of interviews five to seventeen and revisiting the first four interviews for unseen concepts that related specifically to this process.

Theory building involved identifying a number of categories and their properties. Through further analysis, these categories were collapsed, leading to more mature categories and hypothesis making about the relationships between categories. As analysis progressed, it became clear that the young men in this study resolved their core concern by transcending suicidality. Hence, theoretical sampling in later interviews specifically explored the process by which they moved beyond suicidality, or *how* this occurred and the manner by which this was facilitated. This led to development of the core variable which was conceptualized as *re-vitalizing worthiness*. This describes how the young men regained their worthiness to be as individuals and found a worthy place in the world, which entailed remaking their sense of selves. This process involved synthesis of their conflicting desires for life and death, which gave rise to a fragmented identity, replacing this with a coherent identity that focused on living while being aware of death. This was made possible through inner and outer dialogue (Seikkula et al., 1995) frequently initiated by turning points (Strauss, 1969; Denzin, 2001) that led to significant life changes.

The concept of worthiness has been theorized in different ways and terms such as self-esteem, self-worth, self-image, self-concept and self-acceptance have been used in the literature to capture the person's sense of personal value (Huitt, 2004; MacInnes, 2006; Wislesky, 2007). Some authors make clear distinctions between these terms, for example seeing self-concept as a cognitive process and self-esteem / worth as an emotional aspect of the self, while others use the terms interchangeably (Huitt, 2004; MacInnes, 2006). One definition of self-worth describes it as the feeling that one is a worthwhile human being despite one's faults and imperfections (Milliren & Maier, 2004), relating it closely with self-acceptance, which is said to underpin psychological and physical health (MacInnes, 2006). In the context of this study, worthiness is used as an umbrella term referring to the young men's sense of being worthy as individuals and being worthy of life despite personal and worldly

imperfections thereby incorporating their acceptance of their selves and lives (Milliren & Maier, 2004). It refers to the totality of the young men's identity that incorporates their cognitive, emotional, physical, spiritual and lived selves which combine to inform them about their value as individuals deserving of life. This view of worthiness situates it as a dynamic and holistic process that both influences and reflects problems in living that are inextricably linked to the young men's social context (Crocker & Park, 2004). The term re-vitalizing is used to capture the process whereby the young men brought to life a part of their being that had been dormant, their worthiness to be, regardless of the degree to which they felt that this was previously present or absent.

Table 7.1: Study Phases

Phase 1: Core Concern	*Negotiating a Dialectic of Destiny*	Working out one's relationship with living and dying and one's place in the world.
Phase 2: Core Variable	*Re-vitalizing Worthiness*	Engaging in a process of re-gaining worthiness as a person and deservedness to be.

The latent patterns identified in a GT study are explained through theoretical codes that implicitly or explicitly bring coherence to the data around the core variable, which in this study is described as a psychosocial process. The substantive theory is then examined in relation to pre-existing theory thereby situating it in a scholarly context. Theoretical perspectives can derive from any discipline as the analyst scans the literature to identify frameworks that enhance and make sense of the emerging theory. For example, this study draws upon social constructionist theory (Berger & Luckman, 1966) as one way of understanding re-configuration of a worthy identity.

7.3 The Core Concern, Core Variable and Theory

The core concern, core variable and substantive theory that emerged in this study are briefly described below and some theoretical concepts from the literature are identified that served to bring coherence and depth to this discussion.

The Core Concern: Negotiating a Dialectic of Destiny

In the initial phase of the study, participants were invited to talk freely about their personal views on suicide-ality and life, and what they considered important in terms of understanding their situation and needs. Data analysis involved identifying initial categories and their properties and formulating propositions about the connections between categories. The aim of analysis at this stage was to establish the core concern of the young men by asking of the data *"What is going on in the substantive area?"* The core concern was conceptualized as *negotiating a dialectic of destiny*. It proposes that these young men were engaged in a process of establishing if and how they deserved to be in the world, thereby capturing a dialectic. Two opposing pulls, one that yearned for death and the other that yearned for life, occupied the being of these young men whose worthiness was both brought into question in suicidality and subsequently re-established beyond suicidality. Hence, the meaning of this dialectic and the manner by which the young men attempted to resolve it depended on their position on the suicide trajectory and life pathway, giving rise to different challenges and existential questions, such as: Should I live or die? and How will I live, with whom, in what world? Therefore, the core concern was a continuous issue for these young men, in and beyond suicidality, and took different shapes over time.

Given the profound nature of the dilemma that these young men were attempting to resolve, transcending suicidality was a complex journey for which they needed to be prepared and resourced. There was forward and backward movement within it as their negotiation process changed its focus and meaning while they moved along the suicide trajectory and life path in a somewhat unpredictable way. This journey was punctuated by turning points (Strauss, 1969; Denzin, 2001) that facilitated inner and outer dialogue (Seikkula et al., 1995). Such dialogue significantly impacted this process, as multiple components of their lives were simultaneously reappraised, changed and consolidated, from their inner core to their outer presentation in the

world. Hence, the core concern of the young men, *negotiating a dialectic of destiny*, was an unending process of evolving their being which consolidated at points along this journey, and remained part of who they became. In summary, the core concern captures the central issue for the young men in and beyond suicidality, working out their relationship with life and death and their place in the world.

The Core Variable: Re-vitalizing worthiness

"A process consists of unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between. The temporal sequences are linked in a process and lead to change. Thus, single events become linked as part of a larger whole."

(Charmez, 2006, p.10)

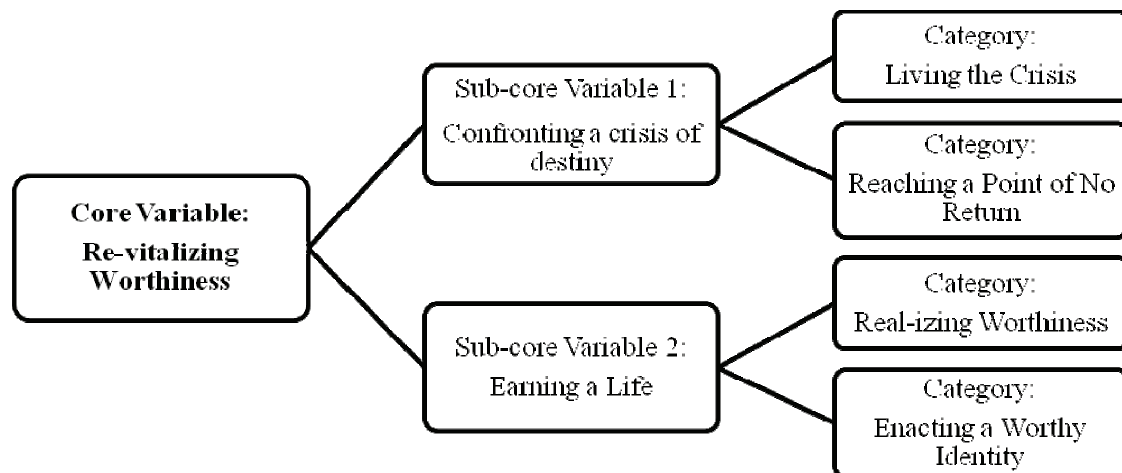
The second phase of the study involved further unstructured interviewing wherein interviewees were invited to talk specifically about the processes in which they engaged to resolve their core concern, *negotiating a dialectic of destiny*. Data analysis at this stage involved building and collapsing categories, identifying patterns across the data, and formulating hypotheses about relationships among categories and patterns. This was facilitated by theoretical sampling that sought detailed information to enrich and delimit categories. More mature categories were identified which, through further analysis, led to the emergence of the core variable *re-vitalizing worthiness*.

A core variable refers to a category that constantly reoccurs in the data and has explanatory power to integrate all other categories, thereby providing an explanatory whole to the data (Glaser, 1998; 2001; 2009). The core variable in this study, *re-vitalizing worthiness*, explains the latent patterns of action and meaning-making in which participants engaged to resolve their core concern. It describes the psychosocial processes in which the young men in this study and social context engaged to resolve their conflict about living, dying and their place in the world. This process entailed identity re-configuration and significant life changes, frequently initiated by turning points and inner and outer dialogue. The young men moved from in suicidality, a position of living and waiting to die, to beyond suicidality, a position of living to live and accommodating the reality of death. They re-evaluated and

rebuilt their selves and their lives, a process which was made possible by validation of their worthiness as persons of value and deserving of life.

A process has a temporal dimension and a number of linked stages that lead to a particular outcome (Charmez, 2006). The re-vitalizing worthiness process described in this study, comprises two stages represented in the sub-core variables, *confronting a crisis of destiny* and *earning a life*. These are distinctive, temporal and incorporate a number of categories and their properties, as diagrammatically presented below. This process required the young men to engage with their selves and their worlds anew, thereby developing a sense of purpose and meaning in life. For some, this involved establishing for the first time their value as persons and their deservedness of life. For others it involved re-establishing and recalibrating those previously lost dimensions of their lives and selves.

Figure 7.2: Core Variable and Sub-Core Variables



The sub-core variables are presented as distinct yet interdependent stages of *re-vitalizing worthiness*. In the first stage, *confronting a crisis of destiny*, the young men, reaching a point where life has become overly burdensome, confronted and resolved their conflict about life and death. They decided that life must change, the alternative being death, and therefore made a choice to give life a chance. During this stage the young men used a number of strategies with the dual purpose of protecting

their selves and others from the dark side of life, suicidality and death. They concealed temporarily their inner fears and anxieties about their life-death battle, thereby avoiding exposure of themselves and others to the suicidal self, which represented failure and unworthiness. It also shielded others from their worlds, which could have been perceived as abnormal, and from the closeness and inevitability of death, which is generally regarded as a painful reality and taboo subject (Becker, 1973).

"I used to put on the brave face myself and nobody knew."

However, it was not possible for these young men to carry the burden associated with living between the worlds of life and death indefinitely. As the pressure and pain mounted they became exasperated and yearned for release. Hence, they were forced to confront their inner crisis of destiny, which required them to make a definitive choice regarding on which side of the life-death boundary to situate themselves. They chose life and discovered that this choice mattered to them and others and they could live differently.

"So, whether I like it or not, if I want to stay alive I have to start changing the things that I used to do in the past…"

The next stage of *re-vitalizing worthiness*, *earning a life*, refers to how the young men established and consolidated their worthiness and new identities in the world. Having confronted their destiny crisis, they were challenged to decide how to go on in life in a meaningful way which required constructing worthy identities. This meant generating a sense of identity that represented them as beings deserving of life. It also meant relinquishing redundant patterns of concealment and denial, and beginning the process of rebuilding a new self and place in the world. It involved becoming real to their selves and others and reappraising their world view and reality by letting go of their shamed past and their fantasy selves and lives. Having questioned their worthiness as persons deserving of life these young men engaged in activities that confirmed their worthiness and built their self and relational respect. They re-engaged with their selves, others and the world in new ways, *as if* beginning life again, and began to see more positive life possibilities. They carefully rebuilt their

lives and living contexts and situated themselves in these new worlds in ways that demonstrated competence and confidence. Once established, the young men could begin the process of living out their new and worthy identities.

"Even my close friends said 'a while back you were in bits……now you are smiling, your eyes are always beaming, like you are a re-born child'."

Undergoing a transformation of their identities was frequently initiated and punctuated by identifiable turning points, which refer to significant catalytic events that change one in a profound way (Strauss, 1969; Denzin, 2001). For these young men such turning points incorporated intrapersonal and interpersonal moments of awakening, achieved through deep personal reflection and meaningful interpersonal encounters, described in this study as inner and outer dialogue (Seikkula et al., 1995). Through personal and interpersonal exploration and exchange, the young men were challenged to re-evaluate their perceptions of themselves and their place in the world, culminating in significant life changes. One such turning point was reaching a point of no return, such as surviving a suicidal act which signalled that life had become untenable and had to change. When given another chance to live the young men embraced this. They challenged the values, beliefs and behaviour patterns that were dominated by a death orientation, transforming these and their selves in the process. It has been suggested that, *"Thoughts of suicide do not easily disappear without the person at risk experiencing some change. Their situation, or their feelings about it, may change, or they may feel more supported and able to deal with it."* (IAS, 2008). In this study, the young men reflected on how their life situations had rarely changed, however, their perspectives on their selves and lives shifted significantly. This allowed them to become more accepting of their ordinary lives and the sometimes mundane aspects of living which they began to recognize as rewarding and enjoyable. It also allowed them to live in the present rather than the past or the future.

"Life is not perfect. You just take the bad with the good – that's life – there's an acceptable level of pain in living."

The young men demonstrated that they could move beyond suicidality and re-establish valid identities in the world. Moving beyond a death orientation raised new

challenges for them and instead of asking themselves *if* they should live or die they asked themselves *how* they should live. Having decided to live, they worked out what life could and would look like, who would and would not be involved in it, and what direction it would take into the future. Hence, they continued to negotiate their place in the world and their pathway in life, while becoming more focused on living than dying. Having had the experience of getting to know death, or acquiring a death awareness (Deci & Ryan, 2004), the process of moving on with life entailed finding a viable life through establishing worthiness and coming to terms with their mortality. It has been suggested that "death awareness" is an extraordinary experience as people, for the most part, move through their lives giving little consideration to death and dying. This can be understood in terms of a defence against the anxiety provoked by the realization that death is inevitable (Becker, 1973; Deci & Ryan, 2004), which contributes to making death a taboo subject (Glaser & Strauss, 1965). This may explain why the young men avoided confronting their dialectic of destiny for so long, however, this realization ironically provided an impetus for change.

"I wanted to change everything nearly in my life, everything, like a new start…"

In summary, the young men in this study felt invalidated, questioning themselves in terms of their worthiness to be and their deservedness to live. They shared a concern about how to negotiate their relationship with life and death that was expressed in different ways depending on their place on the suicide and life trajectory, from painful and negative to determined and positive. They had a strong sense of being a worthless no-body that needed to be concealed from the world when in suicidality, to being a proud visible somebody when beyond suicidality. The process of regaining worthiness was enhanced by inner and outer dialogue frequently triggered by validating encounters with others, while worth-diminishing encounters impacted negatively on their re-configuration process. Transcending suicidality can be viewed as a discontinuous process, punctuated by turning points, that incorporated insights gleaned from inner and outer dialogue. It comprised two stages that were evolving, temporal and interconnected as each stage provided a context for and facilitated the following stage while enhancing the preceding stage.

The Theory: Re-vitalizing worthiness in transcending suicidality

The theory, *re-vitalizing worthiness in transcending suicidality*, captures the process whereby the young men in this study brought life to a part of their being that was dormant: their sense of worthiness as human beings. It describes a two-stage interconnected psychosocial process with a temporal dimension synonymous with transcending suicidality whereby the young men shed their suicidal selves and moved forward to build and enact new lives and worthy selves. This major shift involved the young men making a number of choices about how they positioned themselves in relation to their suicidality, their selves, their relationships and their worlds. Rather than concealing their suicidal selves, they began to accept this as part of who they were and to do so in a way that allowed them to occupy themselves with living rather than dying. Hence, their re-configuration reflected synthesis of their conflict with life and death and integration of their disintegrated selves.

"And all of a sudden I began to think about how I could create a place for myself in the world, a place where I could be comfortable."

For the most part *re-vitalizing worthiness* was a challenging process. It was unpredictable as the young men could not predetermine how the future would evolve, despite their determination to make their new lives viable and shape them in their way. They lived with the unknown about death and entered the unknown about and in life, with the certainty of death incorporated into their being. The process of transcending suicidality can thus be described as moving from a position of living to die when in suicidality, to a position of living to live and die when beyond suicidality. Hence, engagement with questions about living and dying were unceasing as they moved along a yet to be discovered pathway in living and life. It was an on-going becoming rather than a finalized being. However, the unfinished journey may be viewed as a strength rather than a sign of incompleteness, as it helped to guard these young men against the complacency that can set in when one has been there and done that, and the arrogance that can blind one to the potential challenges and pitfalls that might lie ahead. The young men demonstrated a strong sense of having grown and earned a place in the world through their renewed commitments and contributions to self and society, gradually re-vitalizing their worthiness in the entire process. They

reshaped their identities and began to live their lives in ways that were acceptable to them, living life in a world that could not only be tolerated but enjoyed. They established themselves as valuable human beings worthy of life, giving them permission to be.

"I suppose your horizons broaden and your thinking expands, and I started thinking, 'okay well maybe I can start to think about the future and consider what the future might hold for me'. And that is when I started to think about work and what I might do and education and college and all that kind of stuff…"

Embedded Ideas

There are a number of fundamental interlinked ideas embedded in the substantive theory proposed in this study, *re-vitalizing worthiness in transcending suicidality*. Firstly, the theory suggests that it was possible for these suicidal young men to transcend their suicidality and move on to live viable lives. Transcending suicidality suggests that the young men did not merely get over their suicidal crises, but incorporated death awareness into their being and moved on in life with a more integrated sense of their identities, having resolved their dialectic of destiny. It has been suggested that the idea of incorporation of one's past life and experiences reflects the complex process of overcoming adversity (Evans & Lindsay, 2008).

Secondly and centrally, the theory suggests that the process of *re-vitalizing worthiness* was foundational on transcending suicidality for these young men, forming the cornerstone of their self reconstruction. Hence, it was necessary for them to reclaim their worthiness as individuals who were deserving of a meaningful life by way of overcoming suicidality. A sense of being worthy as a person is one of the "illusory basis assumptions" assumptions that people hold which allows them to progress with living while deferring the reality of their impermanence and vulnerability, the unpredictability and potentially destructive nature of life, and the uncontrollability and fragility of living (Lazarus, 1983; Janoff-Bulman, 1985; Reisman, 2001). Hence, this fundamental assumption required re-examination by these young men.

Thirdly, the theory suggests that it was possible for important aspects of the young men's identities to be reshaped and for them to enact new identities. Therefore, it

reflects a social constructionist view of identity which proposes that identity is a multiple, evolving and contextually and historically bound phenomenon (McNamee & Gergen, 1992; Burr, 1995). From this perspective, identity reconstruction is a continuous social process wherein a person can deconstruct dominant world and personal views of their self and reconstruct a more acceptable and rewarding identity (McNamee & Gergen, 1992; White, 1995). Hence, the young men in this study were able to dismantle and rebuild their selves in ways that allowed for the shedding of unworthy identities and the remaking of worthy identities. While identity re-configuration was central to transcending suicidality the theory also resonates with a view that identity coherence and stability is important in promoting a sense of worthiness (Strauss, 1969), thereby balancing self change and stability.

Finally, the theory proposes that *re-vitalizing worthiness* represents a discontinuous change process that is punctuated by turning points (Strauss, 1969; Denzin, 2001). These turning points frequently took the form of validating events that stimulated inner and outer dialogue (Seikkula et al., 1995) culminating in changed perspectives and being.

7.4 Summary

This chapter provided a broad outline of the core concern, core variable and substantive theory that emerged in this study, which relates to how the young men who participated transcended suicidality. This process entailed regaining worthiness and recreating their personal identities by incorporating both life and death into their being and integrating their disintegrated selves. They thereby confirmed their value as human beings and established their deservedness to live.

In the early phase of the study, during the first four interviews, the core concern of participants, *negotiating a dialectic of destiny*, emerged. This refers to the young men's perpetual negotiation of their relationship with their destiny, a process that changed shape and meaning depending on their life-death orientation at a particular point in time. As the study progressed, the focus shifted to identification and conceptualization of the process in which the young men engaged to resolve their dialectic of destiny. This process required in-depth understanding, therefore phase

two of the study involved conducting thirteen further one-to-one interviews that identified specifically the micro processes and their interconnectedness involved in transcending suicidality. This process, captured in the core variable *re-vitalizing worthiness*, allowed for the making of viable and rewarding lives that were workable in terms of the young men's daily living activities and held meaning and value, thereby confirming their place in the world.

Re-vitalizing worthiness is a two-stage temporal process through which the young men moved in their journey from in suicidality to beyond suicidality. Thus, regaining personal worthiness and worthiness to be elevated the young men from a place of darkness, terror and being stuck to one of light, evolution and control. This process is captured in the sub-core variables *confronting a crisis of destiny* and *earning a life,* which describe how the young men transformed their identities as they negotiated the nature and meaning of their relationships with living and dying. This was a complex process that required resilience, courage and commitment on the part of these young men.

Embedded in the substantive theory *re-vitalizing worthiness in transcending suicidality* are some fundamental interlinked ideas. These include: that transcending suicidality was possible and that the young men moved forward in living viable lives, that re-vitalizing worthiness was central to this process, that this entailed identity re-configuration, and that this was facilitated by turning points. These ideas are elaborated further in the discussion in chapter ten.

The next two chapters will describe each of the sub-core variables in detail, helping to explicate the categories that emerged and their properties. This discussion illustrates how the core variable, or psychosocial resolution process *re-vitalizing worthiness*, accounts for integration and conceptualization of categories. It also makes explicit how this process was facilitated by the young men and others in their life contexts, including mental health professionals. These chapters incorporate additional literature from the field of suicidology, among others fields, which demonstrates how the literature can be used as data that enhances inductive theoretical sensitivity in a GT study (Heath, 2006).

Chapter 8. Sub-Core Variable 1: Confronting a crisis of destiny

8.1 Introduction

This chapter describes in detail *confronting a crisis of destiny* the initial stage of *re-vitalizing worthiness*, while the next chapter will describe stage two, *earning a life*, explicating the micro processes involved in each stage. Some preliminary connections are made with the literature in the field of suicidology and beyond by way of adding depth to emergent categories. Direct quotes from participants are used as illustrations of categories and properties, and in keeping with the emic approach of the study, autobiographical accounts of others who have overcome suicidality and highlighted related issues in the area of mental health are privileged. Participant quotes are outside of the main text while non-participant quotes are inserted into the text.

8.2 Confronting a Crisis of Destiny

The first stage of *re-vitalizing worthiness*, *confronting a crisis of des*tiny, reflects the process whereby the young men paused, took note of their life situations and decided that these had to change so that they were no longer pulled between life and death. This awareness was frequently initiated when the young men reached a point of immense crisis in their suicidal existence and found that they could no longer continue with their now unbearable lives. They discovered that they could make a choice about whether they lived or died and they made a clear decision to live and to change their lives. They thereby resolved their crisis of destiny by initiating synthesis of their disparate lives and selves. Reaching this point of decision-making and choosing to live represented a significant turning point on the suicide trajectory. This initial stage of the re-vitalizing process is conceptualized in two mature categories, *living the crisis* and *reaching a point of no return*, each with a number of minor categories and properties as represented in table 8.1 below.

Table 8.1: Confronting a Crisis of Destiny

Sub-core variable	Mature category	Minor category	Category	Property
Confronting a Crisis of Destiny	Living the Crisis	Losing Worthiness	Being Different	Invalidation, loss, failure, comparing, blaming, shaming
			Living in an In-between World	Not belonging, limbo, trapped, disconnecting, hating
		Concealing the Dark Side	Invisibling	Going underground, protecting, losing self, being denied, death awareness
			Dancing with Death	Living on the edge, losing control, escaping, waiting, soothing the pain
	Reaching a Point of No Return	Reaching Saturation	Escalating	Built-up, worn down, depleted, explosion
			Getting the Wakeup Call	Shock, decision time, life must change
		Turning the Corner	Signalling	Something is wrong, need help, this must stop, giving a sign
			Choosing Life	Seeing and making a choice, taking risks, another chance, my call

8.3 Living the Crisis

Living the crisis describes the first mature category involved in *confronting a crisis of destiny*. It refers to the growing intensity of the young men's suicidal crises which eventually became untenable, influencing their decision to live rather than die and to change their lives. This unfolded over time wherein they become progressively more discontent and dismayed with their lives, more preoccupied with death as the only solution to their intolerable and unacceptable state, and more detached from their selves and their worlds. The latter, in addition to making them feel more alone, served to partially protect them and others from the dark side of life while, driven by

ambivalence they tested both life and death. Key processes that emerged in this stage were conceptualized in the minor categories *losing worthiness* and *concealing the dark side*.

Losing Worthiness

Losing worthiness, the first minor category involved in *living the crisis,* describes how the young men found themselves devoid of value as human beings, frequently associated with invalidation as persons that reinforced in them a sense of being different, not fitting into their world and forcing them to occupy a place on the outside. They gradually moved further out of the world, away from their selves and others in order to protect themselves from their inner pain and turmoil and to protect others from their dark worlds and the inevitability and close proximity of death. This is described in the categories *being different* and *living in an in-between world*.

Being Different

Over time and for various reasons these young men noticed that they were different from other people. They had a strong sense that they did not fit into their lives and the world around them, hence, they felt as though they did not belong, that they had little to offer the world and that it had little to offer them.

"…like you don't know who you are and it's horrible to feel like that, that you don't know who you are and a lot of people don't understand when you say that. I didn't know who I was and they were looking at me, 'What do you mean? You are not sure what sort of person you are?'"

The young men attributed their profound existential dilemma to personal invalidation that implicitly, and sometimes explicitly, delivered the message '*You do not deserve to live / have a life'*. Accepting this message as valid compromised their sense of worthiness as individuals and their deservedness to be. Identifiable invalidating episodes included multiple levels of child abuse and neglect and / or a general feeling of being misplaced in their lives as young men in a foreign world which was not associated with specific events. Over time the impact of unworthiness on the daily lives of the young men mounted, resulting in strong negative self-conception, the

emergence of suicidal ideation, and engagement in suicidal behaviour which frequently culminated in a suicide attempt.

"My father said to me 'You're a worthless human being'."

"I think in some ways it was loss of personal meaning but it was very much also a broader sense of, I was very obsessed with the awfulness of the world and I was almost hypersensitive to the pain and suffering in the world I was very much an idealistic teenager and young person…"

A link between traumatic experiences, loss and suicide-ality in adult life has been found, for example in relation to childhood sexual abuse (CSA), where estimates of mental ill-health are three times greater than in the general population (Smith, 2009). While some stressful life events (SLEs) no doubt contributed to the young men's suicidality it is important to stress that suicidality is multifaceted and complex and can seldom be linked to a single causal factor (Maris et al., 2000; Leenaars, 2004). Individual responses to life events also vary and depend on a range of personal and contextual factors. Furthermore, there may have been a myriad of other life events that were not reflected in the data that could also account for the young men's' sense of unworthiness. Nevertheless, awareness of and attention to possible associations between SLE's and suicidality can enhance a holistic and humane response to the suicidal person, thereby extending professional response beyond crisis management, a process the young men found validating.

"…There was Dr. (name). He was a very, very good man. He wanted to know what was going on with you, he wanted to know why suicidal thoughts were coming, why you were feeling depressed…"

However, regardless of its origins invalidation was real and had a real influence on the lives of these young men who also engaged in efforts to assess their worthiness. At times they were confirmed as failures which increased their sense of ambivalence, confusion and fear, while more latterly they were confirmed as competent people which enhanced their sense of control and determination. According to Crocker & Park (2004) the pursuit of self-worth can result in both positive and negative

outcomes, as success provides short-term satisfaction but may have long-term costs associated with carrying the burden that one "must" succeed.

"I was always trying to prove myself, achieving academically to justify being alive."

By way of exploring these questions, the young men began to scrutinize and test their difference and their being. They monitored themselves closely, comparing themselves with other people and measuring their life performances against perceived social norms and personal goals. Social comparison / self-other comparing is a common process whereby one measures oneself and one's life against perceived norms, and according to Leenaars (2004, p.49) *"Sameness is identity, whether good or bad, whether life-enhancing or suicidal-inducing."* Social comparison is said to be a major determinant of self-evaluation of abilities and affective state, even when this process is outside of one's awareness (Epstude & Mussweiler, 2009). Social comparison processes impact the affective response of a person to another's emotional state and there is a strong drive to feel equal to members of a similar (we) group in order to maintain affective and cognitive balance. This drive however, does not appear to exist when a person feels dissimilar to another (them), when indeed one may react to the other with discordant responses. Hence, emotional or mood change in terms of contagion is a complex and contextual phenomenon (Epstude & Mussweiler, 2009).

"…I'd see these fellows I went to school with and they are driving Jeeps and have big houses and stuff, and what do I have to show for myself, do you know?"

Accepting an unworthy identity frequently occurred in a context where the young men felt powerless to challenge their negative self and other assigned descriptions. This was sometimes due to the power differential in the relationship between them and the person or event that delivered the strong message of failure and worthlessness. In an effort to prove their worth the young men put themselves under enormous pressure to achieve and were self-critical when they did not attain their goals. Failure confirmed to them that they were different; they became saturated with self-blame. Blame for their situation was also assigned by others, including the mental health professional, which had negative consequences for the young men.

"I thought everything was kind of my fault. I used to blame myself for everything that happened…"

"He [psychiatrist] told me one day that everything that happened in my life was my fault. I went off that day, took an overdose and almost killed myself…"

With repeated failures and a sense of being defeated by life the young men felt inferior and their lives were experienced as impoverished. Others similarly relate invalidation to the burden of living with stressful and invalidating events such as mental ill-health, which made them question their selves giving rise to loss of meaning. For example, Champ (1999) refers to how his sense of worth and value in society declined as he became disillusioned with life and sank into a depressed mood.

"I was just really depressed and felt that life was going nowhere and that I was a failure and a nobody, and life wasn't worth living …"

"Strip by strip it wears you down, your self-worth and everything is gone."

According to Leenaars (2004) the suicidal person has frequently experienced a steady toll of life events that undermines their ability to cope with life challenges. Orbach (2001) suggests that a sense of loss and future expectation of loss is a central feature of suicide-ality. Thus, the personal life narrative is perceived as a sequence of losses of self, objects, goals, values or ideas, creating emptiness and meaninglessness to which the person cannot adjust or endure.

"I lost myself; I have struggled for years to find my identity, part of myself that died."

"*I lost everything, that is what I felt like and I was only a kid, it was hard to take in…"*

These young men felt defeated by life and their efforts to be part of life seemed to fail repeatedly, confirming their difference and lack of worthiness. Defeat can be experienced in relation to *"…a perceived social message concerning self-worth, social belonging, rejection, failure to achieve and irreversible loss of roles or*

significant others" and can negatively impact narrative memory and one's interpretation of social situations so that a person is more sensitive and attuned to negativity and increased self-attention (Johnson et al., 2008, p.969). Self-attention leads to feelings of being watched and it has been postulated that *"…awareness of oneself as an object of attention leaves people susceptible to the idea that other people are more interested in the self than is actually the case"* (Campbell & Morrison, 2007, p.64). Hence, self scrutiny can increase feelings of other surveillance and vice versa. It is therefore understandable how these suicidal young men, with their preoccupation with self-performance, could become entrapped in self-consciousness and be overly sensitive to the perceived negative attention of others, highlighting and fuelling their negative self-conception in relation to their imperfections (Williams et al., 2005; Campbell & Morrison, 2007).

"I still do think about what other people think about me. I still do daydream and when I daydream I go into deep thought. I could be sitting at work on a break, I could sit there for half an hour and stare into space thinking about why this person did this to me or why that happened. It is really bringing things into detail and to explain it is absolutely impossible..."

"I'm strong now, I was too sensitive."

"I was hypersensitive to the pain and injustice in the world – I was appalled by the world but I felt paralyzed to do anything about it which made me feel meaningless and depressed – the most appropriate response to the world, a terrible world."

The young men in this study described how feeling different and isolated compounded their experience of being valueless and led to them taking on personas that reflected this in designations such as the black sheep, failure or freak. These personas reinforced in them that they were unworthy and influenced how they managed challenging situations, for example, giving up rather than risking the possibility of further failure inherent in confronting difficult life situations (Orbach, 1994).

"I am the black sheep in the family, I was always in trouble, it is just that all my brothers and sisters have a higher standard than me, in my opinion they had a lot more going for them than me, education wise, financially..."

"In the end I was so sick of trying to make excuses, going in and just being no good…I just made up my mind I'm not going back to work. I totally regretted it afterwards, but that was it."

Expectations and experiences of failure were sometimes associated with striving to have a perfect world and achieve goals that were situated in the young men's fantasies and associated with fears of not being good enough in this life. Some of the young men described themselves as perfectionists, striving to influence an imperfect world and to be flawless which was not achievable. O'Connor and Sheehy (2001) have noted the link between perfectionism and rumination associated with negative self-perception and suicide-ality.

"I wanted to change the world."

"I thought I wasn't up to the task, I couldn't keep people happy, I always put others first."

Powerlessness associated with failure perpetuates a sense of victimhood, blame, shame and being voiceless. Having voice is a central aspect of personal empowerment, while loss of voice leads to restrictive and defensive responses (Fishbane, 2001), fuelling self-loathing and other-loathing. This pattern gives rise to further negative interactions and feedback which are perceived as threatening, making conflict (fight) and concealment (flight) appropriate self-preservation strategies. As a result the young men became consumed with self-loathing, which was frequently coupled with despise of others resulting in self directed-and other-directed violence (Aldridge, 1998).

"...I was so pissed off with people around me and so pissed off with myself because there was nothing I could do to change it [life]."

The cyclical process of how the young men came to hate themselves and then proceeded to live out their negative self conception that confirmed this is complex but common among suicidal young people. This escalates as a sense of burdensomeness increases, associated with the realization that one is a liability to others but is helpless to change one's destructive path (Esposito-Smythers et al., 2004). Feeling consumed with negative thoughts, how to ease their pain, and preoccupation with death further reinforced the young men's difference in the world as others were moving forward with their lives while they were waiting for death.

"Others are doing their damndest to live and you're going the other way."

Living in an In-between World

These suicidal young men were caught in a conflict of being as they were pulled toward life and pushed toward death. Their destiny was uncertain as was their sense of identity because ultimately a worthless person does not deserve to "BE" (Baechler, 1978). Their felt difference and fear of further failure and humiliation made them withdraw from many activities and relationships until they found themselves in a place between worlds, between life and death and between living and dying. Occupying this limbo world ironically kept them alive as making a definitive choice about their destiny was deferred. Therefore, whilst feeling partially dead they continued to live partial lives, always conscious of their no-place state. Champ (1999, p.120) describes a similar experience of being in an ambivalent and in-between world, *"At times I was in a dilemma because I did not want to live but was afraid of death. It seemed at times that Earth had become my purgatory."*

"I was acting it out, playing the part, partially dead."

As the young men were more exposed to and enacted their unworthy selves, they became more disempowered and their suicidality became more over-powering. Their sense of aloneness and being an outsider increased giving rise to the desire to escape, which if perceived as impossible exacerbated their sense of entrapment. According to Williams et al.'s (2005) entrapment theory, experiences of humiliation, loss and rejection may trigger suicidality in situations where one cannot escape. From this perspective it may be the combination of being invalidated and seeing a future from

which there was no escape due to intrapersonal, interpersonal and contextual factors that increased these young men's level of suicidality, making suicide an attractive and logical option.

"I wanted peace of mind…I remember saying I need to stop all the running in my head, a thousand things going through my mind at the one time."

"It was a way out, it was a way of stopping very, very serious on-going distress and it seemed like a very viable option at times. It seemed like almost a wise thing to do, almost the thing that made sense…"

Williams et al. (2005) suggest that entrapment is associated with deficits in interpersonal problem-solving, giving rise to over-generality of negative personal memory retrieval reflected in sensitivity to environmental cues signalling defeat. This may initially serve to protect the person from more hurt as his expectations of others are lowered, but eventually becomes disabling as he becomes more detached from reality. The young men demonstrated similar patterns of overwhelming negativity and sensitization, such as taking offence easily and describing themselves as overly sensitive to the views of others, in particular negative judgments. This may have made them more prone to interpret neutral comments negatively as their defeat lens sharpened and their focus on self failure narrowed.

"I'd had enough, I wanted to end everything. There was nothing in my life."

"…I don't know if I am now more sensitive than other people, I think when I was younger I was very, very sensitive…"

Concealing the Dark Side

Concealing the dark side is the second minor category in *living the crisis*. Concealment of their selves became a continuous task for the suicidal young men while occupying their in-between worlds. They developed many strategies to conceal their dark thoughts and feelings from themselves and others, thereby denying and shielding themselves and others from their pain. However, concealment of self was costly in terms of self-sacrifice and difficult to sustain as it required continuous

vigilance and energy. The young men, with their secret dark side, moved further underground and made themselves invisible as far as possible, thereby becoming shadow people while struggling to engage with some semblance of living. This frequently took the form of teasing life and death by living on the edge. Hence, the tensions about their being were barely containable at times yet they struggled to keep the show of life on the road, as described in the categories *invisibling* and *dancing with death.*

Invisibling

The young men were living lives of little reward or comfort as they remained tortured by their sense of unworthiness and the pain associated with their lost identities. As they became more aware of their aloneness in the world and more preoccupied with thoughts of escape through death, they also became frightened by their desire to be no more, forcing them to conceal this inner world.

"Yes it is very hard, it is not easy, sometimes you feel like just standing and screaming at the top of your voice. It is very hard to do but you don't want people knowing what you are really thinking."

"Yes it is kind of trying to blank what is really going on with you. What I used to do was put on a brave face and go out for a few pints with the lads."

Being disappointed by and disappointing others in life led to feelings of anger, guilt and shame whereby the young men's selves or parts of their selves were denied. They managed to make themselves disappear in the world by separating from the parts of their selves for which they felt shame, guilt and fear, thereby losing personage and becoming unreachable. Relinquishing parts of the self can be viewed as pathological, as it involves giving up significant aspects of the self that are important to one's self-image thereby losing touch with one's self. However, it can also be seen as a survival strategy protecting one from further failure, humiliation, hurt and rejection, by splitting off from others in order to survive (Lazarus, 1983). Ironically, self-concealment was also made possible by the young men's ordinariness. Most were not identified as being different or particularly vulnerable, despite their felt difference and fears about their selves and their lives.

"I certainly tried to push people away at times. On one particular time I tried to sever contact with all my friends because I felt that I couldn't engage with people on any meaningful level because to do that was to open to the possibility of being hurt, and the possibility of being hurt felt as if it was too distressing for me at that time."

"I was just an ordinary guy, going through the motions...I didn't stand out in any way..."

Self-denial was also related to harbouring secrets about themselves regarding issues such as their sexual orientation. Some young men feared the consequences of this for their future relationships and lives. Hence, their awareness of how they were different forced them to remain concealed, while concealment confirmed their difference. For example, one participant described himself as "asexual", which could be interpreted a way of denying a part of himself that was uncertain or intolerable to him, while another concealed his homosexuality for many years.

"I was not comfortable in my own skin. But the fact of the matter is, the one thing that I didn't say was I am gay, because I didn't want to break my mother's heart."

"There was nowhere to go, nobody to speak to. It was embarrassing."

The young men were vigilant, aware of how they were in the world and how others were responding to them. This heightened awareness resulted in guarded living, whereby they carefully revealed and concealed parts of themselves by wearing armour to keep private their vulnerability.

"I wore so many masks, happy masks, sad masks, please me masks, please you masks, you know I am a good person, I am a bad person, you know all of them…they all worked for a while."

Self-denial exacerbated a sense of unreality as the boundary around the young men's being became more blurred and their identities faded, increasing their sense of unworthiness. The young men relinquished parts of themselves in the face of unbearable inner pain and turmoil that left them fearful and distressed. They

dissociated themselves from painful events in the past and present and depersonalized the self that such events represented, thereby splitting their cognitive, emotional and physical selves.

"I was emotionally illiterate; did not connect my physical and mental pain."
"You're connected outside but cut off inside."

Dissociation refers to a mental process of denial whereby the person, to a greater or lesser degree, cuts himself off from painful experiences. This may be a conscious and voluntary or unconscious and involuntary escape mechanism. However, it does not tend to reduce feelings of self-blame or shame for the troubling event (Smith, 2009), and therefore, serves only as a temporary relief strategy. Depersonalization is a common feature of dissociation, referring specifically to the process of self-self separation (Kreidler et al., 2000). Fisher (1999) describes how he withdrew from living, turning to silence as a way of gaining control and fixing a life that was becoming progressively difficult in the face of a number of stresses, such as relationship difficulties and the diagnosis of his father's illness. Consumed with blackness, and hopeless about resolution of their conflicts and fears, the fear of living was sometimes greater than the fear of dying. Hence, loss of control of self and life became more apparent as the young men disappeared into unreality.

"The fear and anxiety around living was just unbearable. It was so overwhelming because in some ways life is open ended, the possibility for on-going distress and pain is so frightening if you are in distress."

"…'are these people trying to run my life, am I in charge or what is going on like?' You don't know if you are running your own life or it is being run for you and you don't know what to think sometimes, you just get so confused…"

The young men had a dominant orientation toward and awareness of death, which is a well recognized feature of suicidality. Beck et al., (1975) view the person's focus on death as deriving from depression which is characterized by constricted and predominantly negative thought processes and mediated by hopelessness. Shneidman (1996a; 2001) sees this in terms of extreme psychological pain that becomes

unbearable and from which one desires relief, and Heisel and Flett (2006) see it more in terms of an existential crisis wherein one loses a sense of meaning and purpose in life, no longer seeing any real point in living. Feelings of increasing unworthiness due to loss of meaning and purpose in living have similarly been identified by others as closely associated with suicide-ality (Frankl, 1959; Baechler, 1978). Concealing such thoughts protected the young men from their fears of their own thoughts and of being judged as mad, bad or sad as reflected in the theoretical literature and society at large.

"I wouldn't want to be telling people. Like are you going mad or something, you know."

"As I said the main thing would be humiliation and just being embarrassed about it. It is not nice obviously that I thought like that or to think that I did those thing ...I am nervous even speaking about it out loud, but in my opinion I am doing it for the right reasons..."

Thoughts of death and dying engulfed the young men to the extent that they retreated into their own world which protected themselves and others from death awareness (Deci and Ryan, 2004). They were acutely aware of other people's fears about death and dying; this reinforced their compulsion to conceal themselves. The young men were attuned to how others facilitated their withdrawal and denial through non-acceptance of behaviours that signalled their distress, such as physical aggression and emotional unavailability, thereby reinforcing their isolation. Hence, they enacted and were facilitated to perpetuate the stigma associated with their suicidality and death. Simon (2003), having survived the suicide of her brother, supports the view that death is something most people avoid, making it unmentionable in some contexts.

"Others are fearful of suicidal thoughts; they try not to think about such things."

"...I was having feelings and experiences that were very, very difficult…but I managed to keep them reasonably hidden, certainly from family."

"They [parents] didn't know what to do, mostly because it [suicide attempt] was a bit of a shock. I think to a large extent they kind of pretended it never happened..."

The mental health professional can also participate in denial of the person's distress when unable to hear their different perspective / reality. Snow (1999, p.169) suggests that, *"If you want to make things better for people who get into the psychiatric system, remember to work with them from the perspective of their reality, as best you can."*. However, she notes that imposing the professional perspective comes all too easily to the expert who may unwittingly reinforce invalidation of the other. This perpetuates one's sense of being voiceless and consequently one's capacity to reveal their distress (Fishbane, 2001). In this study, the young men described disempowering episodes, which served to make them feel less visible, while positive experiences enhanced their worthiness and facilitated engagement with professionals.

"Like you tell them [social workers] how you are feeling and they kind of say 'oh don't be silly, you are only a young person, you should be full of life'. But I am trying to tell you how I feel and you are telling me how I should feel, like I know I should feel like that but I don't."

"…And she [key worker / occupational therapist] listened in a very different way, for a start she did listen, maybe that was partly what was different. But she also listened in a very different way. She was very collaborative, she was very open to hearing…it wasn't that it wasn't very challenging, at times it was but in a very safe way, very safe, and there was the relationship that was there, and it was so significant…"

Strike et al. (2006) found that unsatisfactory experiences of healthcare staff and services impacted negatively help-seeking patterns among suicidal men. In this study also the young men described episodes where mental health professionals sometimes made it more difficult for them to avail of the help that they desired. Services were also configured in ways that were experienced as cold, further reinforcing their lack of belief in the system and themselves.

"I had a big argument with her [addiction counsellor / nurse] and I was asked to leave, and when I left there I thought,' fuck it, like if the treatment centre can't do

anything for me there is no hope'. So I went back on drink and drugs, I was twice as bad as I ever was before, I was bananas you know."

"I was on 'special' as it is termed...minimal human contact, sense of a conveyor belt, of being you weren't a person - you were a participant in a timetable."

It has been suggested that responses that establish and help to maintain the "them and us" divide protect others (sane) from fear of difference (Snow, 1999) and from recognizing the closeness and potential benefits of insanity (Perkins, 1999). Ironically these concerns are reflected back on the suicidal person who, through fear of his own difference, is compelled to withdraw in silence. Such responses were also evident in contexts outside mental health settings, such as EDs.

"To be truthfully honest with you I got absolutely no reaction, you know, and I went up to the hospital and they bandaged up my arm and I was sitting there for about ten hours before they even stitched it and they just stitched it and sent me home..."

"In the hospital itself you were just sitting there in a waiting room and you were stuck for hours and they just put you on a trolley...and there was no, 'Are you all right, what happened?'"

The health professional can be perceived as acting out of negative discourses that surround suicide-ality and the suicidal person, as described in the literature pre-view. For example, suicide-ality in young people is frequently explained in terms of: lack of understanding of the finality of death due to magical thinking and media portrayal of suicide as normal or indeed glamorous; motivation to punish others for perceived wrongdoing resulting in an unfortunate permanent solution to a temporary problem; and lack of regard for the impact of their behaviour on others, such as family, friends and professionals leading to the person being described as selfish. Cain (1972, p.154) suggests that *"…the person who commits suicide puts his psychological skeleton in the survivors' emotional closet; he sentences the survivor to deal with many negative feelings and more…"* However, Sommer-Rothenberg (1998) argues that frequently it is the concern that the person is a burden on others or unworthy of others that leads to the suicidal act. Therefore, rather than being a rejection of others or life, suicide can

be seen as a rejection of the pain of living. The young men supported the latter view, demonstrating an acute awareness of the potential harm their suicide might have for others. Some described how this realization was the only barrier to them completing suicide, while others also feared the act itself, and the unknown after world.

"I think the number one thing would be I don't want to hurt my mother, you know, and that keeps me from killing myself…"

"I think fear stopped me, fear of the act, fear of carrying through with it, some very basic fundamental sense of not being able to go through with it…some sort of inhibition, but it's hard to say in a concrete way what those are…I think at other times I would have felt quite connected to certain people and certain relationships and I think that they may have caused me hesitancy. But at times when I felt most alone there were other things stopping me which I would struggle to put words on."

Dancing with Death

In the absence of a sense of worthiness and working hard to conceal their selves from the world, the young men tested both life and death by way of living out their crisis of destiny. Therefore, while a death orientation dominated during the suicidal phase, efforts were made to try out different ways of being in the world that served to make them feel alive, however painful this might have been, for example self-mutilation (Shaw, 2009). Experimenting with life and death meant engagement in activities that explicitly or implicitly reflected the young men's ambivalence about their destiny as they became more preoccupied by questions such as: "Am I?", "Who am I?", "Do I belong?" and "Where and how do I live?". This took the form of distracting and dangerous acts, such as alcohol and drug misuse and dangerous driving. In addition to denial mechanisms, these activities served to numb their pain, providing temporary relief and enabling them to play the game of living. For example, in this state of altered consciousness they were able to engage socially with others although often at a superficial level. Thus, similar to other escape mechanisms, self-destructive acts allowed the young men to prolong living.

"That is why I started taking drugs, to blank it out…Oh it helps when you are out of your head because you forget everything…"

"...you know that you are drinking a lot all the time...essentially it was almost self-medicating, you are not in the best of form, go out, get drunk, then you have the feeling of being out and doing stuff which did cover the worst of it..."

"It was all coming to a head in the sense that I was drinking more, like I started kind of cutting myself a bit because I was so low all the time and there was still that anger there and that frustration..."

The paradoxical self-soothing or cathartic component of self-harming has been noted by others (McAllister, 2003). Allen (1995) cites the leading self-reported reasons for engaging in self-harm as a way of managing painful moods, feelings, thoughts, or relationships / interactions with others. This notion of management is reflected by Pembroke (1998) who refers to how being close to a potentially harmful method can paradoxically induce feelings of being safe or in control.

"It was a comfort knowing it could happen, but there was fear of the act."

While overt acts of self-destruction such as DSH and suicide attempts explicitly signalled distress, it was also more covertly expressed. This covert death invitation was understood as a slow death, whereby the young men tried to die in a respectful way, making their death appear accidental rather than intentional and protecting all concerned from the stigma associated with suicide. Menninger (1996) and Shneidman (2001) refer to self-destruction as malignant self destruction and subintentional death respectively, seeing such acts as indirect expressions of suicidality. It has also been noted that risk-taking and other behaviours associated with traditional masculinities can be exacerbated when a person feels ambivalent about himself and his sense of self is under threat (De Visser & Smith, 2007). Similar patterns were evident in the young men's compromised identities and uncertainty about their destinies and lives.

"...I know that I was certainly engaged in very, very risky behaviours which put me in a lot of physical danger when I was younger, almost as a way of bringing about my death without me having to actually do it."

"Mad thoughts come into your head, 'I have to get someone to kill me, them suicide doctors whatever they are called, doctor deaths'. At least I wouldn't be doing it…"

"I smoke an awful lot…and the reason I smoke an awful lot is that I hope that I will hurry up and die…I was there with my chest wheeze and it only twigged with me then that was why I was doing it…"

While providing an immediate solution, temporary distracting mechanisms inevitably became problematic both in the short and longer term for the young men. For example, acute alcohol and drug misuse disinhibited them leading to engagement in activities that seemed out of character, including suicidal behaviours (IAS, 2008), while chronic misuse resulted in addiction problems (Connor & Chipella, 2004; Hawton, 2005).

"I wouldn't dream of doing that [being aggressive] if I wasn't drinking or taking drugs, they were really turning me into a dark horse."

"I was drinking and taking drugs kind of heavy then because every time I was drunk and out of it I wasn't really thinking normal so that wasn't really working, you know, but it was kind of numbing me…you have to drink more and more and go on more drugs to get that out of it…I wanted to stop and I kept on doing it."

A number of the young men tried to resolve their crisis of destiny by attempting suicide, which was frequently unanticipated by others. Impulsivity is cited as a contributory factor in suicide (O'Connor & Sheehy, 2001), and while some of these acts were unplanned for the time of occurrence, they had been harboured for extended periods of time. Thus, they frequently appeared to occur on impulse, for example, shortly following a trigger event and a bout of heavy alcohol consumption. The suicidal acts were complex to the extent that the young men found a way out of death by alerting another about the event, or by being rescued unexpectedly, thereby getting another chance to live. Foster (2009) interpreted her rescue of a friend following a suicide attempt as reflecting her friend's ambivalence about death wherein she relinquished her power to determine her destiny.

"I phoned a friend of mine whose brother is a doctor and he came…"

"…and then I woke up, and there were two elderly women standing over me as well [as the man who rescued him] who were down walking the pier…so when I look back now I am delighted people walk the pier at night."

Ambivalence was also a feature of the suicidal act whereby the young men, certain that they wanted to die before engaging in the suicidal act, quickly became aware of their desire to live while attempting suicide and desperately tried to save themselves from their own destruction.

"I remember the last seconds before I passed out under the water, I was going, 'Did you really think this through or what?' because it really felt horrible. It was horrible not being able to breathe and you were dying for a breath…it was just a horrible feeling and I was feeling so scared and I was panicking and I actually remember I was trying to undo the rope from around my ankle…"

"I was half scared and half going, this is it like and hopefully there is something better after this. There was a part of me that was scared, I won't deny it, Jesus do you have the guts to do this or not?"

In the aftermath of an unsuccessful suicide attempt some participants remained ambivalent about survival, sometimes being simultaneously glad and sad to be alive. Ambivalence was often compounded by the shame of having 'failed' to complete the suicide act. However, as time passed survival became reinterpreted as being given another chance to live which was then welcomed.

"I don't know if I was more pissed off because I didn't do the job, or more pissed off because I was in hospital..."

"Now I look back and I am delighted I didn't succeed in killing myself, absolutely chuffed I didn't. And at the time it was like, 'How the fuck didn't it work?'"

Hence, what emerged was that in their suicidal phase the young men's struggle with life and death was dominated by a death orientation but also involved complex life saving strategies and mechanisms, reflecting their ambivalence with their being in the world. Ambivalence about life and death is a well recognized component of suicidality and according to Caruso (2009) can be a way to sort through one's issues in order to come to a solution. Ironically, while sometimes viewed negatively as it holds open the option of death, it also holds open the possibility of life. From this perspective it could be hypothesized that ambivalence protected these young men from completing suicide, as performing a partial life provided a safety net for them while secretly waiting for death and believing that it was close.

"…But I think that is something that has often struck me, that notion that suicide was often a comfort, knowing that it was a possibility, knowing that it was there…"

"Knowing the end is close keeps you alive."

During this time of uncertainty the young men had little sense of control over their lives as they awaited a signal to indicate if and how they should go on living. Hence they felt as though they were on remote control and that their destiny was in the hands of others, fate or luck, further compromising their sense of agency. While this can relieve one from feeling responsible for oneself it also increases one's sense of disempowerment and resentment of one's inability to determine their own fate.

"…I felt this terrible powerlessness for myself, my life was completely out of control. I was doing all manner of terrible things, mainly to myself and I felt terrible and I felt I had no sense of power. But also I felt that there was this terrible world over which I had no power, no control, so there was no control or sense that I could make decisions and I could impact on something…"

"It would have been always left to chance, if you live you live, if you die you die. I had made the decision to take whatever, you know."

Loss of self agency was troubling for these young men in a cultural context that espoused a masculinity discourse of power and control (Begley et al., 2004; Cleary,

2005b), hence they became increasingly angry with themselves for their apparent inability to act on their own behalf. They were angry with others for perceived wrongs that had disabled them and for their inability to assist them with their plight. Such responses were sometimes reflected by professionals in their inadequate, inhumane, and inappropriate responses, which denied the men's inner thoughts and feelings due to inability to hear or act. They were angry with society for imposing norms and expectations that they could not meet, denying their suicidality and failing to meet their needs.

"Yes like you wouldn't know yourself how you feel sometimes, you'd question everything you do and everything you say and you get so mixed up with everything that you don't know if you are coming or going."

Intense anger is a common response to life situations where one feels wronged, unjustly treated and a failure. Releasing one's anger can serve many purposes, some of which have positive outcomes such as relieving one from shame, injustice and stigma (Champ, 1999). Therefore, it could be hypothesized that in addition to ambivalence playing a part in the survival of these young men, the intense emotions that this engendered, such as anger, may have provided an outlet for negativity that allowed them to stay alive and provided a building block for their later determination to live. Interestingly, the patterns that served to confirm their unworthiness while suicidal, such as self-comparing, negative and over general memory retrieval, sensitivity and intense anger, were transformed in ways that served them well when reconfiguring their selves beyond suicidality.

"...I let everything build up and I'd get in rages and I'd kind of see black, and before you know it you are in a police cell and you wouldn't even know how you got there."
"I had so much anger in me..."

8.4 Reaching a Point of No Return

Reaching a point of no return describes the second mature category in *confronting a crisis of destiny*. Having lived with their torturous crises of destiny the young men eventually reached a point that signalled that this could no longer be tolerated and had

to change. They became saturated with their unbearable state which had to end one way or another. They were worn down by the on-going burden of their unworthiness, and they began to signal to themselves and sometimes to others that their situation was no longer tenable. Coming to realize that they had a choice about their destiny they chose to move forward in life. This process often appeared to happen by accident rather than design, nevertheless it facilitated them in turning toward life, as conceptualized in the minor categories *reaching saturation* and *turning the corner*.

Reaching Saturation

Reaching saturation is the first minor category in *reaching a point of no return*, which describes how the young men became overburdened with their intolerable lives. As they battled with their indecision about their destiny they became tired and depleted of resources. Their energies were absorbed in negativity and uncertainty and they gradually lost their sense of self-respect, became a burden to themselves and others, and their lives became intolerable. They were saturated with fear of the unknown and frustrated with their own and others inability to change their situation. They lost the will to continue to battle with themselves and the world as they were gradually worn down with little constructive experience or hope to rebalance this downward spiral. Hence, they were forced to confront their crisis of destiny and decide their fate, as described in the categories *escalating* and *getting the wake-up call*.

Escalating

The young men's distress escalated as their level of negativity increased, with their suicidality evolving and worsening over time. Fatigue set in and the young men had to find a way to finally stop this untenable life which had a sense of being endless. Eventually they reached a place where they could no longer continue with the battle between life and death and they could not tolerate the pervasive uncertainty and pain associated with living. They were depleted of energy, physically and mentally, and their ability to survive in an unreal world as unreal people was becoming too much of a burden to carry.

"I suppose at times I was thinking my experiences of feeling hopeless or feeling suicidal happened over a real length of time…from my mid teens to my mid to late twenties."

"Sometimes it can take over an awful lot; it can take over your whole life, like it took over mine for quite a while."

"…everything was building up and as people say, the weight of the world was on my shoulders, 'I can't take this', and I really wanted to be dead."

Prolonged immersion in a painful and troublesome situation not only fatigues one and shapes daily living around one's pain but also affects one's experience of time (Charmez, 2006). Time became distorted for some of the young men, and was exacerbated by their sense of unending torment.

"It's like something hanging over you, you can't explain what it's like, and you feel it won't stop."

"I am 30, I feel like I am 60 years of age."

According to Williams et al., (2005), suicidality escalates as there are seldom positive future scenarios and too few memories of constructive coping to occupy the person. Hopelessness, the tendency to project negatively into the future, is associated more with being unable to envision a positive future than envisioning a negative future (Williams et al., 2005). A pattern of inability to see a positive future was elaborated by some of the young men.

"The way I look at things…I will die and I have nothing left…I have nothing to show for it. I know it's only a few words but it covers an awful lot for me, not even a mark or anything like that."

The emotional and psychological pain, leading to social isolation and self-denial, reflecting ambivalence towards living and dying, became more difficult for these young men to manage and bear. They became more absorbed in negativity and their inner pain and turmoil to the extent that they felt an erosion of self and resources, such as esteem, respect and fulfilment. This tension and turmoil built up until it was not possible to take another day, making suicide a viable option and frequently resulting in a suicide attempt.

"…because obviously suicide is a terrible, terrible thing but when you are in certain circumstances it can be something that is terrible, but it can also be other things…"

Getting the Wake-up Call

The young men described how various events provided them with the impetus they needed to make a choice about their fate and how to live their lives, facilitating them to take control of their destiny by knowing that they had a way out of their unbearable situation. The realization that they had a choice to live or die and could make decisions about how they lived their lives came in many forms, such as surviving a suicide attempt or engaging in significant worth-enhancing or perturbing interactions with others that served as turning points on their suicide trajectory, leading to life changes.

"Yes I frightened the shit out of myself. 'This is horrible like'. I didn't know what I was thinking at the time…that last minute before you passed out, it stuck in my brain, I can remember it so clear…."

"...I mean my options were to throw myself out a three story building or try to change...."

"I remember a nurse said to me once 'It's not so much that you have lost your mind but that you have lost control of it, you need to regain control again'."

A suicide attempt can be seen as an act of surrender to death or it can be viewed as a cathartic act, as the brush with death provides a stimulus for re-evaluating one's life and seeing alternative possibilities for moving forward. Other events such as the nurse-patient interaction described above can have a profound impact on the suicidal person in terms of his decision-making to live or die. Hence there are opportunities for the mental health practitioner and others to influence significantly the young men's suicide trajectory and it is important that validating opportunities are not lost.

"If I wanted to stay alive I had to change my life, I knew I had to change the situation."

"It started a momentum that I can trace back to some seminal moments in my contact with mental health practitioners."

These events initiated a process of sense-making for the young men as they tried to understand their suicidality and lives. While the suicidal act itself remained vague and often difficult to describe and explain retrospectively, some shared concerns following the attempt included: bewilderment as to how it came about, shame about its occurrence, hope that it would provide ultimate freedom through clarity of decision-making, and determination to "do or die next time". This kind of determination was also reflected in the young men's openness to hearing the perspectives of others and re-evaluating their situation.

"...I have a positive outlook now thank God. But it is a hard thing to go through when you get so down, you feel like nobody cares…"

Precisely how such events became significant at a moment in time for these young men, tapping into their readiness and ability to change, warrants more detailed consideration as this was only briefly explored in this study. When asked about this process the young men's responses were vague and some suggested that this was an externally determined chance event. However, the idea of "hitting rock-bottom" emerged as a consistent pattern that forced the young men to reconsider their lives.

"They [other suicidal men] don't necessarily think that life is going to get any better, they don't see any great attachment to it. But in my case I hit rock-bottom, I really had nowhere else to go."

"You hit rock-bottom, well you think you have anyway, now I look back and say 'It's only a girl…'"

Hitting rock-bottom, for example following a suicide attempt, compelled them to make a clear decision to give life a chance, as they had been given a second chance, and to decide how they lived their lives. The suicide attempt also made public what had been for the most part private ruminations about their dialectic of destiny, thereby

allowing others to respond more overtly and directly to what might be considered a clearer distress call.

"I have another opportunity to live it or screw it up."

"I'm meant to be alive for some reason."

When the young men occupied a place of in suicidality their major concern centred on the questions of who they were and whether they should live or die. They were facing the most fundamental and frightening question that a person could contemplate. They were aware that they were simultaneously being pulled toward life and pushed toward death. This was a place of immense torture, with the burden for making a choice between life and death weighing heavily at times. This was complicated by their belief that their fate seemed to be in the hands of others and their uncertainty about their deservedness of life. This conflict left the young men in a state of not knowing whether they were alive or dead; they experienced themselves as being in an in-between world where their contact with reality was compromised. They were acting rather than living life, as it was not possible for them to be fully present in an unacceptable world; however, they knew that it was also not possible to continue in their states of crises. Therefore, regardless of the nature and timing of the event that signalled reaching saturation, its impact allowed the young men to refocus their resources in terms of active change in their lives.

"I'm delighted to be alive, grateful for the chance to live."

Turning the Corner

Turning the corner is the second minor category embedded in the more mature category *reaching a point of no return*. It describes how the young men initiated their life orienting journey, having decided to live. Prolonged and severe distress profoundly changed these young men's relationship with their selves and their worlds, leading to a dominant sense of being in an unreal world and being unreal as persons. However, despite this sense of being cut off from oneself and others they gradually became concerned about their state of being and knew that they must become proactive in resolving their situation if they were to continue living. They had

signalled concern to themselves and had to choose if and how they might also signal this to others, so that they could make and enact their choice to live. This meant creating space to foster their curiosity about alternative aspects of living and challenging their blackness so that they might see brighter possibilities which confirmed their choice to live. This process is described in the categories *signalling* and *choosing life*.

Signalling

Having reached saturation and being shocked by their situation the young men began to signal to themselves and sometimes others that something was seriously wrong and that their situation must change. Signalling to their self represented a beginning acknowledgment that they had reached a point of no return and that their lives must be re-evaluated.

"I was genuinely concerned about myself. I knew I needed help but I didn't know where to go, what to do…I am a private person, wouldn't really talk."

When the young men made gestures that indicated their distress, others were provided with an opportunity to respond in ways that would either confirm or disconfirm their distress and desire for change. If such signals were misread or misjudged, the young men were likely to be further invalidated, while a sensitive and genuine gesture of acceptance of the young men and their situation initiated the process of re-vitalizing their worthiness. If the young men decided to declare their distress more openly, they had to decide to whom and in what way this would be done. Some of the young men signalled their concern about themselves to family members, friends and / or professionals, albeit sometimes in a disguised or vague manner.

"...I sat down and spoke to her [GP] for ten minutes because I had an infection, got a prescription and I was there for an hour and a half. So she was the only person I could speak to about it….."

Others described their reluctance to seek professional help due to fears of being labelled and treated badly. Negative help-seeking attitudes and behaviours have been associated with social and moral stigma, gender role expectations, fear of not being

believed or being blamed for their situation, and mistrust of the mental health care system (Strike et al., 2006; Burke et al., 2008; Smith, 2009).

"If you tell you'll be diagnosed…or told, 'Don't be feeling sorry for yourself'."

"You get depressed and you don't talk to anybody because you don't feel anybody will understand how you feel. It is very hard for other people to see it through your eyes, only you can see the way you feel and the way you see life developing."

While some of the young men felt that their distress signals had been taken seriously and responded to in a manner that was helpful, other responses were viewed as unsatisfactory. These responses minimized their pain and / or led to intense but disengaged observation by others, further invalidating them as human beings by isolating, silencing and objectifying them. Webb (2003) describes such responses as denying his psychache.

"…I went to the doctor, I told my doctor that I was depressed and stuff like that and I was telling him that I can't hold down a job and this and that, and he didn't do any tests or anything like that. He just gave me Valium and I didn't really know and I used to be taking them and then I'd be half stoned or asleep after them. And that was all right for a few weeks but I was going around the place like you were dopey and I was kind of getting sick of that."

There is scope for such signals to be misread for a number of reasons. Firstly, the signal can be misinterpreted due to unwillingness or inability to hear or respond to the young men's distress, or the message may be masked in a way that makes it ambiguous or vague. Debate about the distinction between genuine suicide attempts and deliberate self-harm (parasuicide) continues, as described in the literature pre-view. Self-harm episodes can be viewed as attention seeking behaviours that frequently meet with negative responses from professionals and society alike, thus paradoxically the *cry for help* becomes a cry in the wilderness. This can be further complicated if the person is unable to communicate his distress clearly, which has been described as a component of disempowerment (Fishbane, 2001). For example, Cleary (2005a) found that men's judgment of their intent to die was often ambiguous

and ambivalent and their signals were ignored or misread, hence, their self-description became increasingly more vague to themselves and others.

"It was a mixed feeling, sometimes you would want to die and sometimes you would not want to be thinking like that…"

However, despite their ambiguity about and in conveying their concerns the young men did not view their suicide attempts lightly, emphasizing their strong suicidal desire at the time of their suicide attempt and indeed at other times in their lives. They strongly resented inferences that they were not serious and could therefore readily accept the idea that these were failed rather than pseudo attempts to end their lives.

"At one point I really just wanted to be dead but at other times there was one part of me saying 'do it' and another part saying 'don't do it'. But at one stage when I was about 18 or 19 I just really wanted to be dead, I just did not want to take any more, there was too much happening, too much to take in."

Nevertheless, regardless of how their signals of distress were interpreted, the young men came to a point of making a clear choice about their lives. They began to contemplate the meaning of their survival and, despite this frequently having a spiritual and unexplainable dimension, they were ready to choose life.

"When I failed that time, I fucked up, 'How do I keep failing?'…You think that, but I have a real positive outlook now, if God really wanted to take me he would have taken me and I am still here for a reason. That's the way I look at it now."

Choosing Life

Having lived in an in-between world, these young men signalled their self-concern, reached a place of decision-making about their destiny, and they choose life. Ironically for some, this choice was viewed as imposed rather than taken freely as they found themselves alive having been unexpectedly given another chance to live, while for others this was a more conscious and deliberate choice. Once it was made, the young men began to turn the corner, moving toward life rather than death and

facing the challenge about how to live in a way that was meaningful and worthwhile. At this point, the young men recognized their lived identity crisis that reflected their unease with their place in the world. They confronted themselves to make a decision about their destiny to which they could commit, recognizing that they had some control over how life could be lived. Similarly, having reached a point of immense struggle Fisher (1999, p.131) describes how *"I asked myself if I really wanted to go on struggling and I said, 'Yes, to Life', because I felt I was now living my own life not someone else's".*

"You can't stay in that crisis state. You have to move forward or back, if you decide to go back you can't expect help anymore."

"…but basically your life is what you want it to be or what you make it to be, and the last couple of years I didn't think like that, 'The best way out is down rather than up…'"

Turning toward and away from suicide can be a rapid or slow process. However, this process was profoundly influenced by pivotal moments of intrapersonal and interpersonal communication that impacted the young men's relationship with living and dying. Worth-enhancing episodes facilitated this process, such as events that unburdened the young men from their sense of unworthiness, sometimes with immediate effect.

"Within thirty seconds I felt better."

Feeling unburdened from enacting a life that did not seem to be of their own choosing or one that was laden with shame or blame had a significant impact on the young men in terms of their sense of agency and self-determination. One participant who felt that he had to continue with his studies for his parents' sake described how, following a suicide attempt, his father suggested that he make his own choices regarding his career. This event freed him to make his own career choice. Interestingly he chose to continue with his studies, however, this was now his choice and he was doing it for himself rather than to please others. Others described how their realization that they were not entirely to blame for their life situation, for example relationship difficulties,

allowed them to free themselves from the blame that they had carried for some of their life problems.

"I realized 'I'm not to blame, this is a two-way street, I can't influence others' reactions.'"

"…And then it was my dad kind of admitted to being the cause of a lot of it, and that is when I said to myself, 'There was me blaming myself all these years'…Yes that was a big step for him…I think it was the end of last year that he admitted that a lot was his doing and from that moment on I have had a great relationship with him…"

Realization that nobody else could change their lives was an important turning point for some of the young men. This resembled a shift from looking externally to looking internally for a solution, beginning to shift their perceived locus of control, influencing how they managed their lives and distress. It has been well documented that suicidality is characterized by a sense of loss of control and helplessness to change one's life (O'Connor & Sheehy, 2001; Williams et al., 2005).

"Yes, you kind of have to pull yourself out of it, there is no one else can pull you out of it…"

"I think I remember a time when I completely lost faith in psychiatry, and that gave me a sense of only I can do something about this."

Letting go of a fantasy about changing the world and being realistic about their own achievements seemed to be important for some of the young men. This allowed them to focus on themselves and to put their energy into goals that were more achievable and ultimately more rewarding.

"Like at one stage I was waiting for the world to change but the world is not going to change overnight. I don't know if I realized I had to change myself or I don't know how it happened, or I just changed who I was because I didn't like the person I was at the time and so I just changed me altogether …"

The struggle between the desire to live and die wherein these young men sat between living and dying came to an end and the young men finally made a decision about their destiny. Having another opportunity to make life work was welcomed by all regardless of whether this was viewed as accidental or planned. The young men moved from being in the centre of the battle between life and death, in the depth of distress and depleted of their personal resources, to breaking free of this burden in their decision to choose life. The primary focus of their energy shifted from negativity to making choices about how to move forward in living.

"I started thinking like maybe there is a positive side to life. It was only little bits of me were saying that ..."

Having turned toward life the search for meaning in life became an important part of *re-vitalizing worthiness* and creating a new identity. As noted in the literature this entails a complete turn-around in terms of self conception *"It was the beginning of a mental turn-about, trying to re-establish my life and find a more accurate sense of self.*" (Champ, 1999, p.118). However, this can be a particularly challenging shift for men in a socio-cultural context that demands success but does not always offer opportunities to achieve this, thereby opening the possibility of further failure.

"I think that there are a lot of males, whatever about females, in Ireland at the moment that think like that [suicidal] because they have nothing to work for, or they just don't see what they are working for so they have no incentive."

Despite challenges the young men confronted their crises of destiny and turned their attention toward living. It was no mean task for these young men to reshape their lives in ways that allowed them to confirm their choice to live. This was achieved through a process of establishing their selves as worthy human beings, as elaborated in the second stage of *re-vitalizing worthiness*.

8.5 Summary

This chapter described the first stage of the re-vitalizing worthiness process, *confronting a crisis of destiny*, in which the young men in this study engaged to

transcend their suicidality. This involved acknowledging and confronting their crises of destiny having reached a point where their life-death battles were no longer tolerable or acceptable. By taking the opportunity to choose life they began to turn toward life and living. They then proceeded with the next and final stage of *re-vitalizing worthiness*, *earning a life*, which involved constructing and enacting new worthy selves as described in chapter nine.

Chapter 9. Sub-Core Variable 2: Earning A Life

9.1 Introduction

This chapter describes in detail the second sub-core variable, *earning a life,* the final stage of *re-vitalizing worthiness*. It extends the re-vitalizing process to describe how the young men in this study, having confronted their crises of destiny and chosen life, enhanced their worthiness and moved forward on their life trajectory.

9.2 Earning a Life

Earning a life, the final stage in *re-vitalizing worthiness*, describes how the young men began to build and enact a new worthy identity in the world which confirmed to their selves and others that they had earned a place in life. For some of the young men, making the decision to live resembled a moment of illumination and clarity that propelled them into a life-oriented position, while for others this was a slower process where their decision to give life a chance seemed to emerge and become consolidated over time. Nevertheless, once the choice to live had been made, the young men turned their attention from torturous wonderment about living and dying, to consideration of how to reshape and proceed with their lives. Making the initial choice to live was facilitated by the stark realization that their situation could not continue as it was no longer tenable, and that there was a real and perhaps final decision to be made about which side of the life-death boundary they would occupy. They then needed to work out how their decision would be enacted, who they would be, and with whom and whose version of reality they would engage. This required multiple decisions to be made and multiple perspectives to be integrated in their search to earn a life through consolidating a new worthy identities. *Earning a life* incorporated two key interlinked processes captured in the mature categories *real-izing worthiness* and *enacting a new worthy identity,* each with a number of categories and properties as represented in table 9.1 below.

9.3 Real-izing Worthiness

Real-izing worthiness describes the initial mature category involved in *earning a life*. It refers to how the young men in this study re-established their value as human

beings worthy of life. Firstly, they refocused on living by re-awakening themselves so that they could begin to see their selves and the world around them anew, which allowed them to find reasons to live. It meant confronting their fears and anxieties about life and their value in life, shedding the defences that served to conceal them and their inner world, and risking engaging with others and life again. This process is conceptualized in the minor categories *re-awakening to self and world* and *renewing relatedness.*

Table 9.1: Earning a Life

Sub-core variable	Mature category	Minor category	Category	Property
Earning a Life	Real-izing Worthiness	Re-awakening to Self and World	Orienting Toward Life	Refocusing energy & thoughts, remembering anew, building hope, looking forward, making plans
			Esteeming	Fortifying resources, enhancing self-reliance, self reward and soothing, building support
		Renewing Relatedness	Mattering	Noticing, responding, pausing, seeing, feeling, hearing anew, valuing you and me, learning
			Re-engaging	Reconnecting, recommitting, relationally selecting, pacing
	Enacting a New Worthy Identity	Reconciling Conflicting Identities	Finding Realness & Reality	Accepting self and world, becoming real, making a real world
			Integrating Selves & Worlds	Discovering meaning, reframing, reflecting, consolidating, re-birthing
		Appointing a Worthy Self	Taking a Place	Claiming territory, freeing self, taking responsibility
			Sustaining a new Identity	Nurturing a new self, finding new self-descriptions, consolidating

Re-awakening to Self and World

Re-awakening to self and world is the initial process in *real-izing worthiness*. It describes the young men's emergence from their concealment and in-between worlds to a place where they could review and revision their selves, lives and worlds. This was achieved as they turned their attention to life and living, planned their futures, and harnessed the personal and interpersonal resources required to sustain a life orientation. Realizing that they mattered to themselves and others and that they were capable beings, provided the building blocks they needed to enhance their esteem, awaken the prospect of a more hopeful and enjoyable future, and re-enter the world as worthy beings, as conceptualized in the categories *orienting toward life* and *esteeming.*

Orienting Toward Life

Orienting toward life describes the process whereby the young men shifted their focus from a life that was dominated by a desire to die, to one that was dominated by a desire to live as they re-awakened to their selves, others and the world. They became more emotionally and cognitively aware and available, and were open to see, think and feel in new ways. This allowed them to notice things about themselves and their environment, reappraise their negative world view and identify positive possibilities and resources. Episodes of noticing deepened and the young men were able to reassure their selves that the world could be construed as more life-enhancing. Therefore, in addition to cathartic moments of insight and interaction that initiated re-evaluation of their identities, some participants described observations that enhanced their choice to live.

"I'm starting to see the finer things in life, for example my car, and holidays and things like that. But for all this to happen I have to work for it and that's the bottom line. If you are not willing to work you could lose your head."

The young men realized that they could substantially influence their own destinies and lives. They gradually came to see that life was challenging but nevertheless rewarding, and that their fears and concerns were valid but could be managed constructively. Having options about living meant that they were no longer prisoners

to fate, chance or an uncontrollable world, and that they could instead determine their own pathways in life. They no longer had to accept and endure the pain that was so familiar, unquestioned and enveloping; instead they were free to enjoy life.

"…it's hard at first but then you start living life again and you start feeling better…like you have to feel better in yourself before you start to enjoy life again. That is not an easy thing to do…"

Having felt trapped in a world of negativity and self-hatred where they expended most of their energy concealing their selves from the world, the young men began to direct their energies toward self-reward and purposeful living. They shed their bleak outlooks, focused on a future that was more meaningful, and began to build and use their resources. They reviewed their ambitions and priorities and contemplated how to reorganize themselves so that their renewed goals could be realized.

"I then got into this very motivated thing whereby I started looking into my career…and all of a sudden I was looking toward this future, which not only seemed possible, but seemed exciting and seemed hopeful and meaningful. And I became very, very energized."

However, the past did not disappear. Hence, orientating toward life meant managing a death oriented past and the negativity that this represented in a way that did not undermine the young men in their endeavours to move forward. Remembering the past was frightening and confusing for them, as it was a stark reminder of their darkest moments. However, it also served to alert them to the fact that they did not want to return to that place of intolerable pain. Ironically, remembering the dark times without being consumed by the memories provided a stimulus and mechanism for staying alive.

"Well the way I was feeling before was by far the worst thing that I have ever felt in my whole life, like it is just the fear of going back to that to be honest with you. I'd prefer to go out there and have five or six guys kick the shit out of me, you know. I'd prefer that pain than the way I was before, it was actually disgusting…it's tough but I'm trying and struggling."

This statement reflects the young men's pattern of immense pain and self-loathing while in suicidality and the desire not to return to that dark place. However, it also reflects a shifting relationship with remembering the past which was becoming less enveloping, thereby enhancing their sense of agency. The young men were reminded that creating a new sense of identity required commitment and hard work so that old patterns of thinking and behaviour did not re-emerge and regain control. Thus, they reframed life events as learning opportunities rather than confirmation of their unworthiness, further demonstrating their changing selves and world views.

"Like yes, I would say my life has changed in the sense that I think about things more rationally. But where I'd say it won't change is that I still feel the same, the thought is still there…"

"It is like my real problem on top of all this was anger, sheer anger. When things get on top of me and I can't speak about them anymore, I can't defend myself with my mouth anymore, I just get physical and that is a major downfall for me…"

The young men demonstrated an ability to recall vividly invalidating episodes and destructive coping patterns without becoming overly distressed. They described how these events impacted their selves and lives. Snow (1999, p.169) similarly notes how one must, *"...reclaim one's vulnerability, to become open and light and fully engaged again",* thereby integrating one's vulnerabilities in the transcending process.

"I remember crying a lot as a child. Sometimes my dad would pull down the trousers and the underwear and smack us, and I didn't like that. I feel that was the perverse side of the punishment. My parents were weird individuals, I don't understand them, and I probably never will..."

With awareness that the past does not necessarily determine the future, thereby introducing a temporal dimension into their lives, these young men were able to generate and sustain hope and a sense of control in living. This enhanced their ability to navigate their lives and to reconcile the dialectics that confronted them in and beyond suicidality. These shifts in perspective were important as the young men shed

the cognitive, emotional, and physical restrictions associated with shame, blame and guilt that entrapped them. The prospect of life had been so frightening that they retreated into the place of "the living dead", avoiding any real semblance of being alive. Hence moving from the shadows was experienced as a step into the unknown and as they began to build their confidence the fear associated with living gradually abated, thereby creating space to generate hope.

"I started to think about the future…'I might have a place in the world…What do I want from my life?'"

The literature describes hope as central to overcoming life adversities (Collins & Cutcliffe, 2003), and indeed Champ (1999, p.119) suggests that hope *"…is an essential ingredient in recovery."* This view was echoed by a number of the young men whose sense of hope helped them to overcome the challenges they faced in changing their lives. They developed hope in themselves and their futures by acknowledging and having acknowledged their achievements and resources. This process was enhanced by making tentative commitments to selected aspects of their lives that were manageable and that reinforced their capabilities and sense of control. Hope was also inspired by others through their demonstration of belief in the young men, allowing them to progress in life with confidence. Gestures of genuine belief in the young men provided positive feedback to them about their worthiness, encouraging them to take on new challenges.

"She [liaison nurse] has been good to me and she has given me confidence and stuff for the last couple of weeks, and it helped..."

"…my friends would have had a nice sense of me and would have felt there was a huge amount of potential in me, in a very broad sense, in a very human sense, that was being inhibited…"

"I turned it around myself by talking to my friends. That is what helped me. It was talking to my close friends because they spent hours sitting there and listening to me."

In addition to the role that family, friends and professionals had in this process, peers were identified as important in establishing hope for a different future in the knowledge that others had overcome similar life adversities.

"I think a lot of people with mental health problems feel very isolated. I know I felt very isolated at times, despite very close friendships. But this [group programme] was connecting with people and there was some sense of shared experience, which is very important."

Acknowledging the impact of environmental factors on the re-vitalizing worthiness process highlights critical issues for professionals. Working with suicidal men can be challenging in terms of perceived lack of progress, passivity and external locus of control. Hence, sustaining hope and commitment is essential, while lack of endurance and impatience may reverse the re-vitalizing process.

"It is patience that they [health professionals] need, they have no patience. They are coming to you with loads of questions like, 'How do you feel now?' and ' How did you get like this?' …They don't have the patience to work their way in. And if they saw their patients a lot more I guarantee you a lot more people would open up and they would be able to figure out the root of a lot of people's problems, instead of coming in like 'This is wrong with him, give him this, give him that'."

Orienting toward life meant actively planning their future lives. Planning for a hopeful future is a taken-for-granted activity for most people in the course of getting on with living. Planning ahead is viewed as essential in terms of knowing where one is going in life, anticipating hurdles to progress and benefits from one's achievements, in other words having a sense of mastery of one's life and future. Taking control of their lives required consolidating the shift in the young men's perceived locus of control, from external to internal, and a change in perspective from being controlled to being in control of their lives.

"Yes I am in control, and that is the bottom line. No one tells me what to do and if I don't want to do something I won't do it. End of story, and if they don't like it…'Bye, bye'. That's the attitude I have now…"

Despite inability to tell the future, many people proceed with living *as if* this were possible. However, for the young men who knew that control and prediction were at best ideals and at worst myths, moving forward took on a different meaning. While planning for the future with hope and determination was necessary to bring some order into their worlds, such endeavours were viewed with caution. Hence, the young men engaged in the practices of living while aware of the fragility, uncontrollability and unpredictability of life and death, having had the opportunity to reflect on their position and priorities.

"I am not a religious person, but I have done enough philosophy to have a deep enough suspicion that there is not really much point to life. So in my case those things are very much part of my personality, but I suspect that with other[suicidal] people there is an element of 'What is the point of it all?' to some extent."

Being aware of the precarious nature of living and the uniqueness of each person influenced their perception of society and social practices. Current suicide prevention strategies, as reflected in a national suicide and mental health awareness campaign, were viewed as naive in their efforts to prevent the unpreventable, over simplistic in their underlying assumptions about the sameness of all suicidal people, and blaming in placing total responsibility for one's health on the suicidal person. These views have been supported in a recent overview of the effectiveness of suicide and depression public awareness campaigns across a number of countries (Dumesnil & Verger, 2009). These authors found that such programmes contributed to a modest improvement in public knowledge and social acceptance of depressed and suicidal people. However, no studies assessed the durability of attitude change, or demonstrated that such campaigns increased help-seeking behaviours or decreased suicidal behaviours (Dumesnil & Verger, 2009).

"Everyone is unique. They [suicide campaigners] talk as if we are all the same and they don't get to the real pain of how you are feeling. The language is cold and they put it out that you can just do it [have good mental health] if you want."

Moving from a position where suicidality and a negative self-construction over-powered the young men, to where they regained personal power, required a new kind

of fight response. Rather than fighting against their selves and the world they began to fight against their previously accepted sense of self as unworthy. Life-orienting therefore required the young men to reconcile within their selves conflicts about the past, putting to rest the dominant dark side of their selves and their worlds and replacing this with new insights and wisdom, which enhanced their esteem.

Esteeming

Esteeming refers to how the young men embarked upon a journey of shedding their sense of unworthiness in order to rebuild their personal esteem, thereby creating a new identity. Crocker and Park (2004) suggest that people stake their personal worth on particular contingencies in their lives that serve to define the person's value in terms of success or failure. Esteem can be enhanced through achievement of personal goals that hold meaning for the person, such as academic attainment or wealth (Crocker & Park, 2004). In addition to acknowledging achievements, the young men's esteem was enhanced by exposure to life-giving forces in their selves and their environments, building self-respect and respect from others. Gestures of validation from others sometimes initiated and frequently enhanced the esteeming process, facilitating the young men to build their sense of competency and agency, while invalidation confirmed unworthiness. By fortifying their inner and outer resources in multiple ways the young men defined themselves as persons worthy of living.

"I got the impression that my present partner is giving me the slightest little bit more respect than what she did, so it is making her see that I can do things well. So ultimately it comes down to what I do, and how I lead my life, and my outlook…"

"So only for that [friends] and reading, I find it very chilling playing the guitar…That is how I have learned to deal with it [distress]."

Success enhances self-value and defeat confirms unworthiness particularly when failure cannot be dismissed with defensive self-preservation strategies (Crocker & Park, 2004). However, this is a challenging process when one's personal reputation is perceived to be at stake. Therefore, in foregoing the use of defensive strategies it was important for the young men to move beyond patterns of becoming defeated and hopeless by finding alternative ways to respond to perceived threats to their worth.

"It was work that would be demeaned by a lot of people but it was extraordinarily important to me, and soon I realized I was quite good at it, and I was quite good at making connections with kids..."

The significant challenges inherent in reorganizing their lives and countering their sense of unworthiness meant developing comfort with their selves and their lives so that they could redeem a sense of empowerment. This is an important issue for the professional in terms of engaging with suicidal men to facilitate them to find helpful understandings of their situation. Champ (1999) suggests that a blame culture that seeks out a specific explanation, event or person in one's life in which to locate responsibility for one's unhappiness is not helpful. Hence, reclaiming personal power that the process of suicidality, and indeed treatment, compromised further established a valid sense of self when this was not compromised by self-blame. This allowed the young men to engage in constructive acts of self-soothing and reward, such as recreational activities, family life, work and education. Valuing their selves was important in encouraging the young men to continue on the pathway to a new life.

"...once I got back into full time education that became very significant for me in terms of giving me structure in my life, in terms of giving me meaning, in terms of giving me challenge, lots of things."

In addition to taking up new worth-enhancing activities the young men needed to replace former destructive strategies that fuelled their sense of victim-hood; according to Snow (1999) this is an important part of accepting a new life. Challenging their victim saturated selves meant that the young men relinquished passivity and became more actively involved in directing their lives in meaningful ways, including their care and treatment.

"...but maybe there was something very fundamental in that shift from 'What can be done to me to fix this, to make this better?' to 'How can I do something for myself, what can I do for myself, how can I go about that?' I think that was for me a critical shift."

Having oriented toward life the young men's sense of esteem, once shattered, fragile and mediated by fear, became positive and strong and was mediated by motivation and achievement. This reinforced a sense of personal value that allowed them to become visible and connect with the world.

Renewing Relatedness

Renewing relatedness is the second minor category in *real-izing worthiness*. It captures how, having built their esteem, the young men were ready to accept that others might have a positive contribution to make in their lives and vice versa. It involved reconnecting with others and living in ways that were meaningful and rewarding as they demonstrated that they belonged to a wider social system. This meant recognizing their value in society and allowing others to be part of their worlds by re-engaging with and committing to a social world. However, given their knowledge of emotional pain, this was achieved cautiously to ensure that old hurts and negative interactional patterns did not regain control. The process of renewing relatedness is elaborated in the categories *mattering* and *re-engaging.*

Mattering

The young men began to realize that they were not isolated beings and that their choice to live or die mattered to themselves and others. "Mattering" has been described as a belief that one is significant in the lives of others and it is suggested that recognition of this improves self esteem (Elliot et al., 2005). Hence, this realization made it possible for the young men to build further their worth and to open themselves to the world around them. They had lived in a manner that reflected a lack of care and concern for their selves and others. However, accepting that they were part of a wider community of concerned people helped them to demonstrate interest in their lives and care for those with whom they choose to be involved.

"It is good to know that somebody cares about you..."

"…I was hurting people both physically and mentally and it wasn't right. It does bring you back to the point of, 'Yes, it still hurts me but I just have to cope with it'. You just have to keep calm, and think about it realistically, and growing up, and not saying stupid things to each other…"

In order to decide who they were, and how they would be in the world, the young men had to begin to trust their judgments about themselves, others and life. Self-trust was necessary to take charge of their lives; this allowed them to move on with living in a viable way where they were no longer at the mercy of chance, fate or others. Self-trust also proved an essential part of negotiating relationships with others. Renewing trust in oneself can be a slow process, and was enhanced by the deep knowing about oneself that the young men acquired in their suicidal crises and close encounters with death. They learned to make decisions to which they could commit rather that occupying a limbo world without direction. Decision-making requires one to be able to weigh up the pros and cons of his situation, consider the consequences of different options, commit to a particular position in relation to important life choices, and evaluate and learn from the decisions in order to move forward. This level of trust in their judgment-making capacities was a tall order for the young men who believed that they had no control over minor life situations let alone their own place in the world.

"But I suppose having learned to rely on myself a bit more, having gained a measure of confidence in my own abilities...But the realization that not only is that [peer tensions] normal but that I could meet a new group and get on reasonably well with everybody. That is part of that anger that used to come from failure. I am not sure that [failure] is the correct word, but from what I saw as failure...Yes, but failure is perfectly normal."

These young men began to contemplate previously foreign and frightening ideas, such as, their desire to belong and their ability to connect with the world. However, in their desire to avoid repeating habits of disappointing their selves and others about whom they were concerned the young men paced their personal and interpersonal commitments in ways that were not over burdensome and were more likely to succeed. This ensured that the promises made to their selves and others about their emotional and physical availability, goals, and roles could be honoured which promoted their genuineness and trustworthiness. They demonstrated a capacity for self and relational reflection and trust-building as they connected with the world and established themselves as part of humanity. Their sense of mattering and belonging was enhanced and their new identities began to take shape. They gradually earned a

valid place in life, whether this was in terms of traditional norms or alternative contributions.

"Once I knew I was contributing in some small way the distress abated…I want to be in a position that I can live my life and in some small way do something that I feel is valuable. So I do my things that I think are valuable. I work, work is hugely important…"

The young men began to allow others into their world and let them get to know them anew, which was risky as it opened possibilities for being judged and rejected. However, as they appreciated the importance of enhancing their relational context by way of establishing their worthy identities, they also realized that they and their suicidal selves were part of a bigger context that also permitted and shaped their being.

"…So maybe it's [suicidality] not something internal to me but something I have participated in, something that certainly informs who I am and how I am in the world…"

In the same way as they paced their commitments in life the young men paced their connections with others clearly identifying those who mattered to them. "Pacing" has been described as *"...accepting distressing information at a rate that can be assimilated"* (Reisman, 2001, p.453), thereby reformulating one's relationship with their distress in a way that can be gradually transformed and / or relinquished as alternative relationships with this and with the future are constructed. The young men carefully selected those who were sustaining in their lives and shed worth-compromising contacts. Disconnecting from sources of torment was important in sustaining control and a positive direction in life. This was challenging when making decisions about severing contact from loved ones, as did some of the young men, however, establishing life-enhancing connections took precedence.

"I'm cut-off from my family now; I got the blame for everything."

"Well there are a few that I have grown up with that I still hang around with to this day…the rest of them, 'Piss off, you aren't real friends'…"

The young men also repaired relational wounds relinquishing their burden of self and other resentment and criticism, and replaced this with self care and acknowledgement and worth-enhancing environments. This allowed them to use their contextual resources in more constructive ways despite past hurts.

"…but now I turn to my da, I used to hate him, I used to hate him with a passion. But now if something personal like that happened years ago, I'd go up to my da and talk to him, and he'd sit down and listen and tell me what he thinks, and I could take and work it out for myself."

Regaining an ability to respond in other than defensive and demeaning ways required a shift in perception of their selves and their contexts, opening space for alternative and more constructive action. Therefore, as the young men learned to challenge their selves and their world view they were enabled to respond to their world and those in it differently.

"...she [partner] gave me a list of problems that we were having and I spent the whole weekend, from Friday to Monday night, going around to people apologizing to them, explaining why things had happened..."

Realizing that they mattered allowed the young men to see that they cared about their relational network. Rather than seeking out others to blame or loathe, they sought those with whom they could have rewarding experiences, enhancing their personal worth and interpersonal connectedness and transforming their sense of self. Fishbane (2001) suggests that negative and rigid interpersonal patterns narrow the experience, presentation and enactment of self, while subject-to-subject experiences expand one's sense of self, fostering relational competence and emotional intelligence, and enhancing possibilities for further such encounters. Vigilance for imperfections in self and others was replaced with an open mind, eye and ear for opportunities to connect meaningfully, shifting the young men from victims to authors of their lives and inter-subjective selves (White, 1995; Fishbane, 2001).

Re-Engaging

Acknowledgement of a desire for relatedness facilitated the young men in their movement from isolation to belongingness, enhancing re-engagement with the world. The young men saw that they mattered and were part of a wider community and world and that they had a contribution to make to this world. Therefore, *re-engaging* with their selves and their worlds was important in generating purpose and meaning. It also enabled expression of thoughts and emotions previously withheld from self and others, expression of which consolidated their connections with those in their lives, including social and professional relationships.

"…she [partner] said 'What's going on in your head?', and I said, 'Basically I am hurting'…"

"…Over that year I kind of learned to, not necessarily avoid, but learned to deal with stuff that makes me uncomfortable...and I came through it then. Overall I probably spent the guts of a year going to counselling, anything from one to four times a month, and that allowed me to work out the issues of frustration or whatever. I learned that what I felt was normal."

The importance of re-engaging with humanity in recovery following a suicidal crisis has been highlighted in the literature, and it is suggested that this can be facilitated by the mental health nurse through compassionate care (Cutcliffe & Stevenson, 2007). Perkins (1999) identified support from others as significant in helping her to overcome mental ill-health. She suggests that a significant aspect of support involves conveying belief in the distressed person's human worth, in addition to providing practical help in times of crisis. Hence, caring and concern needs to demonstrate belief in the person in addition to empathic understanding, challenging the dark side and supporting and reinforcing their renewed bright side. This process was identified by the young men as validating their being and giving them permission to be part of a living community, in spite of flaws.

"…So even those friends I tried to push away in a very concerted way. Luckily they didn't accept it, but I tried to. I think my friends had to show a lot of resilience…I

think they saw glimpses of a different (name) that was less distressed and less angry and less difficult to be with, and maybe those glimpses were little reminders of the relationships we had when things were good."

In the same way as the young men learned to trust themselves they also learned to trust others. Trust in others was necessary in order to re-engage with the world and re-establish relationships that were real and significant in moving forward. This included relationships with family, friends, colleagues, peers and professionals, thereby creating social support systems and professional help networks to further validate their emerging new sense of self. Having lived in an unreal and destructive world, seeking real and helpful relationships was important. They monitored others in terms of their motives to be connected and selected those who were genuinely interested in them as individuals, otherwise the relationships were terminated. They also sought to establish other people's perspectives on issues that were important to them. For example, one young man described how he challenged the stigma associated with suicide-ality and explored the acceptability of rational suicide with others by way of selecting like-minded people with whom he could connect. Hence, others had to prove their worth to the young men in order to be included in their new worlds. Ironically, this represented a reversal of previous patterns of engagement where the young men tested their own deservedness to belong, reflecting a significant shift in their views of their worthiness.

"Yes I am not changing for nobody because I like me the way I am now, and my close friends like me the way I am now."

The young men also tested professionals to ascertain if they would be judgmental of or open to their worlds, including their suicidal selves, and to establish their trustworthiness and integrity. The contribution that a positive working alliance, based on mutual trust, can make to therapeutic / treatment process and outcome has been well recognized (Hubble et al., 1999). Trust in a professional can be enhanced through the gradual sharing of personal thoughts and emotions which are accepted by the other as valid, however irrational or unusual they may appear on the surface (Orbach, 2001). This was important so that the young men could share and explore

their emotional turmoil and their hopes and dreams for the future, thereby resolving their distress about their lives and creating an optimistic future.

"…at least you can build up a relationship of trust with them [therapists] and then you might start opening up…I had a few sessions before I would kind of, I wouldn't talk about much at first, and then one day I just went in and 'opened the floodgates' as they say."

The re-engagement process was enhanced by self-acceptance, which was necessary in order for the young men to notice that they were accepted by others and to accept an imperfect life and world. Acceptance also increased their sense of responsibility for their selves and their lives, including their mental health. They began to appreciate their deservedness to negotiate their own space in the world, developing confidence in their ability to make judgments and to follow through on their commitments and decisions.

"It is the first time I have actually loved myself properly like…I like me, that is all that matters. And if I can wake up every morning, looking at myself in the mirror and say, 'I love you,' that's brilliant. If I can't love myself no one is going to."

"…I first started thinking about mental health in terms of coping and dealing with that, and then a little bit about how do I manage my life. 'What do I want from my life, what would make my life something that I want to go on with, something that I enjoy, something that I value?', as opposed to something that previously I had sought to rid myself of."

The young men began to appreciate the reciprocal nature of relationships and to find new ways to invite and respond to others that were sustaining rather than damaging. Bille-Brahe et al. (1999) highlight the important place of reciprocity in relationships, particularly male relationships, which has implications for how one engages with men in suicidal distress. For example, within the mental health services, help has traditionally been viewed as a linear one-way process delivered by a professional to a client where he is viewed as a passive recipient of care (Anderson, 1999). Hence,

incorporating reciprocity into the mental health care system challenges this perspective and can potentially enhance collaboration.

"My life has completely turned around now, anything I can do to help…I enjoy giving back."

"Yes, I wanted to do this [interview] because if I can help one person I will be a happy man…Because that is why I want to join the army, go abroad, help people in these poverty-stricken countries that have nothing…"

As the young men re-engaged with their selves, others and life again they became ready to establish and enact their new sense of identity in their daily lives. This process is described in the final category incorporated into *earning a life, enacting a new worthy identity*.

9.4 Enacting a New Worthy Identity

Enacting a new worthy identity is the second mature category in *earning a life*. Having built their esteem and value as individuals and established themselves as a valid part of humanity, the young men began to view themselves as beings worthy of life and all that this had to offer. They emerged from their dark and lonely worlds aware of their personal value which allowed them to become visible and connected. They were no longer islands in stormy water but persons in a world that was manageable and calm. *Enacting a new worthy identity* describes how the young men integrated their disjointed identities and re-established their new worthy identities in the world. This process is described in the minor categories *reconciling conflicting identities* and *appointing a worthy self.*

Reconciling Conflicting Identities

Reconciling conflicting identities is the first process in *enacting a new worthy identity*. It describes how the young men established their selves in the world as integrated beings. They had lived in an in-between and unreal world, and faced with the ultimate existential question about their deservedness to BE, they pushed themselves to finally answer this question by choosing life over death. Resolution of the pull

between life and death and the integration of the unworthy and worthy selves can be described as a dichotomous synthesis whereby the young men brought union and harmony to their selves and to their worlds. This involved embracing their newly found realness and realities by letting go of their ideal or fantasy selves and their real or experienced selves, neither of which had served them well in life. They established their emerging new identities as worthy of living and belonging in what was previously a foreign world. Hence, the young men and those around them were challenged to adjust to this new integrated being, as elaborated in the categories *finding realness and reality* and *integrating selves and worlds.*

Finding Realness and Reality

The lack of self and relational authenticity with which the young men had lived resulted in extreme isolation, whereby living in an in-between and unreal world became the norm. Thus, *finding realness and reality* describes how the young men became real to their selves and engaged with the real world where they had previously lived a life of acting. They risked being their selves with others and allowed others to be real with them as they yearned engagement with others and were not prepared to continue to expend their energies in superficial living. Thus, they began the task of finding their own reality, a real self, real relationships and a real world in which to live, which required them to re-evaluate their world view and existing patterns of living. The importance of a sense of real relationships and being part of reality in overcoming mental distress has been endorsed by others (Champ, 1999; Fisher, 1999). Becoming real with self and others facilitated a sense of being worthy as individuals in the world and having a right to live in their preferred way.

"...Okay, so I can't change the world, but I can do something that has meaning, that fits with my values."

The young men saw that they had allowed themselves to become pulled between a world absorbed in negativity and a fantasy world where everything was perfect. They discovered and accepted the ordinariness of living and viewed life in more realistic terms. They realized that life is challenging and that many people work hard to succeed, frequently with little obvious reward. They came to accept that life, for most

people, involves challenges and uncertainties, hence they attuned to this new version of reality.

"Well as I said…despite how miserable this country is, there are good parts, you just have to look for them."

"The world is not a nice place, so you have to stand up and be counted."

Following their suicidal crises, life for these young men did not reach the heights of expectation and reward that they previously imagined and had scolded themselves for failing to achieve, however, it was and felt real. They no longer played a game of living as they did in their divided worlds with their fragmented selves; instead they were present in the world. They were given the opportunity to be ordinary people, living ordinary lives, and they accepted this with enthusiasm. They transformed their view of life, once regarded as meaningless and unfulfilling, to purposeful and rewarding, enriched with the simple things that living could bring.

"I am open to everything now. I still think it's a horrible world we live in, but I take the positives from everything."

Alvarez (1971, p.30) supports this view when he proposes that his own recovery from suicidality came about when he discovered that death, *"is simply an end, no more, no less",* and experienced relief in the realization that unhappiness is a "*condition of life*" to be endured. Thus, he was critical of the Western emphasis on having problems and seeking solutions, which one may or may not find. This is one of the paradoxes inherent in treatment that implies that cure and remedies exist, leaving little space to accept oneself and the world as they are.

"I didn't need to have complete control over every aspect of my life in order to start feeling okay. Those tiny little incremental steps brought disproportionate benefits in some ways, which is great, which is quite hopeful…"

Being real meant that the young men became present. Having previously absented their selves from life by making it unreal and making themselves invisible, this was a

frightening shift. Conveying a carefree and positive persona that was plausible to others required them to shut down or deny parts of their selves, hence they gradually become unreal. Nevertheless, if they chose to live they had to risk returning to and being present in an uncertain world in order to establish their place therein. Presence also meant staying in the moment, which is by no means easy as people tend to look backward and forward, thereby removing themselves from staying with and in the moment. A form of self and relational mindfulness was required to sustain the young men in the present, while also being able to reconcile the past and plan for the future; this could be seen in the calm composure adopted and internalized into the young men's new being. This disposition focused them and harnessed their capacity for regenerating worthy identities by reawakening their genuine concern about themselves, their futures and others.

"So I just came to the conclusion basically, there was only one thing that I was really living for, and that was my kids..."

Having found a sense of realness and reality in their selves, life context and relationships, the young men established that they were worthy of living. They began to demonstrate that they had earned a place in this world and a life that was less painful, however ordinary it might be. Their sense of integration and completeness as persons was facilitated by engaging in grounding activities such as relaxation, meditation and reflective inner and outer dialogue.

"...I am going to see (name) and to be honest I am after putting a lot of effort into changing my life. I am going to the gym now, and playing snooker, and getting a lot of things on the computer and things like that..."

Integrating Selves & Worlds

The young men felt disintegrated and incomplete as people and embarked on reconciling their contradictory selves and lives. Fisher (1999, p.129) captures this sense of disintegration when he says, *"I felt fragmented and lost, like a 'rolling stone' with neither a sense of self or a sense of direction in life"*. He uses the metaphor of Symbolic Interactionism to suggest that when his I, the inner spiritual self, and his me, the outer social self, united, an opportunity arose for human wholeness. To

achieve a sense of integration, the young men confronted their fears and reshaped their identities in the world. They reconciled parts of their lives that had seemed irreconcilable and accepted their being which appeared troubling and foreign in the past. Some had viewed their disintegration as a sign of insanity. However, they realized that they were not mad, bad or sad but that they had become absorbed in their inner world and turmoil and could not see options for living because they were consumed with death and dying.

"So I realized it's not my head that isn't right, it's that I'm using it the wrong way…"

Integration required that the young men accept their selves and worlds, reconcile their inner and outer conflicts, and experience themselves as whole and worthy. Inger and Inger (1994) suggest that a profound shift in one's being in the world that requires the coordination and consolidation of conflicting identities means that the person can never be as they were previously. This sense of being re-born is captured in the following quote, which was also used in chapter seven.

"…Even my close friends said, 'A while back you were in bits'…'You are smiling in your eyes and your eyes are always beaming, like you are a re-born child'."

Hence the young men and those in their environment needed to adjust to this new being that was hitherto seen as worthless and fragmented. Cutcliffe et al. (2006, p.800) incorporate the notion of integration of the person's conflicting identities in the "learning to live" stage of overcoming suicidality, whereby the existential crisis shifts *"…from 'what do I have to live for?' to 'how do I go on living in the context of surviving a suicide attempt?'",* which necessitates accepting the reality of living and dying. These authors also note that for many people life cannot be the same again as they come to terms with having attempted to end their lives. From this perspective suicidality can be viewed as dis-ordered identity searching, whereby the young men having sought and found meaning in their dis-order, began to re-order their selves and lives. In a social context, where death is a taboo topic, coming to terms with the inevitably of death has been described as a profound existential experience (Deci & Ryan, 2004). This idea is reflected in the personal accounts of people who have overcome severe mental distress (Webb, 2002, 2003; Barker et al., 1999), describing a

fundamental change in being as a spiritual or psychic awakening (Clay, 1999). The concept of "re-birthing" can also be found in the psychoanalytic literature, referring to one's yearning for a new life through death, akin to the suicidal person's yearning for release from their world of pain to one of peace. In keeping with this view Alvarez (1971) proposed that adults who attempt or complete suicide may harbour fantasies about the power of suicide to bring about ultimate and final freedom, peace, damnation or revelation. Thus death might not only end the pain associated with living, but perhaps also explain the very act itself. This suggests that if one loses connectedness or commitment to a set of meaningful values loneliness or emptiness ensues and life becomes meaningless. From this perspective it is understandable why the young men felt somewhat haunted by their suicidality and impending decision about their destiny. However, the young men in this study achieved re-birth in the form of a new life.

"I feel like a completely new person, everything has changed in my life now…It's hard to explain…"

Existential explanations are frequently viewed as lacking in scientific robustness and logic given a prevailing spiritual naiveté in Western society (Pesut, 2009). It has been suggested that the leap to scientific explanation, and hence logic, provides us with a defence that diminishes humanity (Barker et al., 1999). This raises fundamental questions about if and how the spiritually naive professional can facilitate another to explore the unexplorable and embrace uncertainty in a world that seeks certainty. It is perhaps the existential aspect of suicide-ality that sustains its mystique despite the volumes of literature that attempt to explain it (Shneidman, 2001), and why living on with some mystery is essential for survival in its aftermath in a world that demands logical explanation.

"I don't know really what it was, what caused it all you know."

It is suggested that people desire co-ordination of meaning as this brings coherence to one's world and identity (Pearce Associates, 1999) and that meaning-making facilitates the self-integration process. One way of making sense of a situation is to find purpose in it (Frankl, 1959), thereby re-establishing a belief in an orderly and

comprehensible world (Janoff-Bulman, 1985). The idea of gaining insight into and power over one's troubles and life is supported in much of the psycho-therapeutic literature as a means of achieving self-understanding, revisioning one's relationship with the world, and moving forward in life (Freedman & Combs, 1996). Openness to re-evaluating their lives and learning from experience was demonstrated in how the young men moved beyond suicidality.

"I don't take the negatives out of it [life experience]. I always go for the positives out of it and what I can learn from it, the experience. Like everything to me is a new experience. Take the positives out of every new experience and bring them with you…And you pick up thing as you go along and every day you learn something new, that is true."

A number of people have attested to the importance of discovering meaning in one's pain as part of the recovery process (Champ, 1999; Chamberlin (1999); this allows one to gain power over their suicidality (Cutcliffe et al., 2006). Part of the integrating process involved the young men making sense of their selves and lives and gaining a sense of power in relation to their suicidality. However, this could be described as power with rather than power over suicidality as aspects of their suicidality remained a mystery for some of the young men while they were clear about the nature of their relationship with life and death in general. According to Champ (1999, p.123) recovery involves *"…deep searching and questioning, a journey through unfamiliar feelings, to embrace new concepts and a wider view of self."*

"I needed a career, I felt that was meaningful to me because in some ways I had framed my depression around life not being meaningful enough, not having found meaning."

"…I don't know where it actually started that I started seeing the other side. I don't remember why it all started but when I started double questioning myself. I'd be there, like ' Hang on a minute, don't let this happen to you again'…"

For the young men, such searching involved engagement in a form of intrapersonal and interpersonal reflection. Intrapersonal reflection refers to an inner process of

integrating a range of perceptions in order to realize what is known within the self, influencing action and interaction. The reflection process is undertaken in order to gain understanding, insight and new knowledge, thus it plays an important part in "personal knowing" (McKenna, 1999). Reflection requires a disposition of open-mindedness and motivation, the skills of analytic thinking and self-awareness, and the process of integration of new learning (Atkins & Murphy, 1993). In addition to personal reflection the young men highlighted the important place of relational reflection in reappraising their lives and accepting their selves. This refers to an interactional process between them and others that stimulated new learning or real-izing, which the young men internalized. Both intrapersonal and interpersonal reflection served to challenge these young men's preconceived ideas about their selves, their lives and their realities and helped them to formulate a constructive psychic base for more fulfilling forms of action. Andersen (1987) views the reflective process as a movement between speaking and talking, described by Seikkula et al. (1995) as moving between inner and outer dialogue, which evokes a change in perspective. Making sense of life and the suicidal experience involved seeking out coherent stories about a life that pushed the young men toward death while also puzzling about how to live.

"A lot of my framing has been re-framing. A lot of my framing has been coming to understand and manage it myself. But that is a luxury I have had because I have gone on and had the wonderful opportunity to think and talk about these kinds of ideas a lot through my professional training and my professional work."

Replacing rumination with reflection was evident in the young men as they used negative life events as a source of learning rather than a source of torture, enabling them to live differently and to construct selves that were acceptable. Williams et al. (2005) describe how rumination can overtake the suicidal person as he becomes absorbed in trying to figure things out without being able to make helpful sense of his situation. The young men were sometimes only able to make partial sense of their lives and suicidality, which meant finding resources to go on living despite continued questioning about their past and uncertainty about their future. Sometimes this involved putting the suicidal episode aside and focusing on their daily routine while at other times it meant engaging in deep searching of the self and life.

"There would have been times when I would have been almost obsessive about the idea, it consumed me."

"Well, firstly I think the person who has suicidal thoughts, that is suicidal, they need to address the underlying issue, and there's no point in saying that they don't know what it is because they do…For two years I was going to counselling, then the counsellor sat down and made me tell her every single thing that happened, down to the last detail…"

While contact with health services frequently allayed the young men's fears, thereby enhancing worthiness, it sometimes served to confirm their fears, leaving them more desperate and uncertain about their own worth and capacity to overcome their distress. Champ (1999) suggests that an unstable and uncertain relationship with oneself, compounded by the effects of medications and confinement practices, can make one feel that he no longer knows or can trust himself and that he has become the illness. On the other hand, making sense of one's distress allows one to gain perspective on and control in his self and his life. The power of contact with a health professional to enhance or reduce opportunities for sense-making and regaining control through validation was echoed in this study. The young men distinguished between helpful and unhelpful encounters describing the profound impact that both had on their sense of worthiness.

"But I just thought that this transparency, this openness, this sense of collaboration whereby not only do I have a voice but this person is even willing to say 'Well this is how I work, and if it is something you are interested in I will share even the mode of work I do with you and see if that is interesting for you, or see if it might inform how we work together'. I think that is extraordinary..."

"...and at the time the powerlessness, the injustice, the lack of being heard, was excruciating. It was absolutely horrific. I have talked about that with friends and family lots of times and still when I think back to it, and talk about it now, I feel quite upset. I still feel angry about that."

Integrating their selves and their lives was challenging when the young men were reminded about their vulnerability and dependence on others. For example, being in receipt of disability allowance served to reinforce the view that they were not part of a normal functioning society. Nevertheless, they demonstrated their growing sense of worthiness by taking increasing responsibility for their lives and futures and committing and contributing to their new worlds.

"So that is one of the reasons I am here [interview] because I know there is a problem [suicide-ality]. There is a massive problem and it has to be sorted out. Generally because I have experienced it first hand and I don't think it is right in this day and age."

The young men got more in touch with their inner selves and their outer worlds, reconciled their conflicting identities, and developed a sense of reflective calm as their inner battles resolved themselves. They found a reality with which they could engage and established their new identities in their new worlds.

Appointing a Worthy Self

Appointing a worthy self is the second minor category incorporated into *enacting a new worthy identity*. It refers to the way that the young men repositioned themselves in their lives and the lives of others, which was possible having redefined their selves as persons of personal and social value. They reappraised and changed many aspects of their selves and lives as they reconfigured their new integrated identities. This required them to claim a firm place in relation to who they were and to establish what life and others meant to them in order to enact openly and sustain their new worthy selves in everyday living. They introduced their new selves to their wider living contexts in a meaningful and manageable way, as elaborated in the categories *taking a place* and *sustaining a new identity.*

Taking a Place

Taking a place refers to the young men's demonstration that they had answered their troubling questions about their deservedness to live as they came to know how they wished to present their selves to the world. With new insight into and awareness of

their strengths and vulnerabilities and a sense of control in their lives, they redressed the imbalance in their predominantly negative self-conception and world view and began to manage the external world. They claimed territory for enactment of selves and freed themselves from the chains of convention so that their uniqueness could be appreciated and performed in their daily living, thereby consolidating their identities. Having faced their own mortality - paradoxically facing death in order to face life - the young men took their place in a reappraised and reconfigured world.

"All of a sudden I began to think about how I could create a place for myself in the world, a place where I could be comfortable."

Redefining oneself in relation to the profound issues of suicidality and its origins can have a ripple effect on how one redefines oneself in the world generally. Champ (1999) describes how overcoming psychosis influenced his redefinition of masculinity and his self, which had been compromised by his perceived failure to achieve societal expectations. In terms of masculinity, men in crisis may well discover that men experience and express emotion. Through such discovery it is possible to reclaim a renewed form of masculinity, shedding the sense of emasculation that contributed to suicidality and exacerbated life problems in general (Champ, 1999; Cleary, 2005b). The young men found ways to engage in living that were viable and experienced as worthwhile and rewarding to them as men, and that fitted with their perceived needs in life. This meant finding new ways to identify, understand and express emotions that were previously uncontrolled or suppressed.

"I let go of a lot of the anger. That is the main difference, that I let go of that frustration and I learned to deal with it, and I learned to recognize it as being more common than I thought. So even when I do get it now I understand why I am getting it. Whereas before I just had this anger without necessarily an outlet, or even anger without necessarily understanding as to why I was angry. That is the big difference."

Knowing oneself and having a clear sense of why one is living is important in order to face the challenges that life poses (Snow, 1999). Discovering that they had a place in life was a truly transformative experience for the young men who had doubted their deservedness of such a place, permitting them to pursue a life of their own choosing.

This new state of being helped to replace ambivalence with certainty, hopelessness with hope, chaos with direction, and a sense of being lost to one of being found. The young men created selves of which they could be proud, hence they could appreciate their achievement in being alive and their achievements in daily living.

"…but the fact that I had a very strong world view, that I had a real sense of something I hung onto, a value system which, although maybe how I managed that was very difficult for a long period, but once I generated a way of operationalizing that value system, a way of making that value system something that was tangible in my day to day life it became a huge asset to me. It drove me on and it gave me meaning, aspiration and a sense of purpose."

Living a satisfactory life promoted a sense of responsibility for and commitment to their selves and their lives; hence worthiness was enhanced in a circular fashion. Responsibility can be understood as an internal process of taking on the charge of life tasks and their outcome and / or demonstrating response-ability, ability to respond and to live in a relational world. In the context of this study responsibility refers to both, as the young men enhanced their own resources they also enhanced and were enhanced by their relational contexts. Some of the young men defined the moment when they realized that they needed to take responsibility for their lives and that only they could change their life. This was significant in re-establishing their power to act on their own behalf.

"For the first time in my life I'm being responsible."

"…in some ways it was a good thing that I came to see the locus of control, or responsibility, and I came to locate that in myself instead of in this service…It couldn't reinvent myself, it couldn't change everything, there was no magic wand, no silver bullet…"

"…Like the great thing about me is I feel it [distress] coming on now, so when I feel it coming on…like 'What am I going to do to distract myself and get all this away from me?' I used to let it all build up but I don't let it build up anymore."

"From looking for a fix externally it's about me looking after my health and my self – I lost faith in psychiatry, it's only me that can do something."

Viewing responsibility as a daily challenge in which the young men could actively engage and by which they could be rewarded, rather than a burden beyond their capabilities, also enhanced their relational responsibility. McNamee and Gergen (1999) describe "relational responsibility" as a commitment to going on together in the world in harmony which entails making and taking moments for relational enhancement. Taking ownership of self and life meant that the young men were no longer waiting for the world to adapt to their needs or for others to change them, helping them to gain the confidence they needed to resume living on their terms.

"Yes, you have to set a plan as well, like what you want to do with yourself, only you can decide that. No one can tell you, like when you get better 'Do this, do that' blah, blah, no one can tell you that like."

Sustaining a New Identity

Sustaining a new identity refers to how the young men, having taken a place in the world as renewed integrated people, sustained this through their daily lives. Having been a disappointment to self and others through repeated failures, mistakes and misrepresentations of self, sustaining their new selves in life was necessary. Appointing a new worthy identity was a gradual process wherein the young men reconfigured their selves and lives in ways that were viable and acceptable, making these new identities more authentic and increasing their ability to sustain worthiness. With their ability for calm reflection and ownership of their lives the young men became more objective and independent in deciding what would enhance and obscure enactment of their new identities and endeavours in living. Having claimed a place in the world and established what this world meant to them they built upon their newly appointed selves. They felt liberated from the constraints associated with their unworthiness and were therefore free to experiment with life and living in more creative ways, which enhanced their integration and enactment of selves. They were allowed to reclaim important aspects of their selves that had been denied and overshadowed, and this was facilitated by therapeutic encounters.

"I suddenly realized that I could manage. So this year I didn't go to counselling because I didn't need to. I realized that I could survive and I had the strength myself to manage, which again I probably should have always known the whole time, but I didn't have the confidence in myself to do so."

In rebuilding their selves, the process of social comparison once again came into play for the young men. However, in this context it served as affirming rather that disconfirming. For example, the young men compared themselves with less fortunate others (Janoff-Bulman, 1985), as they recognized their stamina and resources for survival. They were acutely aware of the efforts that they had made to re-establish themselves in their lives and worlds and were determined that this would not be wasted energy. They also appreciated that others in their situation might not have the resources to move forward in the same way; hence they were grateful for opportunities that confirmed their efforts and achievements in this regard.

"It is great to be able to go through all that, it is hard work like, very hard work, like a full time job."

"I am after putting effort myself just to do it like. For some people they might be weaker. I don't know how I done it myself, but there are a lot of people that mightn't be able to and stuff like that."

Shedding their unworthy identities and recreating identities deserving of life and of which the young men could be proud, challenged them to find ways of nurturing and living with these new selves. They developed new interests and activities that reflected their sense of caring about their selves and lives and replaced old self-destructive patterns with more life-enhancing routines and activities.

"...In terms of why I am not still depressed, counselling and stopped drinking, that is mainly it. Well I suppose I probably learned to be more comfortable with myself as well, which is partially down to counselling and partially a result of not drinking so much..."

Part of the process of performing their new selves meant finding new and enabling self descriptions, having been labelled and having labelled their selves in derogatory ways such as mad, bad and / or inadequate. This is an important issue for the mental health professional who may use professional jargon and engage in practices that further obscures the uniqueness and resources of the individual.

"When you are a service user of psychiatric services, it tends to be that you are given the terms, I think it is defined for you. There is very little sense of you being able to name or construct what is going on for you with the people you are speaking with who are professionals. Certainly that was my experience…"

Regaining a new perspective and re-configuring and enacting a new identity became possible for these young men having confronted their destiny crises in unique and enlightening ways and reconciled their inner and outer conflicts. Acknowledging that they had the resources to achieve this represented a fundamental change in their being. Learning to live with a new self can be quite a challenge and requires readjustment in the person and those around him (Inger & Inger, 1994). These young men managed to reorganize their lives and negotiated this with others so that they could sustain their new being.

"...I kind of know I could deal with most things because I know I have come out through the other side of pretty serious stuff..."

9.5 Summary

This chapter described the second stage of the interconnected two dimensional process, *re-vitalizing worthiness.* It described how the young men made significant changes to their beliefs about their selves and their lives. They transformed some well established patterns that served to protect them while enveloped in a troubling dialectic of destiny, thereby creating a new sense of identity and being. Having succeeded in facing their worst fears about their selves, their lives and their fates they emerged as stronger and more integrated people who proudly established their place in the world.

The entire re-vitalizing worthiness process captures the central psycho-social process with which the young men in this study engaged in an attempt to answer their profound existential question about the nature and meaning of their relationship with living and dying. It explains how these young men transcended suicidality and repaired their sense of fragmentation in the world by shedding their unworthy identities and claiming worthiness as persons of worth and deserving of life, thereby resolving their crises of destiny.

The substantive theory, *re-vitalizing worthiness in transcending suicidality,* that emerged in this study relates specifically to transcending suicidality among young men. It assumes that: it is possible to transcend suicidality and move forward with living, this is foundational on the process of re-vitalizing worthiness, this entails identity re-configuration, and this process is punctuated and enhanced by turning points. In situating the substantive theory in a wider knowledge base, the following chapter explores resonances with the pre-viewed literature and additional literature from within and beyond the fields of suicidology and mental health, thereby elaborating some of the concepts and assumptions embedded in the theory.

Chapter 10. Literature Re-view: Resonances with Theoretical Frameworks

10.1 Introduction

This chapter explores resonances and dissonances between the substantive theory, *re-vitalizing worthiness in transcending suicidality,* that emerged in this study and the suicidology, and wider, literature. The theory relates specifically to how the young men in this study overcame their suicidality and moved on with living viable lives. It highlights the centrality of worthiness to this transcending process. The theory proposes that this process entails identity re-configuration which is facilitated by turning points in the form of inner and outer dialogue.

In situating the substantive theory in a wider knowledge base, the author will explore links between some of the categories embedded in the core variable and the suicidology literature, and identify additional literature that further enhances and explains the theory and the assumptions embedded within this. These theoretical frameworks are representative rather than all-encompassing and span a range of disciplines. It is the authors' hope that by engaging with this broad literature, the substantive theory will be critiqued in a useful way, highlighting critical areas for reflection and pointing toward anomalies and challenges in the fields of suicidology and mental health. From this perspective, the theoretical frames chosen serve as metaphors for elaborating and reflecting the substantive theory rather than validating it. The researcher will also attempt to juxtapose some key issues by asking where the 'evidence' lies that supports the assumptions underlying a particular hypothesis. For example, if identity re-invention is a central process in transcending suicidality, is there sufficient data within and beyond this study to suggest that identity loss can be a feature of suicidality.

Additional theoretical frameworks incorporated into this discussion include: theories on worthiness and its relationship with overcoming suicidality (Lazarus, 1983; Janoff-Bulman, 1985; Reisman, 2001), and recovery theories, which examine how one can overcome adversity including mental ill-health and illness related phenomena such as

suicide-dality (Deegan, 1988; Webb, 2002, 2003). The author also draws upon identity theories, specifically social constructionist theory which incorporates the view that one can re-construct a new identity (McNamee & Gergen, 1992), and theories that emphasize the importance of identity coherence and stability (Strauss, 1969; Harré, 1998). Turning point theory is incorporated by way of examining how life pathways can be profoundly shaped by certain events and experiences, particularly in relation to death awareness (Strauss, 1969; Pinder, 1994; Denzin, 2001). Finally, the author will summarize some of the key intrapersonal and interpersonal dialogic processes that facilitate *re-vitalizing worthiness* as suggested in this study and body of literature (Linehan, 1993; Inger & Inger, 1994; Seikkula et al., 1995). Throughout this discussion the researcher will draw upon participant perspectives and formal (technical) and informal (non-technical) accounts of those who speak to the issues raised.

10.2 Re-vitalizing Worthiness and the Suicidology Literature

The suicidology literature does not specifically refer to the concept of worthiness, nor suggest that it is central to the process of transcending suicidality, hence the theory presented in this thesis provides a theoretical framework for understanding this process in a new way. However, a number of the categories identified in the data resonate with the extant literature in the field. These resonances will be briefly revisited before turning to the broader literature to discuss links between this and the substantive theory.

Resonating Patterns In and Beyond Suicidality

The young men described a number of patterns in their lives in and beyond suicidality that resonate with the suicidology literature. For example, they confirmed the significance of noted risk factors and processes such as loneliness, mental pain, self and other destruction and ambivalence, which ironically can be a protective factor as well as a risk factor. They also described the negative impact of stigma on their help-seeking attitudes and behaviours leading to profound social and psychological isolation, and excessive alcohol and drug consumption. In terms of protective factors and processes, they viewed social and professional networks and validating life events as central to their survival.

When in suicidality the young men described their ambivalence about living and dying, giving rise to their dialectic of destiny. Ambivalence is recognised as a central component in suicidality which ironically facilitates the person to stay alive while also keeping open the possibility of death (Caruso, 2009). This pattern was evident in how the young men lived on the edge of both life and death. Ambivalence can also be linked to the young men's erratic moods and behaviours as they acted out their conflict, giving rise to what appeared to be impulsive acts of self-destruction. Patterns of other-directed aggression also emerged, which fits with the idea that *"…homicide and suicide are two channels of a stream of destructiveness"* (Aldridge, 1998, p.27). Impulsivity has been associated with suicide-ality and there is frequently a short time-frame between trigger events and a suicidal act (O'Connor & Sheehy, 2001). However, this study demonstrated that while suicidal acts were sometimes unplanned for that particular moment, the process of contemplating suicide was lengthy for the young men. Impulsivity can also be associated with the young men's strong sense of loss of self-control and control over their lives. Hence, they frequently acted out of desperation and panic, rather than organized planning, in many aspects of their lives. Many of the young men's suicidal acts were associated with excessive alcohol and drug consumption which is a common feature in suicide-ality (Hawton, 2005), however, substance misuse was also seen as a soothing strategy rather than a cause of suicidality. These patterns suggest that survival and self-destruction strategies are subtle and complex and that demarcations between these patterns are sometimes difficult to make in the absence of in-depth analysis.

The young men demonstrated extreme mental pain, referred to as *psychache* by Shneidman (2001) and supported the view that there is a link between psychache and a sense of hopelessness and entrapment (Williams et al., 2005). This made their distress unbearable and evoked a strong desire to escape both from the world and from the destructive coping patterns they developed (Orbach, 2001), leading to their self-concealment. The urge to disappear was transformed to an urge to become visible and reconnect when the young men began to transcend suicidality. They described a sense of belonging in the world, demonstrating their "re-connection with humanity" as emphasized by Cutcliffe and Stevenson (2007). This transition was frequently facilitated by validating gestures by someone in their living context, supporting the view that how one engages with the suicidal person can influence his

decision to live (Samuelsson et al., 2000; Shneidman, 2001). Hence, this study demonstrates that it is possible to transcend suicidality and suggests that some intrapersonal and interpersonal processes combined to promote the resilience and resistance necessary for this to happen for these young men. It suggests that the suicide trajectory can be punctuated at different significant junctures through internal reflection and external encounters and events that revalidated the young men. This resonates with the literature that views resilience as a relational phenomenon and emphasizes the empowering aspects of resistance (Wexler et al., 2009). However, the study also highlighted the unpredictability and complexity of the suicide trajectory and recovery path, bringing into sharp focus the importance of making and taking opportunities for validation and life-enhancing interactions with suicidal young men. The study also highlighted that their distress is frequently concealed from others in ways that may mask it and their needs. Hence, awareness of the possibility of extreme distress which may be accessed and alleviated by being patient and demonstrating genuine concern in engaging with them is advocated.

Resonances with Literature on Social and Professional Responses

The young men in this study provided multiple accounts of the kind of social and professional responses that they received in relation to their suicidal distress and the impact that these encounters had on them. The young men encountered varied health service responses, some of which resonate with issues raised in the literature pre-view. This study highlighted the dominance of some discourses reflective of a risk society (Roberts, 2005; MacGabhann, 2008). Such discourses support a monologue and practices of control, such as confinement, overshadowing dialogue and connection. They also give rise to paradoxical injunctions within the professional role, such as, integrating competing beliefs about the person's care value (Bergmans et al., 2007), and promoting positive non-stigmatizing attitudes and behaviours in a context of negativity (Joyce et al., 2007). The literature pre-view highlighted how practices arising from restrictive discourses, myths and misconceptions may lead the client to experience further distress and confusion. Ironically, many of the practice issues and dilemmas discussed appear to perpetuate and mirror the suicidal person's fears and anxieties, rather than allaying these. It seems that the professional, in her attempt to create safety in a context of risk*,* exacerbates the very experience of disjointedness that the young men have sought to resolve. The young men in this

study identified positive practices that enhanced worthiness; these included a collaborative, respectful and individualized approach, belief in the value of the young men, and genuine caring and concern on the part of the practitioner. Such practices and persons influenced significantly their views of their selves and their lives and consequently their movement on the suicide trajectory and life path.

As negative practices continue in the field of mental health in Ireland today, many of the recommendations made by others in terms of changes in attitudes to and practices with the suicidal person, at social and professional levels, are supported in this study. For example, the researcher recommends reviewing attitudes and practices that make access to and connection with services more difficult, such as moving from a position of cure to one of care, and developing risk tolerance while also being alert to the suicidal person's distress and the danger that this can pose for and to the person (Sun et al., 2006; Cutcliffe & Stevenson, 2007). It also supports the need to review moral debates that have been monopolized and polarized by the dominance of psychiatric, psychological and sociological models of suicide-ality (Battin, 1994). For example, use of the term "duty of care", which assumes a healthy moral conscience, tends to close dialogue on the issue of patient autonomy, thereby covertly defending and masking unhelpful practices (Hazelton, 1999).

The literature pre-view highlighted the negative impact of stigma associated with mental health concerns in general and suicide-ality in particular (Burke et al., 2008), which also arose in this study in relation to the young men's help-seeking patterns and their concerns about sharing personal data. Concealment of self and suicidality was how the young men responded to their dialectic of destiny, fearing exposure and the consequences of this, such as being labelled insane, being socially shunned, and being judged as unmanly. This issue arose at a number of levels in the study process also, influencing participant recruitment and concerns about confidentiality of data as discussed in chapter six.

In summary, no literature in the suicidology field speaks directly or comprehensively to the transcending process, hence, this study adds to the field by providing theoretical understanding of this process and offering a concept-based practice model upon which practitioners can draw to enhance therapeutic engagement with young men in

their journey. However, a number of the patterns identified in this study resonate with those highlighted in the suicidology literature in terms of the young men's living and suicidal patterns, and the social and treatment responses they received. In particular the study highlighted the immense distress felt, making suicide an attractive alternative to life, and the significant impact that their personal and contextual resources had on their movement beyond suicidality. The study also highlighted that responding to the issue of suicide-ality at a professional level is complex and fraught with challenges. While the young men found that validating interactions increased their sense of worthiness, invalidating encounters increased their sense of unworthiness. Particular challenges arise in contexts dominated by restrictive discourses founded on principles of control and patriarchal protection. This is consistent with the literature that points to the limits of such risk-focused responses and suggests a lack of professional preparation for practitioners working in the area (Maltsberger & Goldblatt, 1996; Ting et al., 2006). Consequently, the mental health practitioner is unable to manage the unpredictability and reality of suicide-ality and finds herself supporting limiting socio-political and professional perspectives. Thus, she engages in restrictive practices, while the paradoxes and values that underpin these remain uncritiqued. Meanwhile, suicidal young men find themselves immersed in a system of fear and uncertainty that mirrors their suicidal process and their yearned for sense of autonomy and safety quickly become compromised. These response patterns raise a number of issues for the domains of professional practice, training and education as well as social and political policy, as elaborated in the next and final chapter.

10.3 Transcending Suicidality: Recovery and Discovery

"People are not trying to recover the self that existed before the experience of mental distress; they are looking to learn from the experience and, strengthened by it, to move on to a life that meets their needs now and in the future. This is how we need to understand the concept of 'recovery', it's not about 'going back' or regaining what has been lost. It's about developing the 'self'."

(Hitchon et al., 2006, p.16)

The substantive theory in this study suggests that it is possible to transcend suicidality and its underlying issues by regaining worthiness. It reflects a view of recovery as recovery in, with or of, rather than recovery from suicidality. This suggests that the young men emerged from their suicidal crises having discovered new ways to live with the tensions between living and dying, rather than leaving these behind in the sense of a cure. Hence, incorporation and integration of dichotomies were central to the recovery process. There is a vast and growing body of literature in the area of recovery. Therefore, some key ideas have been extracted by way of illustrating resonances between the recovery literatures in general, and in mental health and suicidality in particular, and the re-vitalizing worthiness process. This discussion will identify some potential areas for elaboration and synthesis of theory and practice.

Overcoming Life Adversities

"The concept of incorporation complements the 'journey' narrative used by many of the participants, with a focus on augmentation rather than recovery. As such, a major milestone for many women is when the abusive experience no longer consumes them, but rather is integrated into their sense of self."

(Evans & Lindsay, 2008, p.359)

While it was not possible to include the significant body of literature that has been amassed in the area of overcoming adversity, some studies have been incorporated into this discussion to establish possible connections between overcoming life adversities in general and overcoming suicidality. While there were variations across these studies in terms of age, gender, location and focus, some consistent patterns can be identified in this literature that resonates with some of the processes in transcending suicidality. This suggests that, while recovery from different forms of life adversity, such as CSA, rape, domestic violence, bereavement and suicidality, entail different core processes, some similar processes also occur.

Much of the literature on overcoming life adversities attests to the centrality of reclaiming and rebuilding a sense of self in recovery (Wuest & Merritt-Gray, 2001; Belknap, 2002; Oke, 2008). Self-reconstruction is deemed central in changing one's life circumstances beyond the traumatic life event(s) that led to a negative sense of self (Belknap, 2002), and integration of such adverse event(s) and their effects into

the person's new identity is a necessary part in the recovery process (Clarke, 2001; Smith & Kelly, 2001; Evans & Lindsay, 2008; Anderson & Hiersteiner, 2008). These studies support the view that overcoming adversity is a complex process wherein the person renews his sense of self in a context of caring, facilitated by personal reflection and meaningful encounters with others that inspire hope and personal agency, and is marked by pivotal moments of insight along the recovery path (Cutcliffe, 2000; Smith & Kelly, 2001; Evans & Lindsay, 2008; Anderson and Hiersteiner, 2008; Oke, 2008). This is akin to the process of identity re-construction and synthesis in transcending suicidality through which the young men in this study went, which was facilitated by inner and outer dialogue in the form of turning points.

Some of the sub-processes described in this literature also resonate with processes in *re-vitalizing worthiness*. For example, Cutcliffe (2000; 2004) identified the key processes in overcoming bereavement as: becoming aware of and facing self pain and hurt, finding constructive ways to resolve this, taking charge of life, and gaining a future orientation. The young men in this study also highlighted the centrality of gaining control in their lives, enhancing self-awareness, and having opportunities for reflection and personal growth in the transcending process. Smith and Kelly (2001) identified three interlinked cyclical sub-processes in recovery from a rape: reaching out, reframing the event, and redefining oneself. Again there are resonances with this study, for example, reaching out to others resembles the young men's reconnection with others which reduced their isolation and loneliness, reframing the event resembles their gaining a new perspective on life, death and their suicidality, and redefining oneself resembles how they reconfigured themselves as worthy persons, thereby letting go of their negative sense of self. Oke (2008, p.153) identified personal power and agency as central to remaking of self and developing strengthened narrative identities, which the young men also alluded to as important in re-establishing their renewed sense of self.

In terms of facilitating recovery these studies identified the important place of internal reflection and external communication and support from family, friends, peers and professionals in the recovery process (Smith & Kelly, 2001; Anderson & Hiersteiner, 2008). For example, Smith and Kelly (2001) found that to regain trust the participants needed to feel understood, which created connection with others allowing them to

release themselves to talk and express emotion more freely, thereby rebuilding human relationships. In the transcending process the young men also established self and other trust and connection and, while they seemed unable to make complete and final sense of their suicidality, they were able to learn from their experiences, re-evaluate their lives, and give birth to new identities. Finally, Anderson and Hiersteiner (2008) highlight the importance of "pivotal moments" in the complex process of overcoming CSA. They describe how pivotal moments and peer support confirmed participants' self-worth and empowered them to take voice. This is similar to the place that turning points played in enhancing and consolidating worthiness in transcending suicidality. However, the young men in this study also highlighted that their journey was unpredictable. Therefore, these pivotal moments cannot always be pre-planned, and in order for such episodes to have a positive impact, they must be driven by genuine concern and belief in the person.

In summary, some common patterns can be identified between patterns in overcoming life adversities of various kinds and transcending suicidality, such as, re-authoring life stories and identities to integrate inner and outer conflicts, finding authentic support to combat isolation, and positively utilizing important interpersonal moments to consolidate a new sense of self. However, while there are resonances within these processes none of these studies identified personal worthiness and worthiness of life as central to the recovery process. Nevertheless, given the resonances described above between the processes involved in overcoming a range of life adversities and the processes in which the young men in this study engaged in transcending suicidality, a synthesis of the recovery literature would perhaps be a logical next step in more formally identifying similarities and differences in these recovery processes. It is important to remember, however, that individual responses differ in most situations depending on a range of circumstances, such as his perception of his situation, his life context and his intrapersonal and interpersonal resources. Therefore, formal theory, while identifying more generalizable life patterns, should not mirror some of the unhelpful practices in health care by overshadowing individuality.

Recovery and Mental Health

"Recovery is not a destination, but the journeying task of making sense of life itself,

and I ask the reader to accept the universality of that task. We are all in recovery.”

(Helm, 2009, p.58)

The recovery vision in the field of mental health was born out of the creative linking of “permanent, recovery and life’s ordinary associations” (Hitchon et al., 2006), which gave birth to the realization that recovery in mental health is possible, can be long-standing, and that one can resume an ordinary life in the aftermath of mental dis-order. The recovery movement, while relatively new in the field of mental health (Buchanan-Barker, 2009), has been embraced by service users (Deegan, 1988; Helm, 2009), professionals (Watkins, 2007; Buchanan-Barker, 2009) and legislators (DoHC, 2001; DoH, 2005); Scottish Executive, 2006), emphasizing values such as partnership, respect, empathy, and compassion and invoking practices based on promoting strengths and inspiring hope. The concept of recovery has been developed in the context of evolving ideas about mental illness, and understanding of recovery has been substantially enhanced by the personal accounts of those overcoming mental health problems published in recent decades (Deegan, 1988; Champ, 1999, Fisher, 1999; Webb, 2002, 2003; Hitchon et al., 2006; Watkins, 2007; Helm, 2009; Whitehill, 2009).

The focus on recovery in mental health has been described as the beginning of a paradigm or philosophical shift in the field over the past decade (Watkins, 2007; Buchanan-Barker, 2009), as it reflects a movement from viewing mental distress as an illness to seeing it as “problems in living”. The former was deemed to require expert treatment with a mental health professional positioned as the fixer and the patient as the recipient of intervention, while the latter is deemed to require a holistic response with the mental health practitioner positioned as a conjoint facilitator of the recovery process. This evolving view of recovery dispels myths about mental distress as enduring pathology and a character deficit, and challenges notions of cure and rehabilitation (Watkins, 2007; Buchanan-Barker, 2009). However, while it is generally accepted that there has been a shift in the thinking about and the language used in recovery, the politics in mental health have remained polarized. On the one hand, voices of recovery advocate practices based on values of dignity, respect and autonomy; whilst simultaneously voices of coercion and alienation remain strong, as Watkins (2007, p.2) puts it, *“…although you can take care out of the institution it is*

more difficult to take the institution out of care." The concept of recovery has been critiqued for its implicit biomedical inference that the person was ill and "got over" the illness experience (Helm, 2009). Thus, Buchanan-Barker (2009) argues that it is perhaps more fitting to speak of recovering one's life than to speak of recovering from illness; this idea resonates with the literature on overcoming other life adversities.

The way a person experiences mental distress and the subjective meaning it holds for that person is critical in terms the impact this has over time and of how he responds, therefore, it is difficult to categorize such experiences objectively (Smith, 2009). This means that each individual must be seen and treated as a unique person in their own right; nevertheless, a growing volume of literature that focuses on the perspective of service users indicates that there are some commonalities in how people define recovery and what people find helpful and unhelpful in overcoming mental health difficulties (Fisher, 1999). These personal accounts emphasize that recovery is a process not a destination or an event, that persons undertake and achieve themselves. It occurs over time with setbacks, and is predicated on the incorporation rather than the elimination of symptoms (Chamberlin, 1999). It involves the discovery of hope, meaning, and purpose, and it can be assisted by supportive others, both lay and professional (Deegan, 1988).

The literature also highlights cathartic and restrictive recovery practices and processes. Cathartic processes incorporate those at personal, interpersonal, social and professional levels. Personal processes deemed important include: self-affirmation, decision-making, positive thinking, pacing and balancing life activities (Whitehill, 2009), self-responsibility, realization of one's own worth, acceptance of life and self (Helm, 2009), personal resilience, spirituality, religiosity, stability of location, routine in daily living, self-care, a sense of belonging in the community (Whitehill, 2009), gaining a sense of personal power, tapping potential, enhancing quality of life, and sustaining general well-being (Watkins, 2007), being open to beauty and joy (McGuigan, 2009), and selectivity of environment and persons therein (Watkins, 2007; Helm, 2009). Interpersonal and social processes such as friendship, acceptance, peer support (Helm, 2009), and reconnection with the broader world and humanity (Watkins, 2007), are also identified as important. Professional responses deemed significant include: practical support and an integrated approach to care (Hitchon et

al., 2006), engaging in mutually respectful and supportive relationships, being treated as a person not a label, caring with not for the person, believing the reality of the person, providing skills training, co-ordinating care among professionals, promoting social inclusion (Whitehill, 2009), and the appropriate use of psychopharmacology (Fisher, 2009). Conversely, restrictive practices identified in the literature include: overemphasis on psychopharmacology and containment (Chamberlin, 1999), unrealistic expectations for self and paternalistic approaches (Fisher, 1999; Whitehill, 2009), environmental negativity (Watkins, 2007; Helm, 2009), and stigmatizing and objectifying practices (Webb, 2002; Hitchon et al., 2006).

From this brief overview it can be seen that a number of themes in the mental health recovery literature resonate with the processes the young men underwent in this study. For example, establishing self-determined and self-paced pathways in life, engaging collaboratively and therapeutically with mental health professionals, and engaging with support systems that were validating and life-enhancing. The recovery journey in mental health, akin to the recovery patterns in this study, has been described in terms of both an internally (Helm, 2009), and interpersonally and socially mediated process (Watkins, 2007; Buchanan-Barker, 2009). This study also challenges linear models of recovery and the notion of hierarchically imposed change. Again, as with the recovery literature in general, the mental health recovery literature does not identify the centrality of worthiness in this process.

Recovery and Suicidality

"There is no one response that could be isolated that would be life-saving for all would-be suicides. However, as one begins to understand suicide, it becomes apparent that one can reasonably infer some implications for assessment, intervention and therapy."

(Leenaars, 2004, p.212)

It is suggested that there is a paucity of literature that relates specifically to overcoming suicidality, and that there is little knowledge on what facilitates the recovery process (Rogers, 2001; Talseth et al., 2003; Bostik & Everall, 2007), consequently there is little empirical base to guide professional practice in this specific area (Maltsberger & Goldblatt, 1996; Weiss, 2001; Cutcliffe et al., 2006;

Ting et al., 2006; Cutcliffe & Stevenson, 2007). However, some interesting studies were identified that highlight key factors and processes deemed to be helpful and unhelpful in overcoming suicidality, and some authors have proposed models of care, which are summarized below.

Helpful Factors & Processes

A number of studies have examined the factors and processes deemed helpful in overcoming suicidality. Some of these resemble recovery processes in the literature on overcoming life adversities and mental health problems, and resonate with the transcending process described in this study. These are described from the perspectives of personal, interpersonal and contextual factors and processes although there is inevitable overlap across these domains.

Personal factors and processes incorporate: self-will, religiosity (Knott & Range, 1998), a capacity for personal reflection and ability to open up and relate with the self, others and the world, and a sense of hope and empowerment (Talseth et al., 2003). Personal resilience, while not explored directly in this study, emerged as a possible important factor as the young men alluded to the place of personal strengths, such as determination, in overcoming their distress. Reflective space was also viewed by the young men as central to their maturing process, wherein they enhanced their resources in order to claim their place in the world. However, while religiosity did not emerge as a specific helpful factor, some of the young men alluded to the spiritual dimension of their transformative processes. Factors such as age, gender, and level of distress are also deemed important in terms of recovery (Gunnell et al., 2004). These authors found that while rates of suicidal thinking were highest in young people aged 16-24 years, rates of recovery were also highest among this age group. Recovery was strongly associated with low baseline level of suicidality. They hypothesized that the younger age group may be more likely to recover due to their transience and changing lifestyle, which might lower the possibility of them completing and / or enacting a suicide plan. This suggests that resilience is higher in the younger age group, and /or that this group may be less entrenched in their negative patterns of thinking and behaviour. They concluded that there is a need to better understand the pathway linking suicidal thoughts and completed suicide and recovery. The young men in this

study were in the 16-34 age group and demonstrated a strength of character and determination that undoubtedly influenced their destinies.

Interpersonal factors and processes incorporate a range of processes that enhance positive social and therapeutic relationships, such as: a confirming relationship that involves being open, listening, accepting, having time for the person and communicating hope (Talseth et al., 1999, 2003; Cutcliffe et al., 2006), non-intrusive relationships that respect one's privacy and capacity for self healing (Tousignant & Hanigan, 1993), and demonstrated care, acceptance and availability (Bostik & Everall, 2007). These findings are consistent with the views of the young men who valued self directed engagement, balancing self-other help that enhanced self control and responsibility, and engagement in validating interpersonal encounters which enhanced their worthiness. However, the young men also highlighted the importance of pacing relational engagement. They valued individualized responses and recognition of their uniqueness as persons and their particular situation, supporting the view that the transcending process is a personal journey and can be facilitated in different ways for different people. When participants in Talseth et al.'s (2003) study experienced practitioners as calm, pleasant, welcoming, non-confrontational and available they felt received and heard and were able to ask for help. This view of the helpfulness of the genuinely empathic, available and non-judgmental practitioner was echoed by the young men in this study. McLoughlin (1999) found that communication with patients was viewed as the most important skill in nursing practice by both nurses and patients. This was deemed to help patients resolve their concerns and difficulties in order to move on in living. The importance of therapeutic engagement was raised by the young men, referring to a relationship based on trust and integrity, described as 'real' engagement in this study. Lakeman and FitzGerald (2008) found that connections with others were also instrumental in overcoming negative self-perceptions. The young men in this study also demonstrated the importance of altering negative self-conceptions. They changed their negative sense of self by allowing their views to be challenged and formulating new ways of understanding and seeing their selves, which culminated in the formation of new identities.

Contextual factors and processes deemed to be important incorporate: social support systems that balance self-other help (Eagles et al., 2003), and contextual resilience in the form of worth-enhancing attachments that build confidence and trust and allow one to avail of support structures and resources (Tousignant & Hanigan, 1993; Rutter, 2007b). Knott and Range (1998) found that respondents were split on whether external or internal resources were most helpful, suggesting that this might be different for each individual. Bostik and Everall (2007) found that the formation of at least one significant and supportive formal or informal relationship was central to the healing process. They concluded that demonstrated care, acceptance and availability facilitated a shift in self-perceptions as important, competent and congruent, generated hope, meaning and belonging, and enhanced reconstruction of the person's true self. Consistent with these findings, the young men identified the relevance of attachment to meaningful others, as well as to self and life in overcoming their suicidality, and the impact of turning points in their lives. These studies support the body of literature that suggests a positive association between social supports and social integration and recovery (Watkins, 2007). The importance of balancing self and other help and exposure to worth-enhancing encounters was also raised in this study. The young men highlighted the need for support that recognized, rather than undermined, their own competencies and that was reciprocal in nature.

Unhelpful Factors

Some of these studies also identified unhelpful personal, interpersonal and contextual factors and processes in overcoming suicidality, such as: rejecting comments by others (Knott & Range, 1998), stigma, work pressures and negative media reports (Engles et al., 2003), and lack of confirming (Talseth et al., 1999, 2003). When participants in Talseth et al.'s (2003) study experienced nurses' responses as superficial, they felt objectified and degraded. Cutcliffe et al. (2006) note the danger of instrumentality over presence in the therapeutic relationship between nurse and patient and highlight how the nurse can use defence mechanisms to avoid uncomfortable topics and situations, thereby distancing herself from the patient. These authors highlight the importance of confirming and real engagement as identified by the young men in this study.

Engles et al. (2003) concluded that intensive interventions did not appear to reduce suicidal behaviour among those with serious mental illness and that they might benefit more from low-key supportive measures, explaining a lack of distinction made by participants between social and professional support systems. This conclusion supports the idea, as emphasized by the young men, that care needs to be individualized and that people respond differently. Gunnell et al. (2004) found that unemployment and low income were trends that markedly reduced the likelihood of recovery, particularly among men, and recovery was less likely among those in receipt of treatment with a health care professional. They hypothesized that those in treatment may be less likely to recover due to their higher disease severity. This issue is currently under debate, and some suggest that the care experience itself can further traumatize the person (Barker et al., 1999). This debate was reflected in the accounts of the young men whereby they encountered both negative and positive professional responses.

Models of Care

In addition to the growing volume of psychotherapeutic literature discussed in the literature pre-view that provides models for response to the suicidal person, some studies have specifically examined the processes by which the suicidal person can be facilitated to overcome his suicidal desire, and have proposed theories of care (Sun et al., 2006; Cutcliffe et al., 2006). These theories echo much of the above literature in terms of helpful therapeutic engagement. Sun et al. (2006) developed a theory of nursing care that emphasizes safe and compassionate care through the therapeutic relationship. This incorporates providing holistic assessment, protection, basic care and advanced therapeutic care. They proposed that psychiatric nurses play a vital role in helping to reduce suicide rates through prevention, education and healing care. Similarly, Cutcliffe et al. (2006) examined the psychosocial processes in which the mental health nurse engaged in order to move the suicidal person from a death orientated position to a life orientated position, which they conceptualized as "re-connecting the person with humanity" (Cutcliffe et al. 2006; Cutcliffe & Stevenson, 2007). This process comprises three distinct yet interlinked stages: reflecting an image of humanity, guiding the person back to humanity, and learning to live. The re-connecting process involves establishing trust in the nurse-patient relationship and wider community, encouraging the person to express their private concerns and

beliefs, nurturing new learning; identifying and harnessing support systems, and enabling a deeper understanding of their suicidality.

In this study the pattern of re-engaging with humanity was also identified as central to the young men re-establishing their selves in the world. It was also highlighted that this, to a large extent, was a relational phenomenon foundational on a key process described as “real” engagement. This promoted self-engagement and acceptance and incorporated a number of components, including demonstrated caring and authentic connection. Demonstrated caring by others referred to commitment to the relationship and treatment programme, which reflected a desire for genuine engagement and influenced the young men’s desire to re-engage with humanity. Authentic connection, describes a personalized approach that was non-judgmental of them and their behaviour, making them feel believed and taken seriously and respecting their unique individuality. This entailed acknowledging their suicidality and suicidal event explicitly or implicitly. Implicit acknowledgement involved supportive patterns of behaviour, which enhanced connectedness.

Summary

In summary, while the suicidality recovery literature does not offer a theory on the transcending process, a number of important points are highlighted in the literature and fit with the findings in this study. Firstly, the significance of age and context in terms of the issues and events that can influence the suicide trajectory is highlighted. Secondly, while interpersonal reconnecting processes are crucial for the person to re-engage with life and living, many people in suicidal crisis do not make clear distinctions between the supportive and validating interventions received from those within and outside of the mental health profession, supporting the view that both are important and that all such encounters need to be recognized as potentially validating. Finally, socio-cultural discourses that impact identity need to be addressed in working with the suicidal person as these may overshadow, or indeed undermine, therapeutic intervention. Hence, this literature confirms the complexity and multidimensionality of suicidality and recovery as demonstrated in the complex re-vitalizing worthiness process. It also suggests that there is little doubt, regardless of whether the recovery process is viewed as primarily internally or externally mediated, interpersonal encounters on the road matter (Smith, 2009). Encounters that can serve as positive

turning points for the person in distress involve respectful, humane and collaborative exchanges that facilitate reflection and change, while negatively judgmental exchanges can hinder this process by promoting defensiveness and unworthiness. The issue of engagement also has implications for response to the suicidal young men at more macro levels, for example, within family and social systems, which also profoundly impact their lives.

Challenges to Facilitating Re-Vitalizing Worthiness and Recovery

"I think the best professionals involved in my care have walked along-side me, opening themselves to the mystery that is schizophrenia. They have gained my trust, sharing and supporting my inner search for meaning and understanding of the self in relation to illness."

(Champ, 1999, p.123)

A number of the personal, interpersonal and social processes and practices incorporated into *re-vitalizing worthiness* resonate with themes in the recovery literature and highlight some key challenges that warrant attention. These challenges centre primarily on the tension between institutional and contractual psychiatry (Szasz, 1970). These paradigms are defined in terms of the level of client control in participating in the treatment relationship, with the former reflecting loss of control and the latter reflecting maintenance of control (Szasz, 1970). While some of these issues have been identified in the literature pre-view, they will be briefly revisited here to provide a context for the proposals elaborated in the next chapter.

Social Inclusion and Equality vs. Marginalization

"Where comparisons with other conditions have been made, the mental illnesses are far more stigmatized than other conditions…rejection and avoidance of people with mental illness appear to be universal phenomena."

(Thornicroft, 2006, p.26)

Social inclusion can be viewed both at macro or social level, and a micro or local level, with interplay between both that reflects socio-cultural values and norms (Huxley & Thornicroft, 2003). Hence, the desire to belong to and the benefits from being part of a particular group, such as a mental illness or recovery group, mirror the

values defined at macro level. It has been argued that those who acquire the status of mental illness are among the most excluded in society (Huxley & Thornicroft, 2003), therefore, membership of this group is frequently experienced as a low status achievement (Thornicroft, 2003; Hitchon et al., 2006). These dilemmas were echoed by the young men in this study whereby the social status associated with membership of a group identified by mental illness and / or suicidality brought with it certain challenges above and beyond the challenges associated with ill-health or suicidality itself.

According to Glaser and Strauss's (1971, p.2) "status passage theory", one may occupy a number of different positions in the course of one's life that may *"...entail movement into a different part of a social structure; or loss or gain of privilege, influence or power, and a changed identity and sense of self, as well as changed behavior."* From this perspective, it could be postulated that the young men struggled with the tensions between marginalization and social inclusion, occupying the former status while in suicidality and the latter beyond suicidality, impacting the young men's sense of social value In suicidality they demonstrated low worth, reflected in their private shame, humiliation and concealment of self. However, they demonstrated high social worth beyond suicidality, reflected in their public appointment of themselves in the world and their renewed commitments to relationships and other aspects of their lives. In terms of agency, or the power relationship between the status occupant and the status itself (Glaser and Strauss, 1971), they demonstrated a pattern of powerlessness in suicidality, reflected in loss of control, unpredictability and aimlessness. Beyond suicidality this pattern was one of powerfulness, reflected in their taking charge of their lives, life goals and life direction in a purposeful manner. Finally, in terms of priority, which refers to the precedence the status holds in one's life (Glaser & Strauss, 1971), the young men moved from being consumed with their destiny crises and a death orientation while suicidal, to being able to get on with multiple aspects of living beyond suicidality when their destiny crises were renegotiated and their selves reintegrated.

Wexler et al. (2009) highlight how low status identity affiliation with minority groups can also serve as a prompt to overcome the psychological and social barriers associated with marginalization through meaningful role-based action. They suggest

that a sense of distinct group identity, ideological commitment to a shared purpose, and engagement in productive joint action to address this can combine to enhance resilience by promoting resistance to oppression and discrimination and their effects. This is an important point as it suggests that legitimizing and reinforcing the positive aspects of belonging to a marginalized group can promote resilience and reduce negative outcomes such as suicide-ality (Wexler et al., 2009). While only one of the young men in this study had publicly declared his suicidality and mental health status in terms of being actively involved in advocacy work, others challenged stigma and discrimination in more subtle ways. Thus, the transition beyond suicidality demonstrated how the young men changed their status in living; a process that may have been made possible through resisting their self-ascribed and other-ascribed marginalized status (Wexler et al., 2009).

This discussion provides a flavour of the subtle but compounding challenges inherent in transcending mental disorder and suicidality. These issues require consideration and confrontation if social inclusion and equality are to be taken seriously within the mental health community and society in general (Thornicroft, 2003; Hitchon et al., 2006), as one's sense of self is contextually defined and determined (Champ, 1999). According to Thornicroft (2006) tackling discrimination against people with mental illness is essential to impact negative and ill-informed attitudes and discriminatory practices in society and within the mental health community, including among professionals and clients who self-stigmatize. Addressing social exclusion and inequality includes: attention to the use of language that can both perpetuate and generate stigma, critical review of practices that reflect and promote stigma, and political lobbying for equal rights. However, such activity may require a profound shift in thinking about mental health and illness. Szasz (1970) suggests that the power imbalance in the treatment relationship needs to be redressed. This sentiment is in keeping with Walter (2005, p.76) who suggests that the practices of labelling, and hence segregation and marginalization, can be understood in terms of a risk society culture, *"…a society obsessed with predicting and eliminating risk, guaranteeing safety and even happiness, a society unable to accept suffering."* The author also suggests that the discourses underpinning practices of discrimination and marginalization require deconstruction if meaningful change is to occur in and around the field of mental health.

Social Support vs. Deviance

"Surprisingly, I have found that those with no experience of 'mental health' except their own worldliness have had a dramatic impact on me, often bringing gems of insight and groundedness."

(Nolan, 2007, p.12)

In general social support has been viewed as valuable in compensating for the negative effects of stress, promoting help-seeking and combating feelings of isolation, which are significant factors in suicide-ality (Bostik & Everall, 2007). Building social networks can be challenging and people who have lived their lives as vulnerable or social victims may struggle due to others viewing them as inadequate, responsible for their fate, or being undesirable to be around. This may be due to stigma by association (Janoff-Bulman, 1985), and fears of emotional contagion, whereby one takes on the expressed affect of another, hence avoidance of one whose mood is low (Epstude & Mussweiler, 2009). Helm (2009) emphasizes the challenge for people with a diagnosis of mental illness in working out their new identity as self and social stigma and discrimination still abound. While "blaming the victim" may be an all too common response to the person who has been victimized, social support is essential in helping him to gain a new perspective on his situation, building his personal esteem, social value and a positive perception of the world, and communicating his distress about his situation (Watkins, 2007).

Peer support can be particularly helpful in relieving feelings of deviance or perceived difference from others (Janoff-Bulman, 1985), and in a context of strained and damaged relationships (Tousignant & Hanigan, 1993). Both features were evident in the patterns the young men described, such as, being different and being isolated due to interactions that served to sever relationships through defensive mechanisms such as denial. The consumer movement provides a platform for recovery voices which has challenged the therapeutic pessimism of recent decades (Watkins, 2007). This movement has strengthened over the past twenty years and many have taken up a career as an advisor and advocate for others, providing not only a way of redressing the balance in one's own sense of injustice but also giving one a sense of purpose in their contribution to the lives of others (Champ, 1999). It is particularly important to

recognize reciprocity in living when engaging with young men as demonstrated in this study, which supports the view that they be engaged in collaborative rather than hierarchical relationships (Szasz, 1970). Therefore, optimizing opportunities for providing peer support and finding creative ways to pay-back for help need to be identified as part of the care response. Hence, group identity becomes a stabilizing and protective factor, rather than a disabling factor, which reduces self-blame by placing one's personal experience within a broader socio-cultural struggle and recognizing one's expertise.

Treatment Collaboration vs. Coercion

"All that you need to help most people is a warm, interested and caring human approach. If people can explore their experiences, help them own them and then to make decisions in their life about how they wish to move on and thrive…The process of recovery and thriving is natural."

(Smith, 2009, p. 269)

The issue of collaborative interpersonal relationships has emerged as a recurrent theme in the recovery literature and has also emerged as a highly significant process in this study, in terms of influencing recovery. The recovery process may occur with varying levels of professional help, and the place of the mental health practitioner in this process has been debated. Some suggest that overcoming life adversities is a natural process, and that once a person has hope and genuine support he can work out his own recovery road (Smith, 2009). Others advocate the centrality of the helping professional in facilitating this process (Linehan, 1993; Leenaars, 2004; Cutcliffe & Stevenson, 2007), while some suggest that getting the right balance between self and other help is important in individual recovery (Eagles et al., 2003).

An abundance of literature is available that provides guidance in engaging therapeutically to enhance healing. This literature highlights the importance of therapeutic dialogue and mutuality in the therapeutic relationship, facilitating compassionate, ethical and helpful therapeutic responses. Multiple ways of promoting an ethos of caring with and about, as well as caring for, the client have been proposed. For example, taking a "not-knowing" approach (Anderson & Goolishian, 1992), being "congruent" (Rogers, 1961), enhancing "curiosity"

(Cecchin, 1987; Aldridge, 1998), and adopting an "I / thou" disposition (Inger & Inger, 1994). It has also been suggested in the psychotherapeutic literature that the most powerful and potent tool the practitioner has at her disposal is herself, hence an emphasis on "the therapeutic use of self" (Rober, 1999). Concepts such as "empathy", "counter-transference" and "reflexivity" in therapeutic work refer to the practitioner therapeutically utilizing her responses to the thoughts, beliefs and feelings expressed or located in another, which may happen within or outside of her awareness and may be planned or accidental (Jones, 2005). Such processes are said to be useful in therapeutic work as the practitioner attunes to the other and uses her personal / professional responses to inform her movement in the therapeutic process, hence it is important that she be self-aware and reflect upon the engagement process (Rober, 1999). These suggestions are welcomed in their efforts to redress power imbalance and misuse in treatment. However, inherent in them is the idea that collaboration can be imposed by the practitioner, which inadvertently supports a discourse of inequality and one-way care (Inger & Inger, 1994; Anderson, 1997).

Accounts of those who have had contact with the mental health services, including the young men in this study, attest to the potency of the professional encounter in terms of catharsis and regression. However, as highlighted in the literature pre-view the importance of *"...simple acts of human kindness"* (Helm, 2009, p.59), cannot be underestimated for their potential to affirm and restore one's sense of dignity and self-worth and one's trust in humanity.

Such proposals for therapeutic engagement are similar to a movement taking place in the broader field of mental health that promotes collaborative and equitable client-practitioner relationships, or contractual psychiatry (Szasz, 1970; Barker, 2009). This movement is aimed at neutralizing traditional change methods based on an ideology of pathology that support practices of coercion, where the expert practitioner reinforces processes that privilege the interests of society above those of the individual (Inger & Inger, 1994). Perhaps this indicates that more integration and shared learning across the disciplines would help to consolidate and promote a more therapeutic response to the person in distress. This study suggests that such movement toward a more collaborative and equitable system of care would be welcomed by suicidal young men. This, together with tackling social and moral

stigma, might allow them to rely less on concealment and trust more in humanity and the care system.

Self-Discovery and Acceptance vs. Concealment

"The first crucial step to changing our way of being in the world is to increase awareness. To be more alive, moment to moment, to the flow of experience, to what we are sensing, thinking, feeling, intuiting, doing. It is this deepening awareness that reconnects us with the essence of our being, with others and with the natural cosmic world. It re-acquaints us with the purpose of living…"

(Watkins, 2007, p.9)

Psychological theories suggest that one's life can be enriched through openness to one's self, one's experiences and the world, while defensiveness to these aspects of being and living can distort and limit living possibilities (Rogers, 1961). Numerous avenues to self-discovery have been sought which promote self-awareness and self-acceptance and bring personal fulfilment, such as, counselling / psychotherapy, spiritual guidance and eco-consciousness (Watkins, 2007). The importance of self-discovery and self-acceptance has been highlighted across the recovery literature. Helm (2009) argues that the beginning of the recovery process is a belief in one's own value. This is a challenging move in a social context that views mental distress as a taboo subject. The young men in this study reflected the centrality of self-discovery and self-acceptance in the transcending process as they demonstrated their newly found awareness of self, others and the world, their openness to engage with the world in new life-enhancing ways, and their sense of freedom that came with being themselves and no longer acting out their lives. Having opportunities to reflect and reconsider their lives facilitated self-discovery and self-acceptance, which was central to building trust and identity re-configuration. However, this was only possible in contexts that permitted them to become internally and externally visible.

Resilience and Resistance vs. Compliance

"[resilience refers to] the phenomenon that some individuals have a relatively good outcome despite suffering risk experiences that would be expected to bring about

serious sequelae. It implies relative resistance to environmental risk experiences, or overcoming of stress or adversity...".

(Rutter, 2007b, p.205)

Resilience refers to the process of overcoming acute and on-going life adversity, while resistance usually refers to protest against a particular phenomenon (Wexler et al., 2009). Enduring and overcoming negativity, by whatever psycho-social mechanisms, requires resilience and or indeed resistance that allows for rekindling hope and agency in circumstances nurturing of hopelessness and passivity. Rutter (2007b) links the concepts of resilience and resistance and emphasizes individual differences in response to adversity, a non-linear stress-response relationship, and the contextual foundation of resilience in, for example, attachment relationships. Wexler et al. (2009) highlight the importance of viewing resilience as an evolving dynamic, communal and political process, rather than a static individual characteristic or amalgam of risk and protective factors. This perspective suggests that interpretation determines the meaning given to and effects of a situation rather than the situation per se. Resilience and resistance impact coping processes including help-seeking. Tousignant and Hanigan (1993) suggest that help-seeking among suicidal young people may reflect learned patterns of self-reliance and fear of failure due to inadequate care and support in living.

From these perspectives it could be suggested that resilience and resistance operate both as protective and risk factors in suicidality. While adversity may increase self-reliance, it also prevents the person from being able to seek help as this does not fit with their usual coping strategies and may signal failure. Therefore, while initially their coping patterns of resilience and resistance work well they may eventually lead to burn-out (Tousignant & Hanigan, 1993). Resistance may be associated with the person's capacity to perceive that the cause of distress lies in the environment rather than in personal failure; this unburdens the person from personal guilt, shame and blame (Fritsch, 2006). It may also be a way of retaining agency in the face of demoralizing circumstances (Wexler et al., 2009).

The young men in this study identified some processes that reflected and enhanced resilience and resistance, such as important interpersonal relationships, self-

determination on their part to overcome adversity, a capacity to shift their views on their selves and their lives, and an ability to avail of appropriate help in a timely manner for their survival. However, while resilience and resistance may be central to overcoming life adversities, institutional psychiatry operates from a philosophy of external control and patient compliance (Szasz, 1970). This may negate efforts to take personal responsibility and control in one's life, which was an important process in transcending suicidality and is important in recovery in general.

Hope Inspiration vs. Hopelessness

"Hope is contagious and that is why it is so important to hire people with disabilities in rehabilitation programmes...Very often a person who is only a few steps ahead of another person can be more effective than one whose achievements seem overly impressive and distanced."

(Deegan, 1988, p.59)

The centrality of hope, or positive future expectations, in overcoming life adversities is well documented (Smith & Kelly, 2001; Cutcliffe, 2004). Conversely hopelessness is associated with reduced attention to the future and negative future expectations, and pervasive hopelessness is inextricably linked to suicide-ality (Beck et al., 1976). The suicidal person can become disempowered by the effects of hopelessness on his emotional, psychological, physical, spiritual and social self (Aldridge, 1998; Frankl, 1959; Collins & Cutcliffe, 2003). Hence the suicidal person frequently demonstrates hopelessness which can be transferred to others challenging the professional to maintain a positive outlook for the person and the treatment. However, both practitioner and client hope and positive expectation about change are deemed to significantly influence the therapeutic process and outcome (Hubble et al., 1999).

The practitioner can transfer her sense of hope, support and respect for the client and their work together, consciously and unconsciously, implicitly and explicitly. Therefore, given the close relationship between hopelessness and sucide-ality, it is suggested that practitioners need to understand that hope is a subtle, essential, dynamic and changing phenomenon that can be inspired in the therapeutic exchange (Frankl, 1959; Aldridge, 1998). Hope inspiration is epitomized in the communication to the person that that one cares about and respects him as a person of value, hence

hope is viewed as a life-sustaining force that can be enhanced in the therapeutic encounter (Collins & Cutcliffe, 2003). In this study a number of the young men alluded to the importance of hope in helping them to move forward in living. A sense of hope was enhanced by validating interactions with others and belief in their own capacity to turn their lives around.

In addition to other recent accounts, this study highlights the haphazard fashion or indeed absence of such basic humane skills and values in much of the encounters between health professionals and the suicidal person. These practices are experienced as disempowering and invalidating, thereby perpetuating a negative cycle of stigma and alienation. It is noteworthy that many of the worth-enhancing processes discussed here have been documented in the literature for some considerable time. However, while some studies have hypothesized about why change in care attitudes and practices are slow, it remains a real challenge to shift from a philosophy of expert control, reflected in institutional psychiatry, to one of collaborative compassion, reflected in contractual psychiatry (Szasz, 1970).

Summary

The recovery literature is quite diverse and there are resonances in the psychosocial processes of recovery and healing in overcoming life adversities, mental health problems and suicidality, which lend credibility to the findings in this study. This literature supports the view that self integration and reinvention are part of the recovery process, that this is a complex process, and that it can be influenced by a myriad of factors in the person's life. This study also highlights challenges associated with *re-vitalizing worthiness* in view of the philosophical tensions inherent in mental health care (Szasz, 1970).

Despite resonances between the transcending suicidality process and the recovery literature there is no specific reference to the process of *re-vitalizing worthiness*, while associated ideas about self re-configuration and some of the sub-processes inherent in this are strongly recognized. Examples of these are persons reaching new understandings of their selves, building their self-esteem, and viewing themselves as having acquired a new sense of being (Smith & Kelly, 2001; Buchanan-Barker, 2009; Helm, 2009). Thus, the substantive theory, *re-vitalizing worthiness in transcending*

suicidality, is distinct from the extant literature on recovery and yet contributes to it. Specifically, it suggests that regaining worthiness permits discovery of self and life, which is key to the recovery process, and can be significantly enhanced through intrapersonal and interpersonal dialogues that serve as turning points. The theory therefore provides a new way of understanding transcending suicidality and indicates some core processes by which this can be enhanced by the mental health practitioner.

10.3 Worthiness and Suicidality

"When people know their own interests and can risk making mistakes without losing self-esteem, they can determine for themselves what actions to take…because they know what they can and cannot do…"

(Wislesky, 2007, p.123)

The second idea embedded in the substantive theory in this study is that regaining worthiness is central to transcending suicidality. In this study worthiness is viewed as one's ability to know and accept one's identity despite acknowledged shortcomings, and to be able to engage with a world that has its limitations, thereby creating an acceptable self and living a satisfactory life. It also incorporates the idea that one is deserving of life. Hence, in order to enact their worthy selves the young men had to make sense of their world anew, accept that they had imperfections, and acknowledge that there were real limitations in life and in living. Two theoretical ideas, "validation" (Linehan, 1993) and re-organization of "illusory basic assumptions" (Lazarus, 1983; Janoff-Bulman, 1985) are explored in terms of understanding the centrality of worthiness to the transcending process.

Worthiness and Validation

"Invalidation has two primary characteristics. First it tells the individual that she is wrong in both her description and analyses of her own experiences, particularly in her view of what is causing her own emotions, beliefs, and actions. Second it attributes her experiences to socially unacceptable characteristics or personality traits."

(Linehan, 1993, p.49-50)

Validation is viewed as central to a positive sense of self while invalidation leads to a disjointed and confused sense of self (Linehan, 1993). As validation can be achieved through positive experiences and feedback, and invalidation can arise from negative experiences and feedback, it is an inter-subjective process. According to Linehan (1993), invalidation arises when a person assumes that he has inaccurately interpreted his self and his world due to faulty personal characteristics and / or processing mechanisms. Hence, the person believes that he cannot trust his own judgment of his situation and that he is responsible for this shortfall, making him feel vulnerable and defensive in a foreign world; this frequently leads to distress and dysfunction (Watkins, 2007). The person finds himself in a bind as he tries, but fails, to change in a way that reconciles his inner and outer contradictions. In keeping with this definition the use of the term invalidation in this study refers to the young men's belief that their personal values, thoughts, emotions and selves were not valid in their life and living context, calling into question their deservedness to be in the world. In other words, there was a poorness of fit within them and between them and their world, rendering them unworthy of life and living.

Invalidating episodes can arise in a range of contexts and are frequently associated with traumatic life stresses. In this study, the young men described patterns of invalidation in their lives and selves. This was enacted in their daily living reflecting a self-conception of being unworthy persons undeserving of life, let alone a rewarding life. Patterns associated with invalidation, such as loss of control in their lives, self-blame and hopelessness, were clearly evident in the young men's living patterns in suicidality. It was not until they entered a stage of re-vitalizing their worthiness through self and other validation that they were able to enact a life that reflected and established their new being as worthy.

The link between SLEs and invalidation and psychological disturbance has been well established (Linehan, 1993; Read et al., 2001). However, while there is a clear acceptance of the association between SLEs and suicide-ality and between childhood trauma and mental distress (Read et al., 2001), it has been suggested that inadequate attention has been paid to the association between early traumatic stress and suicide-ality (Grad, 2005; Watkins, 2007). This situation is compounded by a predominant clinical focus on suicide risk and presenting diagnosis, the fact that abuse histories are

underreported, and a dominant pattern where men are less likely to be asked about such issues; despite findings that childhood trauma does not differ in its effects in terms of suicidality on men and women (Read et al., 2001). Indeed it is postulated that there is an increased morbidity and mortality rate, including suicide, among those who have been exposed to traumatic loss (Reisman, 2001). Failure to take SLE's into account arises in particular when the trauma is not the presenting complaint, if it occurred in the distant past, or, if it involves a stigmatized subject such as CSA (Elliot & Frude, 2001; Mehlum, 2005). As a result the accuracy of suicide assessments with adult clients is compromised, and important life experiences remain unexplored and unresolved, fuelling suicidality (Read et al., 2001; Tarrier et al., 2007). Interestingly, decline of meaning in life associated with profound loss, of self or other, has been identified as an area that warrants further theoretical elaboration (Neimeyer, 2005). It is important to note that while traumatic events can have a particular "psychological toxicity" the impact of a traumatic event on an individual can be more complex and requires consideration of additional issues such as: the resulting intensity of fear and helplessness experienced, the person's personal coping resources, and opportunities for restorative experiences and available support in the aftermath of the event (van der Hart et al., 2004; Mehlum, 2005; Fritsch, 2006). Some participants in this study suggested that their responses to life situations may have reflected their personal sensitivity to invalidating episodes, while others clearly indicated their felt lack of support in their invalidating life contexts.

It is proposed that there is also a link between traumatic stress and attachment patterns. Attachment styles are said to develop in relation to caregiving figures in childhood which form the basis of subsequent models of self and other (Bowlby, 1997). Hence, negative childhood caregiving experiences can predispose one to various forms of insecure attachment which can be compounded by subsequent experiences of loss, threatening one's basic sense of coherence, safety and fulfilment (Neimeyer, 2005; Bostik & Everall, 2007). Such experiences can challenge one's self-narrative which requires reconstruction to restore coherence of meaning (Neimeyer, 2005). Insecure attachment was particularly striking among the young men in this study, most of whom were not involved in permanent or stable relationships at the time of interview (Appendix 3). Furthermore, one's sense of integration and cohesion inevitably impacts attachment; therefore, it could be argued

that the young men's lack of sense of a real self, which accompanied their dissociative state, initiated relationship difficulties. Thus, it could be postulated that invalidation, impacting their identities and relational competencies, contributed to and exacerbated the young men's suicidality.

Re-Vitalizing Worthiness and Revalidation

"...I needed someone to validate my human worth. It came in the form of a music tape sent to the hospital…That tape gave me life…His songs were the turning point in recovery."

(Helm, 2009, p.63)

Validation confirms personal value and deservedness to be in the world. Validation requires a search for the wisdom and / or truth in the person's communication about and interpretation of their own world (Linehan, 1993), which invalidation has questioned, leaving the person bereft of worthiness. Validation requires openness to the potential impact of traumatic stress and its invalidating effects, raising some important issues for clinical practice in relation to assessment and intervention with suicidal men whose exposure to life stresses may have initiated or perpetuated their suicidal journey. Nevertheless, while some of the suicidal distress experienced by the young men in this study was related to specific SLEs, others described a more insidious loss of meaning not directly ascribed to a particular life event, and multiple unaccounted for events may have also influenced their suicide trajectory. Furthermore, suicidality was experienced as traumatic in itself indicating this is a complex non-linear process. These patterns further highlight the unique nature of the young men's responses to life events and the need to treat people as individuals firstly, facilitating them to regain a sense of being worthy human beings.

In summary, revalidation as persons facilitated the young men in re-vitalizing their worthiness, however this was not a predictable linear process. The complexity of the help and recovery is captured by Barker et al. (1999, p.185) when they say that the irony of help is that *"Virtually* anything *appears to be of help to someone, but* no one thing *is of help to everyone.*" However, on the basis of the processes identified in this study, there seems little doubt that external forces impacted validation and served as directed reflection, whereby interaction with others reinforced the young men's belief

in their selves (Milliren & Maier, 2009). This confirmed them as worthwhile beings and enhanced their worthiness.

Worthiness and Illusory Basic Assumptions

"In effect, we pilot our lives by virtue of illusions that give meaning and substance to living. Life cannot easily be lived and enjoyed without a set of both shared deceptions and self-deceptions, that is, without beliefs that have no necessary relationship with reality."

(Lazarus, 1983, p.8)

In contrast to a traditional view within the health disciplines that the well-adjusted person has an accurate perception of the world, the future and the self, and the maladjusted person holds an inaccurate view clouded by illusions, the reverse has been suggested by way of understanding human functioning in an imperfect world (Lazarus, 1983; Janoff-Bulman, 1985). It is proposed that, in addition to self-deceiving beliefs, people hold collective "illusory basic assumptions" or working assumptions, which are unrealistically positive views about the self, the future and the world, that promote adaptive functioning by allowing one to get on with the business of living despite the negativity of reality and life (Lazarus, 1983; Janoff-Bulman, 1985; Reisman, 2001). Indeed Lazarus (1983) suggests that life would be intolerable without illusions; therefore, they are necessary for one's mental health.

These illusory basic assumptions have been variously described but incorporate three interrelated types of assumptions: a belief in personal invulnerability and a benevolent world, a perception of the world as meaningful and comprehensible, and a positive view of oneself as worthy (Janoff-Bulman, 1985; Reisman, 2001). These positive illusions usually remain unchallenged unless one is exposed to overwhelming stress (Grad, 2005), which Reisman (2001) refers to as "higher order stress". Such stress engenders insecurity and fear and destroys the ability with which the person is ordinarily able to function (Janoff-Bulman, 1985), and may produce profound changes in the person's attitudes towards the self, others and the world as a whole (Grad, 2005). Through invalidation the young men in this study demonstrated lack of trust in their selves, their futures and their worlds, which resembled a shattering of their basic assumptions.

People whose worthiness has been shattered no longer view themselves as safe and secure in a benign world, as they have experienced a malevolent world. Integrating their vulnerable selves, including the unreality of impermanency was therefore essential for the young men in re-establishing a sense of safety in the world. Believing oneself to be invulnerable rests in part on the assumption that the world is meaningful and coherent, that it makes sense and has order, and that it is controllable. Loss of meaning derives from one's inability to make sense of their situation; therefore, making-meaning is important regardless of the apparent logic that is created (Janoff-Bulman, 1985). Finding meaning in the world and in their suicidality, however partial this might have been, facilitated the young men in integrating their selves and bringing coherence and control to their lives. Finally, it is assumed that the world is just, one gets what they deserve and one deserves what they get (Lazarus, 1983). Therefore, having attributed blame to their selves for their situations, shedding self-blame was an important part of regaining worthiness for the young men and accepting their selves and worlds despite shortcomings.

Unbearable distress frequently leads to a desire for and active efforts to escape (Shneidman, 2001; Williams et al., 2005), promoting the use of "denial like processes" (Lazarus, 1983; van der Hart et al., 2004; Fritsch, 2006). Indeed, Fritsch (2006, p.303) suggests that the most common survival techniques that young people employ in the face of adversity are to *"...defensively numb themselves to the nuances of the outer world"*. Thus, they inhibit their capacity to think, feel and make sense of the actions and intentions of others, and / or retreat into fantasy while dulling the sensations of reality. This enables them to endure negativity until they encounter positivity that becomes a transforming experience, hence, denial serves as a protective mechanism. In this study the young men showed signs of numbness and disconnection which can be interpreted as an expression of their inability to assimilate their life experiences, including their suicidality, with their previous constructions of reality and self. Conversely, later signs of awakening and being present could be viewed as expressions of integration and coherence of their conflicting worlds.

Re-Viatalizing Worthiness and Re-organizing Illusory Basic Assumptions

"What then is the resolution of the seeming paradox…that the use of denial is both harmful and beneficial; that although we venerate reality testing as the hallmark of mental health, life is intolerable without illusion?"

(Lazarus, 1983, p.15)

Invalidation and suicidality contributed to the young men's unworthiness as their fundamental beliefs about their selves, their lives and their worlds were shattered, which impacted their sense of meaning, purpose and control in living. Hence, regaining worthiness was central to their being able to reassemble their dis-assembled selves, lives and worlds. Incorporating one's experiences of invalidation and victimization involves reworking one's assumptions about oneself and the world so that they fit with one's new personal data. This is a unique process for each individual depending on the nature and extent to which his basic assumptions have been shaken (Janoff-Bulman, 1985).

From this perspective, it could be postulated that these young men overcame their suicidality, in part, by re-engaging with a certain level of illusory thinking that served to protect their previously over-exposed and over-sensitive selves from the harsh realities of living. This view supports that of Lazarus (1983) that illusion is necessary for positive mental health. In other words the young men shifted their frame of reference for determining and sustaining worthiness to incorporate into their being space for normal illusory assumptions and daily living postulates, thereby meeting their needs for identity stability and coherence and achieving adaptive functioning. This fits with many of the young men's self-descriptions of being overly sensitive to the injustices and cruelty of life, and needing to toughen themselves up by way of moving forward with their lives. Perhaps they gained perspective and drew distinctions between higher order postulates, abstract and generalized, and lower order postulates, specific and concrete (Reisman, 2001), which had previously become blurred, fuelling their unrealistic expectations of their selves and worlds. Hence, they began to re-evaluate their lower level postulates and to replace these with more attainable expectations and assumptions, and to let go of seeking clarity and

understanding of higher level postulates; instead reinstating these as protective defences against life's vulnerabilities, such as mortality, in a way that did not compromise their new realities.

From this perspective the paradox of denial is that it kept the young men alive in suicidality through splitting off from the world, and also helped them regain new lives through the same mechanism by re-organizing their illusory basic assumptions beyond suicidality. With their shattered illusions they faced their worst fears in relation to their selves and the world, that they might not deserve to live and that life might be meaningless and unjust. Re-organizing these illusions enhanced their worthiness by protecting them from the harshness of life and establishing attainable living goals.

Summary: Regaining Worthiness

In summary, the young men's suicidality could be understood in part in terms of the interrelated processes of invalidation of their selves and shattering of their illusory basic assumptions, while revalidation of their selves by self and others, and rebalancing of their illusory basic assumptions helped to free them to regain their worthiness and transcend suicidality. The latter incorporated positive blame-attribution, which protected them in their emergence into living an ordinary life in an imperfect world. Hence, it could be postulated that they young men's entirety as people, while suspended, was not entirely lost and that this was rekindled through revalidation and re-organization of their illusory basic assumptions, allowing them to re-configure their selves and lives.

10.4 Re-Vitalizing Worthiness and Identity Re-configuration

"Identity as a concept is fully elusive as is everyone's sense of his own personal identity. But whatever else it may be, identity is connected with the fateful appraisals made of oneself by oneself and by others. Everyone presents himself to the others and to himself, and sees himself in the mirrors of their judgments. The masks he then and thereafter presents to the world and its citizens are fashioned upon his anticipations of their judgments."

(Strauss, 1969, p.9)

The third idea embedded in the substantive theory in this study is that *re-vitalizing worthiness* entails identity re-configuration, which allowed the young men to re-establish themselves anew in the world beyond suicidality. The nature and meaning of '*identity*', sometimes referred to as sense of self or personhood, has long captivated the interest of theorists across a number of disciplines, spanning philosophy (Harré, 1998), psychology (Gergen, 1998), sociology (Strauss, 1969), and anthropology (Cerulo, 1997). Therefore, there is currently a range of ontologies of self, or ways for understanding the bio-psycho-social-spiritual domain that constitutes identity (Gergen, 1998; Cerulo, 1997; Harré, 1998). Some versions of identity are context-dependant, for example in Western cultures the self has been viewed primarily as an independent phenomenon, while in Eastern cultures the self has been primarily viewed as a collective phenomenon. Furthermore, some versions emphasize particular aspects of the self whilst others take a more holistic approach. While it is beyond the scope of this study to engage with and critique this immense volume of work, it is important to incorporate some prominent work in the area that informs and lends credibility to the substantive theory.

Versions of Identity: Coherence and Transformation

Two distinct metaphors for understanding identity can be identified in the literature, representing a positivist and a constructivist viewpoint. A positivist perspective privileges a view of the self as singular, stable and fixed, while a constructivist perspective sees the self as multiple, evolving and contextually and historically bound. From a positivist perspective, *we are who we are*, and our success or failure in living our lives is located within the individual, depends upon his personal characteristics such as motivation, will power, intellect, personality dynamics and so on, and is measured against standard norms (Burr, 1995; McNamee & Gergen, 1992; Gergen, 1998; Denzin, 2001). Harré (1998) examined the core assumptions that underpin the notion of self as entity - that is a sense of personal distinctness, continuity and autonomy. He suggested that loss of one or more of these aspects of self is associated with depersonalization, fitting with the process of losing identity through invisibling as described in this study. Hence, establishing a sense of self-permanence was important in the re-vitalizing process.

Within the constructivist world view lies a body of knowledge referred to as "social constructionism" (Berger & Luckman, 1966), which exemplifies the social, multiple and constructed nature of identity (Burr, 1995; Gergen, 1998; Boston, 2000). From this perspective *we are both who we are and who we are not*, therefore, we are always open to being transformed in unpredictable ways that are unique to each person and situation. This perspective holds that there are multiple realities and selves that can be brought forth and enacted in the course of our lives in constantly changing social contexts. This notion of perpetual identity transformation fits with the transcending process described in the substantive theory in this study, whereby the young men re-configured their selves *as if* re-born.

There is scope for an ideological clash between the positivist and constructivist positions, however, these can also be seen as complementary ways of viewing identity. Harré (1998, p.19) highlights that while there are multiple selves, *"...when compromised the very existence of a human being as a person is under threat."* This acknowledges the 'inter-subjective' perspective and the complementarity of *both* self *and* system, and the embodied *and* the embedded self (Flaskas & Perlesz, 1996). This description fits with the pattern of transcending suicidality described in the substantive theory which incorporated a version of identity that is both stable and evolving, allowing the tension between permanence and change to co-exist. For example, while the young men transformed their identities in significant ways in transcending suicidality, they also incorporated their previous selves into their new being and valued a sense of identity that confirmed their individuality.

In summary, both a positivist and constructivist perspective on identity offer ways of understanding the identity re-configuration process in which the young men engaged in transcending suicidality. The substantive theory suggests that identity can be both singular and multiple and stable and evolving. The young men were able to enact different selves in different contexts over time that were shaped and reshaped by their social and personal contexts. It also attests to the importance of a stable sense of identity in terms of the young men knowing, trusting and believing in their selves. Hence, it is coherent with a view of the self as inter-subjective, which takes a *both / and* position on the tension between subjectivism and objectivism (Harré, 1998), and

a view of the self as having permanence while also being capable of transformation (Strauss, 1969).

Re-Vitalizing Worthiness and Identity Re-Construction

"…the synthesis in a dialectic contains elements of both the thesis and the antithesis, so that neither of the original positions can be regarded as "absolutely true". The synthesis, however, always suggests a new antithesis and thus acts as a new thesis. Truth, therefore, is neither absolute nor relative; rather, it evolves, develops, and is constructed over time."

(Linehan, 1993, p.34)

There is a vast and growing literature that attests to the centrality of identity reinvention in overcoming life adversities (Smith & Kelly, 2001; Buchanan-Barker, 2009), which has gained increasing attention in the literature in recent years (Clarke, 2001), and fits with how the young men gained a new perspective on their selves and lives. Two distinct yet interlinked processes, "dialectic dialogue" (Linehan, 1993) and "dialogic turns" (Inger & Inger, 1994) will be explored to elaborate the integrative and transformative nature of identity re-configuration described in transcending suicidality.

Dialectic Dialogue and Dialogic Turns

Identity reconstruction can be facilitated in a number of ways and it is suggested in this study that this involved inner and outer dialogue that facilitated synthesis of the young men's dialectic of destiny and re-configuration of their selves. It could be said that inner and outer dialogue was significant in these processes as it involved engagement in dialectic dialogue (Linehan, 1993) and dialogic turns (Inger & Inger, 1994) that facilitated transformation beyond dichotomies and rigid world views. Dialectical dialogue facilitates change in perspective by making use of the potential of difference and oppositions inherent in one's world, thereby enhancing integration of selves (Cronen et al., 1985; Linehan, 1993). It involves synthesis of dialectics which refers to the integration of opposites that retains elements of both but extends beyond their original tensions and polarizations. The tension in dialectical growth is often described as a painful crisis with resolution or synthesis involving a new way of being in the world. A dialogic turn refers to how existing world views transform as they no

longer work well for the person which is central to identity integration in overcoming a crisis of uncertainty (Inger & Inger, 1994). According to Inger and Inger (1994), a crisis of uncertainty can bring about considerable tension that may not abate until the beliefs and practices based on certainty have transformed to those based on uncertainty.

In summary, in negotiating their dialectic of destiny the young men brought synthesis to formerly polar opposites, the desire for life and death. It could be hypothesized that this was made possible through dialogic synthesis whereby these opposing desires were integrated without compromising their past lives. In the re-vitalizing process the young men's world views were transformed in ways that allowed them to re-configure their selves and their worlds in order to establish and enact worthiness and their place in the world, resembling a dialogic turn. Having previously viewed these as competing worlds and identities, based on assumptions of certainty, a new self-self and self-other dialogue emerged that reconciled their selves and worlds, thereby shifting fundamental beliefs that incorporated a reality based on assumptions of uncertainty in living. From these perspectives it could be postulated that in transcending suicidality the young men engaged in dialectic dialogue and dialogic turns that enhanced coherence of their identities, thereby resolving their sense of being fragmented and living in a fragmented world.

Gendered Identity Construction

"The emergence of a crisis discourse around masculinity has served to obscure the different conditions under which men live their lives, and to exaggerate in turn the radical dichotomy of men and women. Binary divisions along gender and sexual lines can be seen as an historical fiction which conceals a much more confused mixture of fears, anxieties and desires about what being a man means."

(Weeks, 2005, p.53)

As this study was concerned specifically with identifying patterns central to the concerns of young men who experienced suicidality it is important to comment upon the place of gender within the self reconstruction process. Furthermore, it has been proposed that culture and gender influence how one defines one's identity (Linehan, 1993; Gergen, 1998). According to Cerulo (1997, p.387) gender identity studies have

focused on *"…the ways in which socialization agents organize and project the affective, cognitive, and behavioural data individuals use to form a gendered self"*. These studies have exposed factors influencing gendered identity such as: definitions and practices of masculinity, agents of socialization (family, popular culture, the media etc.), and the processes by which gendered norms become social realities, for example, discourses that inscribe gender on the body. It has been suggested that men inhabit, succumb to, reflect and recreate socio-cultural discourses some of which have gained more discursive power than others (Weeks, 2005), such as traditional masculinity discourses of power, rationality, independence and success (Burck & Daniel, 1995). Hence, Weeks (2005) advocates vocalizing new masculinity narratives that speak of emotion, vulnerability, diversity and connectedness that can accommodate men and women in a world of transition and that rebalance traditional masculinity myths. Weeks (2005) suggests that there is an ever growing crisis discourse around masculinity that implies that men are losing their foothold in society and urgently need to re-establish their place of significance. This discourse highlights men's deteriorating educational performance, poor and neglected health, risky life styles (Connell, 2005), and loss of family and social status (Weeks, 2005).

It has been hypothesized that men are more likely to feel deprived in times of change because they have been forced to move from a position of privileged and coherent subjectivity, underpinned by rationality and control, to one of equalled and fragmented subjectivity. Women, on the other hand, have moved from a position of de-centred objectivity to one of increased self-definition. Hence, men are likely to lose their patriarchal status as the power differential between the genders has been altered (Burck & Daniel, 1995; Cleary, 2005a). However, Weeks (2005) also points out that despite current discourses about women's power in the family, educational system and society, in general men remain to the forefront in arenas of decision-making that affect the lives of men and women. He concludes that masculinity and femininity only exist in relation to one another and while destabilizing of traditions is indeed happening, this is a gender issue for and within genders as opposed to a male crisis. To see this otherwise allows the conditions that give rise to such assumptions to become obscured and the binary divisions that preclude meaningful exploration of their origins and impact to be exaggerated.

Gender discourses are helpful in identifying issues specifically related to certain groups and how these can be politically used to reinforce norms that benefit certain members of society, usually the privileged, whilst subjugating others (Burck & Daniel, 1995). However, there is a danger in over-emphasizing the entrapping effects of discourse, thereby reducing personal agency and in effect re-establishing restrictive discourses (Strauss, 1969; Weeks, 2005). There is also a risk of becoming embroiled in the discourse without paying adequate attention to the context within which such discourses arise (Cleary, 2005b; Weeks, 2005; Connell, 2005).

While gender did not emerge as a key issue in this study the young men alluded to the place of gender in their patterns of living in and beyond suicidality. While they did not describe feeling powerless because of changes in gender power differentials, their anxieties about exposure seemed to be associated with their acceptance of traditional masculinity norms. They concealed their selves and their suicidality, fearing exposure and blame for their failure to meet societal expectations, which also impacted their help-seeking and recovery processes. The consequences of some gendered discourse were also evident, for example, the trend of high risk-taking behaviour among men (Langhinrichsen-Rohling et al., 1998). The young men in this study recounted patterns of engagement in risky behaviours that served to distract and numb them and test their destiny crises. Hence, they reflected some of the lived effects of "liminality", or living in in-between worlds and identities, as their lives mirrored the pull between tradition and their desire to be other than the norm, for example in relation to work, relationships and sexuality. It is noteworthy, however, that the young men also highlighted the importance of personal agency and acceptance of the imperfections in living in their recovery process, and some challenged their preconceived ideas about their selves as men in order to reorganize and reshape their lives. This emphasizes the importance of being able to challenge and work outside of discourses that may otherwise be experienced as entrapping. Therefore, it may be useful to explore such issues as suicidal young men attempt to free themselves from their in-between worlds and emerge in a reality that poses challenges to them in terms of their preferred identities.

Summary

This study has demonstrated that there are complex processes inherent in *re-vitalizing worthiness*, which involves identity re-configuration while identity coherence was also important. This dual process can be understood from the perspective of multiple socially constructed identities that can incorporate a sense of continuity and coherence which is drawn upon and strengthened at key junctures in the re-vitalizing process. The tension between identity change and stability and particular issues related to gendered identity re-configuration need to be considered when working with suicidal young men in order for them to free themselves from the constraints of social discourse and gain self control.

10.5 Turning Points and Suicidality: A crisis as an opportunity

"Those interactional moments that leave marks on people's lives…have the potential to create transformational experiences. These are 'epiphanies'…In these moments, personal character is manifested and made apparent…Such moments are often interpreted, both by the persons who have them and by others, as turning-point experiences (Strauss, 1969). Having had such a moment a person is never quite the same again."

(Denzin, 2001, p.34)

The final suggestion embedded in the substantive theory is that transcending suicidality is a non-linear and dynamic process. This process was influenced by turning points that significantly impacted the young men's worthiness and recovery journey, and structured and made sense of their reality by punctuating the flow of events in their lives. According to Strauss (1969), some transformations of identity and perspective are planned, some are fostered, others happen despite conscious direction, and others take place unexpectedly. He refers to the latter as "turning points" or significant turns on one's personal career that can be positive or negative. A turning point, therefore, refers to *"an experience that so profoundly alters a person's life that it can never be the same again…forcing us to recognize that 'I am not the same as I was'"* (Pinder, 1994, p.212), hence it can promote and reflect a personal transformation. Denzin (2001) describes four types of turning points: major (an experience that shatters a person's life rendering it different), cumulative (a series

of events that build up to change a person's life over time), minor and illuminative (underlying tensions that are revealed leading to new insights), and finally relived (re-experiencing a major turning point in life and making new retrospective sense of it). He suggests that turning point encounters occur within the wider context that surrounds the individual and frequently occur when one confronts and experiences a personal crisis. Hence, they are embedded within a context that influences how one responds and as such are micro-representations of broader social and cultural issues. The impact of turning points and the manner in which they mirrored broader social issues was evident in this study in relation to the status of and challenges facing suicidal men in contemporary Ireland. For example, surviving a suicide attempt was a significant turning point described by the young men wherein they came face to face with the reality of death and also their innermost fears about their selves and their lives, compelling them to reconsider their situations.

Transcending Suicidality and Turning Points

"In every moment of crisis there are both danger and opportunity – opportunity to be free of fear and open to the turning points in every conversation…"

(Draper & Hannah, 2008, p.10-11)

In this study the young men described two kinds of turning points that impacted their position on the suicide trajectory, those that stole their worthiness and sowed the seeds of invalidation, and those that replenished their worthiness and facilitated the transcending process. In terms of the former Strauss (1969) refers to the potential impact of an event that signifies to the person that one of their chief self-referential terms is erroneous, posing an identity maintenance juncture as a fundamental anchor is abruptly removed. The latter, however, set them on the road to re-vitalizing their worthiness and re-constituting their selves and their lives. Wasserman and Gallegos (2007) describe how moments of mis-meeting, dissonance, or disorienting dilemmas occur in social encounters on a regular basis. They suggest that these moments provide opportunities for transformative learning if engaged in with curiosity and empathy, hence, a paradox of a potentially dis-abling life crisis lies in the opportunities for new life that can emerge from it. Alternatively, such interactional moments can represent episodes of conflict, hurt and confusion if avoided or defended against, which gives rise to contradictions and ambivalences in self and other

conception. This perspective holds that communication *"…consists of an action that makes rather than reports meaning"* (Wasserman & Gallegos, 2007, p.3), drawing attention to the power in language as action (Cronen et al., 1985). These perspectives help to make sense of the significant shifts in the lives of the young men, wherein new selves and worlds were negotiated. Hence, it could be hypothesized that in re-vitalizing their worthiness they availed of the positive opportunities inherent in turning points, which could be said to reflect their open-mindedness despite their distress.

Constructing and validating a new self and self-narrative following a significant turning point can be viewed both as an internal process, and a socialized and socializing process (Strauss, 1969), insofar as one relies on external validation of sense of self and social discourses to redefine and re-establish one's social role (Neimeyer, 2005). Hence, persons seize moments of privacy and contemplation to think through challenges of identity, emerging with personal and social revelations, while also availing of external support to *"…validate and re-validate new found conceptions of ourselves"* (Strauss, 1969, p.130). It is the combination of these inner and outer dialogic processes that facilitated the young men in moving forward and gaining balance between identity change and continuity, and their singular and multiple selves.

Summary

In summary, turning points came in different shapes and held different meanings for the young men yet had a significant impact on their place on their suicide trajectories and life paths. In recovery they comprised significant intrapersonal and interpersonal moments that assisted them in harnessing and strengthening their personal strengths and resolve, and noticing and benefiting from the resources around them. This impacted their knowing and enactment of their realities in a different way, allowing them to take ownership of their selves and lives. Hence, they found a weapon to conquer their dialectic of destiny rather than remaining in the 'limbo' land between living and dying. It could be hypothesized that those who remain suicidal are unable to respond to such turning points as growth opportunities, and / or to risk such profound change at that moment in time. Hence, whilst one may not know in advance or indeed realize the potential impact of such exchanges, the nature and timeliness of

one's response to the suicidal young man is of paramount importance as it may represent a validating or invalidating encounter in his life that influences his decision-making about his dialectic of destiny.

10.6 Summary

"Suicide results from a struggle with the most fundamental questions about the meaning of life. Although extensively investigated from statistical, medical, psychosocial and existential views, suicide remains an enigma, not only for researchers and practitioners but also for those at risk and those whose lives are seriously affected. Little is known about what it is like to live in the shadow of suicide and very few studies focus on the inner world of the suicidal person."

(Talseth et al., 2003)

This chapter was concerned with situating some of the key processes and ideas embedded the core variable and theory into a wider literature base in order to enrich, stretch and diversify the theory. It highlighted that while aspects of the substantive theory resonate with theoretical frameworks from a range of disciplines none of these frameworks in themselves comprehensively speak to or coherently explain the substantive theory. Indeed the substantive theory from this study challenges some taken for granted ideas, such as: linear models of change and recovery, polarization of identity transformation and coherence models, and pathologizing of denial processes that can serve as both survival and destructive mechanisms.

The core concern of the young men centred on their movement between the dialectic of living and dying. While in suicidality, they had a sense of fragmentation of their selves and loss of worthiness. Hence, it was necessary for them to reclaim their worthiness as individuals who were deserving of a meaningful life by re-vitalizing their worthiness and becoming different in the world. This transition was possible through a range of complex and interrelated processes, some of which are reflected in the suicidology, mental health and wider literature. A number of links were made between categories and the literature in relation to the young men's living and coping patterns in and beyond suicidality, and the social and professional responses they received. In particular the study highlighted patterns that signified their distress and

disempowerment while in suicidality, resonating with much of the suicidology literature. It also highlighted their renewed selves beyond suicidality, resonating with much of the recovery and identity literature.

The substantive theory in this study explains how the young men transcended suicidality. It suggests that regaining worthiness is central to transcending suicidality, which is a dynamic process, mediated internally and socially, and punctuated by turning points. A number of theoretical frameworks were employed by way of explicating these ideas. The theory suggests that recovery from suicidality is possible and that the young men moved forward with living beyond suicidality. The general, mental health and suicidology recovery literature emphasizes that: experiences of recovery vary hugely, overcoming adversity is a complex process that involves self-transformation, recovery is related to a range of intra-personal, interpersonal and contextual factors, and that mental health practitioner's responses to the distressed person serve to both enhance and sometimes unfortunately hinder recovery (Watkins, 2007). These ideas fit with the transcending suicidality process which incorporates the idea that the young men did not merely get over their suicidal crises but incorporated them into their being and moved on in life with a more integrated sense of self, having resolved their dialectics of destiny. The influence of others in this process was also highlighted as moments of interpersonal interaction impacted profoundly their journey.

The theory suggests that overcoming suicidality is foundational on regaining worthiness and two key theoretical frameworks were used to explore how this process occurs, personal validation (Lenihan, 1993) and illusory basic assumptions (Janoff-Bulman, 1985). It is suggested that one way of understanding the centrality of worthiness in the transcending process is to consider that the young men regained worthiness through revalidation of their selves as worthy and rebalancing their illusory assumptions, thereby bringing order, coherence and meaning to their lives. Hence, these ideas are useful in exploring how worthiness can be dismantled and rebuilt, while not explaining the theory in its entirety.

The theory also suggests that it was possible for some fundamental aspects of the young men's identities to be reshaped and for them to enact new identities, while also

retaining a sense of self stability (Strauss, 1969; Harré, 1998). Hence, the young men in this study were able to deconstruct and reconstruct their selves in ways that allowed for the shedding of unworthy identities and the remaking of worthy identities. It is suggested that this process was enhanced by a number of interrelated internal and external dialogic processes in the form of dialectic dialogue (Linehan, 1993) and dialogic turns (Inger & Inger, 1994) that transformed the young men and their world views.

Finally, the theory suggests that turning points (Strauss, 1969; Denzin, 2001) were significant in punctuating the young men's journeys in life. It is suggested that they availed of the positive opportunities inherent in life epiphanies to progress their movement from in suicidality to beyond suicidality. However, precisely why these young men were able to take and make opportunities that reoriented them toward life requires further examination.

Re-vitalizing worthiness in transcending suicidality can be viewed as a dynamic and multi-layered process that transformed the lives of these young men, bringing them beyond suicidality. This process was profoundly influenced by intrapersonal, interpersonal and social discourses and practices, raising a number of issues for professional and social policy and practice in terms of meaningfully responding to the suicidal young man. Thus, the implications of the substantive theory, for the fields of suicidology and mental health in particular, are elaborated in the next and final chapter.

Chapter 11. Discussion: Light at the End of the Tunnel

"…the idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity-activity designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny for man…the fear of death is indeed a universal in the human condition."

(Becker, 1973, p.xvii)

11.1 Introduction: Where to go from here?

The preceding discussion outlined a number of ways that the substantive theory, *re-vitalizing worthiness in transcending suicidality*, can be understood and elaborated, implicitly challenging social and professional discourses and practices. This chapter is concerned with exploring the contribution that the theory makes to the fields of suicidology and mental health. It suggests that the substantive theory provides a broad theoretical framework that can underpin engagement the suicidal young man and a concept based model that guides interaction with him at different points on his suicidal and life paths.

Locating suicide-ality within the specialist domain of mental health may be interpreted as a strategy for protecting man from his greatest fear. This study supports the view that death, self-appointed death in particular, is a complex area that arouses unease and is strongly denied in multiple cultural contexts, including Ireland, making it a fundamental, inescapable, and universal challenge (Becker, 1973). Denial of the reality of suicide-ality presents a paradox that was reflected in the young men's dialectics of destiny and in many of the social and professional responses that they received. Responses predicated on denial overshadow the personal, interpersonal and social relevance of suicide-ality in everyday life and are underpinned by an ethos of risk-management. Such practices mirrored and exacerbated the young men's distress. However, practices predicated on acceptance, reflected in open-mindedness and genuine concern, assisted the young men in transcending their suicidal crises. While labelling suicide-ality as self-destructive and those who engage in it as insane may serve to protect others from the reality of death and the fact that some people choose

death over life, it ironically also alerts those with responsibilities to and within the mental health field to their duty to seriously attend to the issues of suicide-ality. This has given rise to a range of practices and policies at local and national government levels that have impacted the suicidal person and those associated with him, formally and informally, in terms of understanding and responding to his dilemma. However, the study also highlighted that there remains an epistemological gap between espoused and lived values in this area.

This chapter will identify and explore some of the key issues that this study has raised in relation to the current socio-political status of suicide-ality and the consequences of this for young men and those with whom they engage, particularly the mental health practitioner, in contemporary Ireland. It will evaluate the substantive theory, *re-vitalizing worthiness in transcending suicidality*, in terms of its contribution to the fields of suicidology and mental health, and examine the robustness of the study.

11.2 Implications of the Substantive Theory

Researchers are challenged to demonstrate the worth of their studies, and different criteria and writing practices have been developed to assist them in this endeavour. Attending to this important task enables the research audience to be satisfied that the findings can be relied upon to guide action in certain domains of practice and identify areas for further inquiry in and beyond the substantive area (Kvale, 1996; Willig, 2001). Based on a thorough review of the literature this is the first study that has proposed a theory explaining the processes by which young men transcend their suicidality by regaining their personal worthiness and deservedness of life. The emergent theory, *re-vitalizing worthiness in transcending suicidality*, has a number of implications for professional practice, training and education, further research in the field of suicidology, and government health policy. The implications along with some tentative proposals for action are discussed below under discrete headings while there is inevitable overlap across these domains.

Implications for Clinical Practice

"Continual dialogue and reciprocity of exchange will create the healing of both the

legacy of our system and improvement of current-day practices."

(Helm, 2009, p.63)

The discussion thus far has highlighted a number of interlinked social and professional dilemmas, contradictions and challenges surrounding suicidal young men that influence responses to them and consequently their life paths. It is timely to raise these issues as critique of current policy and the manner in which services are organized and delivered is widespread (Cutcliffe & Stevenson, 2008). Furthermore, changing trends in client expectations of professionals and services further strengthens the case for review of mental health practices and examination of avenues for change (Hitcheon et al., 2006).

The theory suggests that young men can transcend suicidality by regaining worthiness and that this is to a large extent influenced by contextual factors, such as the support and encouragement they receive from key others in their lives and the opportunities they have for reflection and growth. The young men's experiences in mental health services were mixed, from highly satisfactory to highly unsatisfactory. The former is encouraging and suggests that some practices have changed for the betterment of suicidal young men. However, the latter supports the view that some services and service personnel were influenced by a philosophy of expert control, leading to denial of the young men's distress and their capacity to participate in their own care decisions. This suggests an inability on the part of these practitioners to acknowledge and respond to the fundamental dilemmas these young men have in negotiating their dialectics of destiny. Multiple hypotheses have been proposed to explain the phenomenon of inadequate care, from the use of defence strategies (Hale,1997), to inadequate training, and the interplay between both (Ting et al., 2006; Cutcliffe & Stevenson, 2007). Nevertheless, it is a real issue that warrants serious and immediate attention as clients are currently being denied adequate care, or more worryingly, being re-traumatized by care (Barker et al., 1999). While this is far from a new issue, as evidenced in the literature pre-view and re-view this study highlights that it remains a significant concern in mental health practice in Ireland today.

Suicidal young men are young men who have lost their way in life, feel on the outside, and are unsure about their deservedness to live and hence their destiny. They

are part of a wider social, cultural and gendered system that has not been, for the most part, rewarding to or encouraging of them. Hence, they need alternative life experiences that perturb the foundations of their bleak, lonely and troubled worlds, and that are also respectful and validating of their place therein. While it must be emphasized that validating processes can occur in everyday living and social exchange this discussion is primarily concerned with how the mental health practitioner can become an active agent in the dynamic re-vitalizing worthiness process. The study suggests that this can be facilitated through establishing a safe context for reflection and disclosure of inner turmoil, and engagement in worth-enhancing encounters. These young men moved along the suicide trajectory in an unpredictable way, hence, their futures were uncertain. However, they were acutely sensitive to cues in their life contexts that signalled to them their (un)worthiness and (un)deservedness to be. Therefore, any interaction with a young man, regardless of his level of suicidality, needs to be considered as a potential turning point encounter impacting his journey. While processes that facilitate worthiness may not directly impact the young man's mental pain it may impact his suicidal urge at a moment in time. Hence, a validating encounter may serve as a deterrent against suicide. It may also trigger or create momentary space for reconsideration of his life, which may serve as a catalyst for reorientation toward life and reorganization of self-destructive patterns.

This study demonstrated that while the young men's recovery paths are influenced by a myriad of contextual factors that are sometimes unpredictable, the therapeutic encounter between them and the mental health professional can be viewed as a foundation and a catalyst for the development of meaningful relationships within the helping system and in their wider living context. In this study a number of key practices and processes were described that significantly impacted the re-vitalizing worthiness process, facilitating internal reflection and change. The mental health professionals identified as making the most positive difference in the lives of the young men were those who worked with rather than on them, could tolerate and work with the uncertainty / mystery of their experiences, and could sustain a supportive role throughout their unpredictable journey of self-discovery. Specific interrelated processes identified as important are described in this study as *real engagement, demonstrated caring and authentic connection*. These processes were perceived to be

associated with belief in the young men's potential to recover and renew their lives, and practitioner capacity to engage with them in relation to their dark side, thereby embracing the opportunities inherent in uncertainty. Practices that were identified by the young men as unhelpful included controlling, confining, coercive and stigmatizing practices, such as, pejorative labelling and exclusion from their own care and treatment. These practices further reinforced their unworthiness and invalidated their sense of self.

It is well documented that many frequently used strategies in the care and treatment of the suicidal person, based on a paternalistic approach (Szasz, 1970), and an assumption that prevention is always possible (Hawton, 1994), lack effectiveness evidence, can be counter-productive and traumatizing, and are used in the absence of adequate training (Weiss, 2001; O'Donovan, 2007). Such practices also reinforce the power hierarchy between "them and us" (Inger & Inger, 1994), reinforcing the client's sense of being different and powerless. Hence, the mental health practitioner needs to consider the potential therapeutic usefulness of an intervention with each unique person and tailor her response to the individual rather than relying on convenient and conventional methods. However, in addition to specific therapeutic processes, it is important to remember that "small is beautiful" and apparently minor ex-changes can make a big difference in the life of the person in distress. It has been suggested, for example, that ensuring "protected time" for staff and patient interaction can have enormous benefits for both groups (Barry et al., 2006).

The specific area of assessment has been identified as unsatisfactory as it is frequently viewed as a task rather than a process, has a significant focus on risk management procedures, and fails to take the person's context and history into account (Anderson, 1999; Read et al., 2001). This has resulted in responses to the suicidal person being uni-dimensional and the privileging of physical safety. As a result there has been less emphasis on how to create and sustain psychological safety and a safe space for emotional and psychological exploration and growth. It has been recognized that practices based on confinement, while sometimes necessary in an acute moment of risk, if practiced in the absence of other interventions and out of context can reduce opportunities for emotional and psychological growth (Anderson, 1999). Therefore, the practitioners' capacity to tolerate and contain risk, rather than avoid it, and to

focus on his entire safety and not just his physical safety, needs to be nurtured (Sun et al., 2006). It has also been suggested that assessment needs to be more holistic, by incorporating life stresses that may be impacting the young man's suicidality and his entire being (Read et al., 2001). Finally, viewing assessment as a continuous process rather than a one-off task is recommended to enhance continuity and coherence of care (Anderson, 1999).

Interventions with the suicidal person have been critiqued for focusing on some aspects of the person to the exclusion of other important dimensions, for example, on the body, mind, soul or social context, which has led to incomplete and sometimes inhumane practices (Webb, 2002; 2003). This partial focus is also reflected in the notable absence in recognizing the impact of traumatic stress on suicide-ality, despite the prevalence and sometimes interrelatedness of both (Grad, 2005). Hence, the practitioner needs to broaden her lens to incorporate the totality and uniqueness of the person in her response. To do so she needs to be able to challenge taken-for-granted assumptions, such as, considering the possibility that mental distress and suicidality can be enriching experiences that allow self reconstruction, as evidenced in this study. She might also consider the possibility that mental distress may be a secondary cause of severe emotional distress rather than arising from discrete causal factors such as biochemical disorder (Miller, 1990).

The care and treatment status of the suicidal patient seems to be defined at a number of levels that reflect wider uncritiqued suicidality discourses. A demarcation is made between those who are seen to be genuinely unwell and those who are viewed as attention seeking. On the basis of this judgement a distinction is drawn between those that are deserving of the attention of the practitioner and those less deserving of this, with self-destructive young people falling primarily into the latter group and ultimately determining the care response (Bergmans et al., 2007). Care and treatment priorities determined by such judgements frequently go without either explicit recognition of or critical reflection on the underpinning moral conventions that define the rights and wrongs in how one engages with living and health. Lack of attention to discourses that impact practice can obscure competing demands on the practitioner, such as: ensuring safety in a context of risk, providing certainty in an uncertain world, collaborating while also protecting, and, being person-centred while also meeting

organizational, professional and legal requirements. These factors may not always be appreciated or acknowledged by the practitioner herself, her colleagues, the organization in which she works or society. Hence, the professional and the client continue to muddle in the twilight together while also trying to avoid ultimate darkness. Therefore, it is essential that the practitioner be provided with space to explore such issues and that their impact on her be acknowledged. This can be achieved, for example, through clinical supervision / consultation which provides opportunities for formative and restorative learning, thereby promoting positive self and other care (Carroll, 1996), and perhaps reducing the risk of practitioner compassion fatigue and burnout.

In summary, this study demonstrated that the mental health practitioner can (in)validate the suicidal young man in her interactions with him at different stages on the suicide trajectory and life pathway, influencing his sense of worthiness. This can be covert or overt, conscious or unconscious, deliberate or unintentional, and experienced negatively or positively. Some interactions will have a profound impact, in the sense of a turning point, while others will serve to confirm and consolidate existing ideas and experiences. Hence, the engagement between the practitioner and suicidal young men requires awareness about the importance of *re-vitalizing worthiness* through validation. Another important issue relating to practice concerns the area of assessment, which needs to be broad and continuous. The interface between assessment, intervention and evaluation needs also to be considered in order to enhance holistic and collaborative care. The study also demonstrated that the context within which care is provided is frequently dominated by professional assumptions that support unhelpful practices and an exclusionary ethos, which are uncritiqued for the most part. Therefore, bringing a wider lens to the practice domain is essential in addressing these concerns.

Implications for Training and Education

"…considerable biological and pharmacological attention is paid to those disorders under whose rubrics suicide is most likely to occur (affective disorders, alcoholism and schizophrenia), but the clinical phenomena immediately surrounding suicide is scanted. Trainees are taught to tick off items on the DSM IV checklist for the major

depressive syndromes, but they are not taught how to access depressive anguish."

(Maltsberger & Goldblatt, 1996, p.146)

In order for the mental health practitioners to move away from custodial, restrictive and exclusionary practices, they need alternative philosophical frameworks and courses of action upon which to draw. Such alternatives also need to be socially sanctioned in order for practitioners to move into the unknown and live with the unpredictable, rather than being preoccupied with certainty and predictability (Gijbels, 2003). It is important that institutions providing training and education for the professional working with suicidal young men recognize the complexity of practice in this area and reflect this in course curricula. This means acknowledging that working with this group requires more than an awareness of risk and protective factors, diagnostic criteria, and uni-dimensional interventions. This study has demonstrated that working with suicidal young men requires understanding of the complexity and fluidity of care, and commitment and relational competence on the part of the practitioner. Hence, the training and education arenas could usefully create space for personal growth and development of the practitioner to enhance her capacity to respond to such demands.

If practitioners are to be able to sustain emotional tolerance and psychological awareness in the face of conflicting demands, they need support. Some possible areas for consideration in training include incorporation of the multiplicity of theoretical, moral, social, gender, and personal perspectives that can influence practice, so that the practitioner can critically examine her decision-making and its foundations. This has the potential to promote and nurture holistic, safety enhancing practices and therapeutic engagement, thereby embracing a prevention approach, while also shifting professional beliefs from cure to care and actions from control to connection. It means providing opportunities for personal and professional reflection and integration, to build and sustain self-awareness and encourage an ethos of critical inquiry, which can enhance job satisfaction and practitioner morale.

The complex and competing discourses to which the practitioner is exposed inducts her simultaneously into contradictory positions, one of which warns against speaking about the unspeakable and one of which invites her to speak empathically and freely

with others about the issue. It is therefore understandable that the mental health practitioner, in an effort to protect herself from such contradictory and constraining monologues, resorts to a defensive position that masks the reality of suicide-ality and enacts stigma (Joyce et al., 2007). Conforming to the myth of preservation of life in all instances and at all costs, also forces the practitioner to position herself in the realm of "social control", frequently at the expense of therapeutic engagement (Cecchin, 1987). This situation partially explains the sense of failure and confusion experienced by professionals working with clients who self-harm as they question their very being as a practitioner whose primary function is to preserve life (Links, 2001; Ting et al., 2006). Therefore, it is proposed that opening space for reflection and debate about these interlinked moral social and professional issues be incorporated into training and education as well as the practice domain.

The importance of therapeutic engagement between practitioner and client in determining therapeutic process and outcome in mental health practice appears to be beyond dispute (Hubble et al., 1999). However, relatively little training time is devoted to exploring its value and impact, and learning skills that facilitate its nurturance in therapeutic interaction across the helping disciplines. It is of concern that little emphasis to date has been placed on examining how best to work with the suicidal person and those connected with them and that practitioners feel so de-skilled in this area (Maltsberger & Goldbaltt & Maltsberger, 1996; Ting et al., 2006; McLaughlin, 1999; Cutcliffe & Stevenson, 2007), despite the growing volumes of literature in this area (Aldridge, 1998; Orbach, 2001; Leenaars, 2004).

There is also need for different levels and styles of engagement and negotiation with the young men depending on their place on the suicide trajectory and in order to enhance continuity of care. For example, acknowledging the interrelatedness, continuous and intricate nature of assessing, responding, evaluating and so on. This awareness allows the practitioner to judge her movement in her therapeutic engagement, such as shifting between discursive and persuasive modes of interaction that allow her to meet these young men at different points in their suicidal and recovery processes. Engaging with significant others, such as family, is also part of the role of the practitioner in providing coherent and continuous care. Hence, she needs the confidence and skills to engage with the distressed other in a supportive and

encouraging manner, while also maintaining boundaries of confidentiality and a stance of neutrality to ensure that the patient is not further alienated. It is therefore essential that the focus of professional training shift from a task to a process orientation, and from an emphasis on efficient and accurate (evidence-based practice) to an emphasis on effective and humane practice (practice-based evidence). The concept based model described in this study can provide a foundation for such a shift in understanding, for example, realizing the importance of self and other acceptance in the *integrating* aspect of *re-vitalizing worthiness*.

Gender sensitive practices that enhance worthiness also need to be examined and promoted in both the training and practice contexts. For example, the ethos of one-way care needs to be challenged and practitioners need to begin to involve clients in dialogue, not only about their suicidality, but also about their desires for care and their potential contribution to their own care and the care of others. This is particularly important in working with men who have repeatedly demonstrated a desire for reciprocity (Bille-Brahe et al., 1999), as reflected in the expressed motivation of the young men to contribute to this study. Facilitating reciprocity among suicidal young men warrants attention in service delivery but needs to be carefully managed so that the client does not become overburdened by responsibility for self and others. This resonates with the recovery literature that advocates pacing re-entry to life, balancing self-other responsibility, and enhancing peer support structures and processes (Deegan, 1988; Watkins, 2007).

In relation to male suicidality, acknowledging the unique male gendered responses to distress and suicidality is also important. A link between high-risk behaviours and masculinity for many young men has been established; this carries health and social consequences and has been associated with poor health outcomes (De Visser & Smith, 2006). Therefore, education in recognizing and exploring this male paradox would be useful for professionals in their work with young men, promoting sensitive engagement with them and reducing the risk that such behaviours are construed as a challenge to or rejection of treatment. This study also identified the concealment efforts made by the young men in suicidality and practitioners also need to be aware of such trends so that their distress is not overlooked. Furthermore, the young men in this study demonstrated how alternative masculinity discourses and behaviours can be

incorporated into their renewed selves and lifestyles. Hence, the practitioner needs to be aware of how she might help or hinder such reformulations of the self through privileging her own values and beliefs.

The issue of providing inter-disciplinary training and educational opportunities is also important to promote awareness and understanding of inter-disciplinary dynamics that impact team work. This can enhance rich cross-disciplinary discussion and an appreciation of the potential benefits and challenges associated with different perspectives. It can also help to improve collegial support in acknowledging and managing the challenges inherent in working with suicidal young men, thereby enhancing interdisciplinary relationships and collaboration and rebalancing power differentials that work against collaborative and coherent practices.

In relation to policy the young men in this study demonstrated awareness of the limitations of policy that promotes mental distress as a universal rather that individualistic phenomenon, and that perhaps unwittingly, infers blame for ill health. However, without adequate voice to address such issues they may well go unchallenged. This highlights the need to incorporate into training and education awareness and analysis of the impact of government policy on organizational policy and on professional guidelines and concerns. This could enhance critique and deconstruction of the wider discourses that shape practice and promote action in terms of lobbying for alternative regimes (Cutcliffe & Stevenson, 2008).

A growing body of literature supports the involvement of mental health service users / consumers in the training and education of mental health professionals. It has been demonstrated that this enables recognition of recovery and reduces stigma among professionals, in addition to enhancing service user self-esteem and sense of empowerment (Meehan & Glover, 2007). However, despite these benefits service user perspectives are frequently excluded or their involvement is erratic and / or tokenistic due to the *"…current power structures, negative staff perceptions toward consumer involvement, and the emphasis on scientific knowledge…"* (Meehan & Glover, 2007, p.154). Hence, involving service users more proactively in education and training could have enormous benefits for both service users and practitioners.

Finally, an education related curiosity that occurred to the author as she was writing this thesis relates to the number of PhD studies that have been conducted in related areas and that have signalled some of the concerns and proposals contained in these pages. This raises the question about how the findings of such studies can be disseminated in ways that impact those who are most likely to benefit. It is clear that those who read academic literature and attend conferences have the opportunity to discuss the relevance of findings; however, it is less clear how such information reaches those at the centre of the issue of concern, in this instance suicidal young men and those providing social and professional responses to them and their families. This issue can also be seen in the wider pattern of information dissemination in the mental health community. It is noteworthy that many of the issues that emerged in this study have been incorporated into the literature over time, with little evidence of theory-practice coherence. Therefore, the author has been challenged to think about creative ways of disseminating the substantive theory and exploring its implications at local levels and with groups who are less likely to access this information through the usual channels. Some possible ways are to make opportunities to visit local and national groups of service users and practitioners to discuss the study findings and indeed learn more about its implications and limitations in the real world, and to circulate the findings to such groups for discussion and feedback purposes.

In summary, some key areas for attention in the training and education domains include more critical appraisal of discourses underpinning practiced, more collaboration and information sharing across disciplines, and more attention to the voice of the service user.

Implications for Research

The literature pre-view identified some fundamental research gaps in the field of suicidology. In particular, there is a dearth of qualitative research, little that explores suicidal processes from an emic perspective, and an absence of theory based on systematic study (Maris et al., 2000; Shneidman, 2001). The substantive theory, *re-vitalizing worthiness in transcending suicidality*, presented in this study adds to the field of suicidology by offering an in-depth explanation of how young men in contemporary Ireland transcend suicidality. It addresses a research gap in the field by providing a subjectively based and qualitative account of this complex process, and

consequently redresses the current imbalance which favours quantitative and objective approaches to research. It also challenges the idea that professional speculation is adequate in terms of enhancing understanding in the field of suicidology.

The study highlighted a number of areas for further research. Although the study has provided an in-depth description of the process of *re-vitalizing worthiness,* specific aspects of this process could be examined in greater depth. For example: exploration of how certain factors and processes converged to facilitate the young men in reshaping their selves and lives, such as, their readiness to be influenced by events that impacted their self-discovery and recovery journeys, and the personal resources that assisted them in remaking their identities beyond suicidality. In this study, the young men struggled to explain these processes beyond vague descriptions such as determination and indeed luck. Therefore, it might be useful to examine these change processes from a range of perspectives and / or with multiple methods. This would provide a better understanding of the specific aspects of resilience and resistance that helped these young men in the transcending process, how they availed of turning point opportunities, and how personal and interpersonal processes converged at a moment in time to enhance worthiness. It might also provide some insight into why some young men remain suicidal or complete suicide. This suggestion is in keeping with Wexler et al. (2009, p.566) who suggest that resilience inquiry can be further developed to enhance understanding of the mechanisms involved in the process of *"...rebounding after experiencing hardship"*. However, the contextual embeddedness of meaning-making and experience processing needs to be taken into account so that dominant assumptions are not pre-imposed on such inquiry (Wexler et al., 2009), for example defining resilience and resistance too narrowly. Another issue related, while not specifically highlighted in the study, was the impact of gendered discourses on the young men's identity construction in and beyond suicidality. Hence, further research into specific gendered aspects of suicidality and recovery would also inform gender sensitive responses.

The substantive theory highlights the place of (in)validation in the lives of the young men and further research examining the specific relationships between (in)validation, worthiness, suicidality and recovery would be worthwhile to gain an understanding of

their relationships in suicide-ality in general. This could be achieved by exploring the relevance of the theory in a range of contexts, such as among young men in other cultures, with young men at different times in the rapidly changing Irish environment, and / or with groups of young men with different help experiences, including those with no experience of the mental health services. It could also be examined, as suggested, in more detail in relation to studies that have focused on similar processes, such as overcoming life adversities and / or mental health problems. This would further help to elucidate commonalities and dissonances across recovery processes. A substantive theory can be developed to a formal level by generating more abstract concepts and specifying relationships between them and multiple substantive areas (Glaser & Strauss, 1967; Charmez, 2006). Therefore, such a synthesis would form a sound basis for the development of a formal theory of recovery.

Finally, while a significant body of research exists that examines and indeed supports the importance of the interpersonal therapeutic alliance and client-driven services based on mutuality and collaboration, many of the practices to which the young men were exposed did not reflect, rather transgressed, such values. Hence, the complex process of therapeutic engagement and risk management requires further de-construction, and / or the barriers to providing care while adhering to these principles requires explication and dismantling. For example, while this study has confirmed that care of suicidal young men is complex, varied and crucial in determining the fate of many young men, it is unclear to what extent individual preferences and skills, organizational structures and ethos, and / or both, work to continue to mitigate against humane care responses.

In summary, this study adds to the fields of suicidology and mental health research by offering a systematically developed theory of transcending suicidality, and explaining the processes involved in this and how it can be facilitated. It also draws attention to some areas that require further exploration in relation to and beyond the substantive area, which would extend the scope of the theory and add additional knowledge to the fields of suicidology and mental health.

Implications for Policy

"...psychiatry and our society need to shift away from our current perspective, featuring negative feedback and a pathological emphasis on external locus of control; we should shift toward a person-driven, democratic, internal locus of control perspective."

(Fisher, 1999, p.128)

It could be argued, as the overall rates of suicide in Ireland have levelled off in very recent years that policy strategy is working well and that the "problem" of suicide-ality is being addressed in general (NOSP, 2009). However, youth suicide is on the increase in Ireland, therefore, response to date is clearly not alleviating the distress of many young people (NOSP, 2009). It is ironic that government policy incorporates a number of the key ideas about what needs to be done to appropriately address the concerns of suicidal young men. This documentation is underpinned by the values that have been identified in this study as worth-enhancing, such as, collaboration and respect. Furthermore, policy documentation outlines clear practices for responding to the suicidal person at multiple levels within and without the mental health services. However, there is a significant gap between policy and practice and some policy emphases require reconsideration.

This study highlights a number of anomalies and contradictions with the current policy emphasis. For example, the focus on prevention with a connotation that suicide-ality can be totally eradicated, the values that underpin such a moral perspective, and the manner in which these assumptions are enacted in health promotion strategies and service planning. The emphasis on suicide prevention fits with the medico-legal discourse of foregrounding physical safety and risk management, and the prevailing professional discourse around harm-prevention and cure. This leaning impacts professional guidelines, training and practices. For example, it overshadows the reality of suicide-ality (Hawton, 1994), contributing to a social-moral discourse that promotes silence around the issue (Sommer-Rothenberg, 1998). This includes ignoring it as an aspect of professional training, and promoting fear that overshadows future orientated, holistic, life-enhancing interventions. While prevention efforts are worthwhile, as some suicides can undoubtedly be stopped, the

paradoxical injunctions posed for the suicidal person, and those associated with him, including the mental health practitioner, cannot be underestimated as highlighted in previous chapters.

Another issue that warrants consideration at policy level is promoting help-seeking among those who are concerned about themselves and their lives and may be vulnerable in terms of suicide-ality. While this is an appropriate strategy in itself, it only makes sense in a context where relevant information about services, access to services, and actual help is available. While a number of the young men in this study were fortunate to be offered a specific suicide crisis response initiative and other worth enhancing mental health services following their suicide attempt, they reported being uncertain about where to seek help prior to their suicide attempt. Indeed those who sought help at primary care level were not satisfied with the responses that they received, which were primarily psychopharmacology interventions. The young men were also dissatisfied about being denied access to specific services, such as counselling which they had requested, while others were placed on lengthy waiting lists. Hence, it seems that the gap between policy values, such as timely, equitable and relevant responses, and actual response is vast. Perhaps the time has come to make explicit that "singing the right tune" is not equivalent to making a difference in health beliefs and practices.

The wider issue of placing suicidality within the health domain, specifically mental health, also requires consideration. Viewing suicide-ality primarily through a mental ill-health lens can prevent rather than promote help-seeking and engagement with professional services, and overshadow the whole of the person in a way that further marginalizes and invalidates him. This segregation is enacted in his encounters in living, including unfortunately, with many mental health practitioners. This issue was also raised in the literature pre-view in terms of placing suicide bereavement services within the domain of mental ill-health, which could be construed as stigmatizing the bereaved (Walter, 2005). However, as mentioned, practices of compartmentalizing the person, whether within mental health or a less stigmatized category, does not guarantee better social and professional responses for these young men. For example, responses at ED level are experienced negatively by patients outside of the suicidal group, which suggests that this is a wider issue (Kane, 2009). Furthermore, while

some found mental health services unhelpful others did not, and some had mixed experiences.

The young men in this study experienced severe mental distress. A number of them received a psychiatric diagnosis, which some found helpful in understanding their situation while others found this unhelpful in explaining and managing their situation. Some did not have a psychiatric diagnosis despite their involvement with mental health services, which they found confusing. Therefore, it cannot be concluded that psychiatric diagnosis and involvement with mental health services are either helpful or unhelpful to all suicidal young men. However, diagnosis and interventions need to be individually tailored and regularly evaluated particularly given the unpredictability of the suicide trajectory and as it is not clear what exactly makes it possible for the young man to become available to reappraise his self and world in such a radical manner. Raising these kinds of questions may open possibilities for wider debate of the taken-for-granted assumptions in society, and enhance discussion on more humane and creative responses that enable viewing suicide-ality and its effects as a health and perhaps bigger socio-cultural issue depending on the individual's circumstances and needs.

A final concern raised centres on policy decision-making in terms of who decides on policy priorities, how these decisions are made, and who represents the expert voice in this process. There is a tradition in Ireland where the service user is the last, rather than the first, person to be consulted about his care, particularly in the area of mental health. Hence, ironically, policy documents that advocate principles and practices of collaboration, respect, autonomy and shared learning do not always enact these principles in their making (DoHC, 2009). Many of these policy issues are reflected at micro levels in terms of the objective, expert, exclusionary and risk focused social discourses that are enacted in daily practices of living and caring, therefore their review might facilitate social and professional change.

In summary, while national government and local policy espouse values coherent with worth enhancing practices there remains a gap between espoused and lived practices in relation to policy development, and between policy and enacted social and

professional practices. Furthermore, the policy emphasis on micro processes overshadows the anomalies that underpin such policy.

Implications for Society: Whose concern is it anyway?

The findings of this study have implications beyond the mental health arena. It is worthwhile reiterating the fact that many suicidal young men do not engage with mental health services and those who do engage have had multiple encounters with others in their social networks and work / educational communities, and some with primary health care personnel. Therefore, promoting rather than diminishing social ownership for suicide-ality holds open the possibility of empowering others such as, family, friends, peers, colleagues and so on to respond in a more proactive manner in validating young men, or at the very least not condoning invalidating social practices. An opportunity also exists for community based health practitioners, such as school / college health care staff and GP's, to respond in ways that facilitate young men in becoming visible without the fear of further stigmatization and social rejection. In this study the young men vividly recalled multiple efforts of signalling their distress that failed to achieve their desired response due to the vagueness of their signals and inability of others to hear their plea for help, further silencing them. Therefore, suicide guidelines need to incorporate a more contextual approach that extends an invitation to young men to become visible in their communities, which may also serve to reduce marginalizing practices.

In this study, the young men were vocal about the naiveté of the concept of prevention, the lack of regard that this signals for individual choice, and the assumptions that it makes about life in general, and indeed their lives, as being worthwhile. They also noted how a recent national mental health promotion campaign, aimed at stigma reduction and promoting help-seeking, failed to address the lived experience of the suicidal person's agony, by using generalized and objective language and inferring that his mental health is solely his own responsibility. Ironically this conveyed a message of blame rather than acceptance and concern, and undermined the influence of society on one's mental state thereby excusing social responsibility. Perhaps there is an opportunity both to embrace the prevention approach, thereby respecting the value of life, while also enhancing

engagement by promoting social responses that are *"...tailored to fit the special needs, pain, situations, and biology of a particular individual."* (Maris et al, 2000, p.5).

Summary

This study raises a number of issues for consideration in terms of professional practice, training and education, research and policy development. A key message from this study is that youth male suicidality is insidious, hidden and soul-destroying. It can have a lengthy history and be associated with a range of invalidating processes, therefore a thorough and holistic approach bases on *re-vitalizing worthiness* is advocated in order to understand and validate the person and his context. While it is important to understand the factors that contribute to suicide-ality it is also important to remain focused on the individual and to provide him with opportunities to make sense of and take responsibility for his self and his life situation at his own pace. Transcending suicidality is unpredictable and dynamic and is influenced by a myriad of intrapersonal and interpersonal processes. Therefore, multiple dialogic opportunities arise in the course of his life and particular context for re-evaluation of self and world, and the mental health practitioner and others can play and key role in re-vitalizing his worthiness in formal and informal encounters.

This study and much of the literature confirms that many mental health services have an unsatisfactory track record in effectively identifying and meeting the needs of suicidal young men, as they continue to find professional and service responses inconsistent and indeed personally invalidating. As a result many suicidal young men continue to avoid, and / or fail to benefit from contact with services. It is concerning that negative, discriminatory attitudes and poor communication skills among healthcare professionals contribute to this situation. Therefore, despite benevolent intentions on the part of government, service managers and professionals, suicidal young men continue to get a poor deal. That said, there are examples of services and professionals in some areas that enhance the health and worthiness of the client. What seems to be lacking is a consistent effort on the part of all concerned to share, develop and sustain practices that work well for him. Therefore, this study supports the view that services should be more user friendly, user centred and self critical. It also suggests that policy be treated as leverage for proactive improvement rather than

being viewed as aspirational and irrelevant, or setting unrealistic expectations of services and practitioners that instil failure due to perceived implementation barriers.

11.3 Review of the Study

"...each of us should be aware of our limitations, and be satisfied with our contribution to the bigger picture. This requires that the specialist recognize the limited scope her expertise, as well as the legitimate utility of generalists and specialists working in other areas."

(Moses & Knutsen, 2007, p.291)

An important aspect of demonstrating the value of a GT study is to judge it against accepted criteria in terms of methodological rigour and theory robustness. To this end a range of assessment methods has been popularised, and these are elaborated below.

Study Robustness and Rigour

As discussed in the methodology chapter there is a range of criteria that can be used to assess the robustness of a study, some of which are relevant to qualitative research in general and some of which are specific to a GT study. The researcher will use a number of commonly applied criteria to assess the rigour of this study and the robustness of the substantive theory, including: the GT criteria of fit, relevance, workability, modifiability, enduring grab, parsimony and scope (Glaser, 1978); and, more general criteria such as trustworthiness, credibility, theoretical generalizability / transferability, and spontaneous validity (Kvale, 1996; Willig, 2001).

Fit, relevance, workability, modifiability, enduring grab, parsimony and scope are consistently described in the GT literature as criteria for assessing the robustness of the emergent theory (Glaser & Strauss, 1967; Glaser, 1978). These interlinked criteria can be assessed at a number of levels such as the analyst's demonstration of conceptualization, her satisfaction with the final product, the extent to which the core concern is addressed by the substantive theory, and the clinical significance of the theory. However, each criterion can also be assessed independently.

Fit refers to the substantive congruence of the theory. One way of judging this is to examine the researchers' adherence to the methodology, particularly to the analytic method, CCAM. This method, while time-consuming, facilitated the building of categories that were increasingly more conceptual in nature by incorporating and synthesizing new data systematically, thereby ensuring gradual development of the theory. The researcher found the method invaluable in challenging her own biases, bringing depth and coherence to categories, and identifying "outliers" or exceptions that required further exploration. Another important question is how well the core variable addresses the core concern of study participants in the substantive area. This is answered by showing that the core variable was abstracted from data indices thereby further demonstrating conceptualization on the part of the analyst. The core concern in this study was conceptualized as *negotiating a dialectic of destiny*, which encapsulated the deep existential crisis of these young men as they moved between a life orientation and death orientation and from in suicidality to beyond suicidality. The core variable *re-vitalizing worthiness* describes an in-depth process of transcending suicidality which is how the young men resolved their core concern. Hence, the theory specifically relates to the substantive area under study. It clearly and succinctly addresses how the young men reshaped their lives and selves in order to go on living viable lives following their suicidal crises. It also meets the criteria for *parsimony*, as it draws together key processes in an accessible way. It does not, and is not intended to, account for continued suicidality or completed suicide. While these are significant areas of concern in the field of suicidology, addressing them directly was beyond the scope of this study.

Relevance asks if the theory makes sense of and in the substantive area. One way of establishing relevance is to subject the emerging concepts to the rigours of the analytic method and incorporate them into interviews throughout theoretical sampling. The researcher found that many of the concepts made sense to the participants when specifically inquired about, while others were reshaped or indeed abandoned as participant responses indicated a lack of relevance. While it is not expected that participants would conceptualize their situation in the same way as the analyst, to ignore exploring the relevance of the theory with the research participants risks replicating the unhelpful power hierarchy that has been implicitly and explicitly critiqued throughout this text. Hence, discussions took place with one participant /

practitioner and ex-service user, and an independent ex-service user. Feedback on the theory, while not intending to verify the theory in terms of its accuracy, certainly verified it in terms of its usefulness. Both viewed the theory as fitting with their overall pattern of regaining personal worthiness and earning a place in the world that was central to them overcoming suicidality and rebuilding new identities. While they had not conceptualized their own experiences in this way, it made sense to them to think about recovery as recovering worthiness and living rather than recovering from the past of getting over their suicidality.

Workability challenges the usefulness of the theory in everyday practice. It asks how helpful the theory is in explaining the study phenomenon by interpreting what is going on and / or predicting what might happen in the substantive area. The above discussion suggested a number of ways that the theory can be utilized to enhance understanding of the transcending process and promote worth enhancing practices with suicidal young men. It can be further examined to assess the level of sense it makes to those involved in the substantive area through future dissemination. Additionally, to assess workability the theory can be discussed with others in the substantive area, therefore, a practitioner working in the field of mental health was consulted about the substantive theory. She viewed the theory as useful in terms of clinical practice with the suicidal person. In particular she was "excited" about the possibility of *"…affirming what's in front of me – the obvious"*. She also welcomed the suggestion that such validation does not need to happen within a formal psychotherapy session but can occur in a range of interactional settings. Her comment perhaps captures the simplicity of the theory in terms of everyday use, while acknowledging that there is a distinction between doing what is simple and what is easy.

Scope of theory relates to its ability to transcend the study, impacting the substantive area and beyond. The above discussion suggested some ways that the theory can influence clinical practice, training, education, policy and research, which demonstrates its scope in the substantive area. It also identified one way to develop a formal theory in the area of overcoming adversity based on a cursory glance at some literature in this area, which indicates that some similar recovery processes occur. To generate formal theory a substantive theory must undergo additional comparison and

analysis with data that takes it beyond the substantive area to a wider level. Hence, a formal theory has more applicable scope. Demonstrating how the theory can be developed in and beyond the substantive area also demonstrates its *modifiability.*

Finally, e*nduring grab* refers the sense that the theory makes to the ordinary person in terms of applicability to multiple life contexts, which can be established in further dialogue with people in contexts outside of the fields of mental health and suicidology and will ultimately be demonstrated in the life of the theory. The concept of *re-vitalizing worthiness* seems to have appeal in life contexts beyond suicidality which may serve to prolong its grab. One person, outside of the domain of mental health offered *"I can see how in my life, when certain things happened, that I had to re-vitalize my worthiness to move forward".*

Other terms have been used in the qualitative research literature to refer to similar rigour criteria. For example, s*pontaneous validity* (Kvale, 1996) refers to the relevance and consequences of the substantive theory for social and professional practice in the local context, whereas *theoretical generalizability / transferability* of the substantive theory refers to the broader relevance of the theory. As suggested local relevance can be explored through further dissemination and dialogue with those on the ground; clients and practitioners at the coalface of practice. Wider relevance can be examined through further studies, whereby transferability can be confirmed, refuted and modified by the clinical practice and research communities.

The resonances of some of the psychosocial processes incorporated into *re-vitalizing worthiness in transcending suicidality*, with processes associated with recovery and healing in overcoming life adversities and mental health problems, lends *credibility* to study findings. However, the substantive theory has also identified aspects of transcending suicidality that have not been identified in the literature, in particular the centrality of regaining worthiness in this process. This suggests that there may be central processes, such as identity re-invention, in overcoming adversity and pain that transcend the substantive area and have value and applicability throughout the domain of psychosocial health, while there are also specific processes that relate to suicidality among young men. Furthermore, highlighting the centrality of *re-vitalizing worthiness* in the transcending process provides and overall theoretical framework for

understanding this process and engaging with the suicidal young man, while the sub-processes described therein provides a concept based model for specific social and professional action.

Limitations of the Study

No study would be complete without considering its *limitations*. There are limitations to all studies whether located in the research question, methodology, methods and / or unexpected barriers to conducting a systematic and comprehensive study. A GT study has inherent limitations in that it sets out to discover a theory in a substantive area, and therefore while it may have relevance beyond this area, this cannot be assumed without further study. Utilizing only qualitative data and an emic perspective limits the study to a small and specific sample, in this instance young men in Ireland who had been suicidal and had engaged with mental health services.

While the sample was homogenous in terms of age range, gender, and involvement with mental health services, it was heterogeneous in terms of suicidal status. Participants spanned the range of suicidality presentations that typically present in mental health and other services, from suicidal ideation to multiple repeated suicide attempts. Participants, both self-selected to partake in the study (n=6) and were invited by practitioners in the participating site to do so (n=11), which means that some who met the criteria and saw the invitation poster did not volunteer to participate and some who were involved with this particular service may not have been informed about the study. Therefore, one needs to consider how this selection process might have influenced theory development. Therefore, it is also worthwhile asking what the theory might have centred on had the sample been more diverse. Finally, the study did not incorporate the views those working with suicidal young men which might have contributed a richer perspective on the issues involved. However, to expand the sample in this way would have compromised the possibility of generating an emically based substantive theory and would perhaps have generated a theory associated more with the helping process than the transcendent process, while both are related. Finally, saturation is a somewhat subjective concept influenced by multiple factors, hence, ‘enough for now’ in the context of this study might look different at another time.

In summary, having increased the diversity of and subjected the emergent theory to standard research rigour criteria and considered some of its limitations the researcher is satisfied that the substantive theory that has emerged in this study adds to the field of suicidology, specifically it explains how young men in contemporary Ireland transcend suicidality. It meets the rigour criteria for a sound grounded theory, however, those who learn about it can also offer further critique.

Reflection on the Study and Personal Learning – If I were starting again?

A number of challenges arose during the course of conducting this study upon which the author will briefly comment. If she had the opportunity to repeat the study she would have done some things differently while being confirmed in how other aspects of the study were conducted.

There were barriers that influenced recruitment, which perhaps reflected social apprehension and ambivalence about the topic and the research population dominated by a culture of paternalistic self and other protection. Anticipating these barriers in advance might have influenced the researcher to incorporate other methods of accessing and recruiting participants. For example, relying on specific services meant that gate-keeping practices may have impacted selection of invited participants, while use the poster method at the outset may have accessed a wider population of potential participants. This could also have expanded data gathering and analysis processes at an earlier stage in the study, thereby leaving more time latterly for reflection and write-up. Obtaining the accounts of young men in more creative ways such as through the internet and / or email communication, may have made participation more attractive to some potential participants by protecting them from the fear of self exposure.

Adherence to the classic method of GT in this study was both challenging and rewarding. Entering the field with an open agenda meant that patience and open-mindedness was required in order to allow the core concern and core category to emerge, without forcing. There was much forward and backward movement within this process and multiple temptations to bring closure to the process prematurely. Engagement with the young men as the theory emerged and being mindful of the fine

balance between exploring and leading was also challenging. On reviewing interviews the researcher identified a number of inquiry lines that were not pursued and / or were concluded quickly, and indeed others that were pursued beyond redundancy. However, persisting with the method, facilitated by encouragement and support from supervisors and personal communications with Dr. Glaser (Glaser, 2008, 2009) and others in GT seminars, proved worthwhile and indeed the theory did emerge. Furthermore, the substantive theory related to a specific and significant aspect of suicidality, the transcending process, which was unanticipated at the outset demonstrating its fit with the data and contributing to the field of suicidology.

11.4 Summary: Mirrors and Reflections

This study was concerned with suicide-ality among young men in contemporary Ireland and aimed to generate a substantive theory that could be utilized to inform practice, particularly in the field of mental health. The study met this objective and offers a theory on how young men transcend suicidality through re-vitalizing their worthiness. It meets the criteria for a robust GT study in terms discovering a grounded substantive theory, *re-vitalizing worthiness in transcending suicidality*, that contributes significantly to the fields of suicidology and mental health.

The theory promotes understanding of the transcending suicidality process, describing in-depth the core processes involved in the transition from living to die to living to live and die. This theory can inform the domains of clinical practice, professional training and education, policy development and research within the field, in addition to social practice. Given the current status of suicide-ality within the domain of mental health it may be particularly relevant to this area, although there is also scope for application at social and non mental health levels. The substantive theory adds to understanding of how transcending suicidality can be facilitated highlighting helpful and unhelpful values, beliefs and practices that underpin professional responses to suicidal young men, thereby providing a concept based model for engagement.

This is a complex area and some aspects of the re-vitalizing process are worthy of further study. There is opportunity for further research that could elaborate the scope of the theory and this study lays the foundation for a formal theory on overcoming

adversity / recovery. Despite the fact that government policy encapsulated many of the values and practices identified as helpful in this study, the study also raised some issues for policy development and reconsideration. For example, rethinking policy emphasis, which has been influential in supporting the dominant medico-legal discourse that privileges exclusionary and restrictive social and professional practices, ironically furthering invalidation and unworthiness. It has also reconfirmed the gap between espoused and lived values in policy, theory and practice.

It can be hypothesized from the above discussion that the processes inherent in suicidality as described by the young men mirror and are reflected in the responses they receive at micro and macro levels in society. These are frequently dominated by fear of the unknown and the unacceptable, particularly self appointed death. Indeed, the research process itself mirrored many of the dilemmas of the young men, for example, the yearning for clarity and certainty, the movement between hope and despair for a final outcome and emergence of a clear product, and the accompanying sense of worthiness in transcending these challenges.

Despite identification of negative response patterns the substantive theory inspires hope. These young men demonstrated that reclaiming worthiness in order to transcend suicidality is possible and that this process can be facilitated in multiple ways, thereby issuing an invitation for meaningful engagement with them on their journey. On this optimistic yet challenging note the thesis will close with some uplifting comments form some the young men who contributed to the study.

"I made a good recovery...I realized that my expectations of what counted as the good life, or whatever, had changed. That is about it really...There was a possibility of light at the end of the tunnel.."

"In terms of motivation, I think that it is pretty much now moving forward…So there is light at the end of the tunnel."

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Appendices

Appendix 1: Participant Invitation Poster

Suicide and Young Men in Ireland – Can You Help?

Dublin City University (DCU) is conducting research into the experiences of young men who have been suicidal to gain a better understanding of their needs in order to improve health services for this group.

If you are:

- *Male*
- *aged 16-35years*
- *and have thought about or acted with the intention of suicide*

We would welcome the opportunity to talk to you about:

- *Your experiences of being suicidal, and,*
- *What you found helpful and unhelpful when you were feeling suicidal*

Taking part in this study means that you will have the opportunity to voice your ideas about important issues affecting young men in Ireland today and contribute to the improvement of health services for people who are feeling suicidal.

If you wish to take part in this study please contact:
Evelyn on 087 – 9806585 for further information and to arrange a confidential one-to-one meeting.

Many thanks for your help

Appendix 2a: Participant Information Sheet

Participant Information Sheet

Study Title:

Providing Meaningful Care: Learning from the Experiences of Suicidal Men to Inform Mental Health Care Services

Conducted by: The School of Nursing, Dublin City University.

Principal Investigator: Prof. Chris Stevenson
Tel: 7006581

Principal Researcher: Ms. Evelyn Gordon
Tel: 087 - 9806585

What is the study about?

The study aims to gain a better understanding of the views and experiences of suicidal young Irish men, aged 16-34years, in order to inform professionals about how best to respond to the suicidal person and in how to appropriately organize services. Therefore, we would welcome your views about; 1) your experiences of being suicidal, and 2) what you found helpful and unhelpful when you were feeling suicidal.

What will you be asked to do?

Invitations to participate in the study are being made through a number of channels including health services and poster invitation. If you wish to respond to this invitation but still have some questions about what the study involves you can gain more information by talking with the principal researcher, Evelyn, at 087 - 9806585. If you decide to proceed with the interview this will involve a one-to-one discussion with you about your experiences of being suicidal and what you found helpful and unhelpful during this time and your experiences of seeking and availing of professional help. The interview will take about 1.5 hours to complete. Interviews

will be held at a quiet and comfortable location as agreed between yourself and the principal researcher and will be tape-recorded.

Participation in this study is voluntary therefore you can decide to withdraw at any time during the study process without explanation. If you withdraw from the study you will not be discriminated against in any way and you will be given equal access to information and support services. In the event that you become distressed or present as being at risk to yourself or another person during your involvement in the study the researcher will take steps to ensure your safety and well-being. This could include terminating the interview, contacting a professional involved with your care and / or an agreed other, for example a family member.

What are the benefits and risks in participating?

Potential Benefits to Participants Include:

- Voicing your views and experiences to an interested person, and identifying your current needs and wishes.
- Receiving information about local support services.
- Informing professionals about how best to respond to the suicidal person.

Potential Risks to Participants Include:

You could become distressed in the interview by recalling painful personal events and memories. Should this occur the researcher will discuss with you how you wish to proceed.

Who will have access to the information that you share?

Anonymity of participants and confidentiality of interview material will be safeguarded through a number of measures, including:

- Tape-recorded material will be transferred to a password protected computer package for storage and retrieval.
- Only those working on the research team, and named above, will have access to this material.

- Signed consent forms will be stored in a locked filing cabinet and will not carry any identifying codes that connect individuals to specific recorded data.
- No information identifying an individual person or organization will be used in documentation about to the study.

Study material will be subject to legal limitations, which means that it could be subject to subpoena, a freedom of information request or mandated reporting by a professional. This would be necessary if you were deemed to be at risk of harm to yourself, or if you disclosed information that indicated that you presented a potential risk of harm to, or had inflicted actual harm on another person.

NB If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee. C/o Office of the Vice-President for Research, Dublin City University, D. 9.

Tel: 01-7008000

Appendix 2b: Participant Consent Form

Participant Consent Form

Study Title:

Providing Meaningful Care: Learning from the Experiences of Suicidal Men to Inform Mental Health Care Services

What is the purpose of the study?

This study aims to obtain a comprehensive understanding of the experiences and perceptions of suicidal men aged between 16 and 34 years of age to inform Mental Health Services in the Republic of Ireland. This is a critical health care concern given the high increase in suicide by men in this age group and the high rate of attempted suicide. It is anticipated that this study will contribute significantly to existing professional knowledge and practice.

What will you be asked to do?

Participation in this study involves; talking about your readiness to discuss your personal experiences and the consequences that this might have for you at that time; completing some questionnaires that describe your experiences of being suicidal; and, completing and signing this consent form.

The interview will last between 1-2 hours and will be tape-recorded. If you do not wish to have the interview tape-recorded the researcher will take notes during the interview. You can decide on the nature and depth of information you share and you may terminate the interview at any time without explanation. If you choose to withdraw at any time in the study process you will be supported in this decision and will be given equal access to information and support services.

Participant Confirmation:

(Please answer each question)

Have you read or had read to you the Information Sheet?	Yes / No
Do you understand the information provided to you?	Yes / No
Have you had any opportunity to ask questions and discuss the study?	Yes / No
Have you received satisfactory answers to your questions?	Yes / No
Are you agreeable to having your interview audio taped?	Yes / No
Or Are you agreeable to the researcher taking notes during the interview?	Yes / No
Are you agreeable to further contact from the research team?	Yes / No

Participant Signature:

I have read and understood the information in this form and the attached information sheet. The researcher has adequately answered my questions and I have a copy of the consent form. Therefore, I consent to participate in this research project.

Participant Signature:___________________________________

Name in Block Capitals:_________________________________

Witness:____

Date:____

Appendix 3: Participant Profile

Key

ID No. – Participant ID Number

Marital status: Single – Unmarried and not co-habiting, CoH – Unmarried and co-habiting with partner, Sep. – Separated following marriage

Ed Level (Educational Level Attained): Primary level – did not progress to second level, Pre J. Cert – did not sit Junior Cert but progressed past Primary level education, J. Cert – sat Junior Certificate Examinations, Pre L. Cert – did not sit Leaving Cert but progressed past Junior Cert, L. Cert- sat Leaving Certificate Examinations, O levels – sat O Levels Examinations (UK), 3rd level – progressed to 3rd level (University, Institute of Technology)

Work: Prof. – Professional Position, Semi-prof. – Semi Professional Position, Skilled – Tradesperson, Manual – Unskilled Labourer, D/P – Disability Pension, U/E – Unemployment Benefit

Table 3.1: Participant Profile

ID No	Age	Marital status	Offspring	Ed. level	Work	Suicide attempts	Duration of MH service contact
1	27	S	1	Pre L. Cert	U/E	2	6 months
2	25	S	0	Pre O level	Manual	1	6 weeks
3	26	S	0	3rd level	Prof	1	6 months
4	26	CoH	2	Pre L. Cert	Manual	3	6 weeks
5	20	S	0	3rd level	Student	1	6 years
6	30	S	0	3rd level	Student	1	6 years
7	32	S	1	J. Cert	U/E	1	1 year
8	26	S	0	L. Cert	Semi-Prof	2	8 years
9	21	S	0	Primary	Manual	6	4 years
10	26	S	0	3rd level	Skilled	0	6 weeks
11	30	S	0	Pre J. Cert	D/P	20	17 years
12	32	S	0	3rd level	D/P	12	2 years
13	21	S	0	3rd level	Student	5	4 years
14	19	S	0	3rd level	Student	1	4 weeks
15	21	Sep	0	L. Cert	Prof	1	6 weeks
16	34	S	0	3rd level	Prof	0	6 years
17	22	S	0	3rd level	Student	1	6 weeks

Appendix 4a: Theoretical Memo

Theoretical Memo: 'Soothing the Pain' – March 2008

The young men in the study described experiencing severe emotional / psychological pain. This pain became 'unbearable' and overwhelming at times, resulting a desire to 'escape', or 'numb' the pain. Soothing the pain was achieved by numbing and distracting mechanisms. This involved engagement in self-destructive behaviours that included excessive alcohol consumption, prescribed and un-prescribed drug misuse, and dangerous driving. Passive self-destructive and dangerous activities were common and understood as 'trying to die' in a more respectable way, perhaps appearing to be 'accidental' rather than intentional death. Gradually these young men 'lost hope' for a better life and felt 'helpless' to bring about change in their lives, making suicide the 'only option', as a life without 'purpose' and 'meaning' was 'not a life'. However, given the moral and social 'stigma' associated with suicide they remained silent about their concerns and somewhat ambivalent about the status of the act, wondering if it were a 'cowardly or brave' act.

The pattern described here resonates with a number of theoretical ideas including: Shneidmans' notion of *'psychache'* or unbearable psychological pain experienced in suicidality and his idea that suicide is sometimes based on a desire to escape life rather than to die; Beck's idea about the important place of '*hopelessness'* in depression and suicidality; and, Menninger's' idea about an active or passive *'death wish'*.

This pattern links with some other 'escape' processes, such as 'denial' whereby a 'masking' process occurs when the young men 'fear exposure' of their private selves (real selves); and the 'closing in' that happens when they see their options been restricted, leading to feelings of being 'trapped'.

It also highlights the place that *'stigma'* plays in restricting the option for these young men to disclose their distress for fear of being judged negatively; ironically, this also

keeps them alive. The centrality of *'ambivalence'* in suicidality is also highlighted which might be understood in terms of their pull between life and death, and as a mechanism that kept them alive, as some reported great *'relief'* in making the decision to kill themselves. These are areas that might be considered more centrally in working with the suicidal person as resources for living and areas for therapeutic leverage.

Appendix 4b: Field Note

Field Notes – Interview 2

Engagement in interview - Set the scene – pacing 'I'm not a talker', 'don't push me'. Readiness – no expressed anxiety about talking.

Motivation – reciprocity, wants to help others, pay back for help received.

Current situation - now has service and other support. Hopeful regarding the future.

Abstracted Categories:

What is going on in substantive area?

Survival, staying alive, gaining control over life and death.

What are the main concerns of these men?

Overcoming disappointing self and others – guilt, shame i.e. the sins of omission that were being punished. There seems to be a movement from intense fear of death / life and desire to escape from life, to blanking the fear out and then trying to live instead of die. This seems to be a shift from fighting their selves and their worlds to fighting death.

Escape from it – blank it out until it blanks you out – then 'fight' it not self.