Understanding the drivers of suicide: Its influences and its functions

by

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S., Irkutsk State University, 2010
M.S., East-Siberian State Academy of Education, 2013
M.S., Valdosta State University, 2018

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Applied Human Sciences
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KANSAS STATE UNIVERSITY
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Abstract

Suicide continues to be one of the biggest concerns in modern society globally. The understanding of suicide and suicidal ideation has evolved over time and yet there is still a lot of unknowns in how to assess, predict, and prevent suicide from happening. Continued research on suicidal ideation and behavior is essential to increase our understanding of its drivers and identify new prevention strategies. This qualitative study analyzed data on indirect and direct suicidal drivers from 35 adult participants who self-report as having suicidal ideation. Thematic analysis uncovered seven distinct themes that reflect the types of suicidal drivers experienced by participants with active and passive suicidal ideation: being a liability, feeling alienated, perceived defectiveness, low self-worth, emotional anguish, health issues, and external stressors. Some of these suicidal drivers were self-imposed while others were other-imposed. The study explored the function of suicide for participants and identified them as to provide relief, as a form of self-punishment, and to gain control. Implications for practice, policy, and research are discussed.

Keywords: suicidal drivers, suicidal ideation, thwarted belongingness, perceived burdensomeness

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Suicide continues to be one of the biggest concerns in modern society globally. The understanding of suicide and suicidal ideation has evolved over time and yet there is still a lot of unknowns in how to assess, predict, and prevent suicide from happening. Continued research on suicidal ideation and behavior is essential to increase our understanding of its drivers and identify new prevention strategies. This qualitative study analyzed data on indirect and direct suicidal drivers from 35 adult participants who self-report as having suicidal ideation. Thematic analysis uncovered seven distinct themes that reflect the types of suicidal drivers experience by participants with active and passive suicidal ideation: being a liability, feeling alienated, perceived defectiveness, low self-worth, emotional anguish, health issues, and external stressors. Some of these suicidal drivers were self-imposed while others were other-imposed. The study explored the function of suicide for participants and identified them as to provide relief, as a form of self-punishment, and to gain control. Implications for practice, policy, and research are discussed.

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Chapter 1 - Introduction

Suicide continues to be one of the biggest concerns in modern society globally. According to the World Health Organization (World Health Organization, 2019), approximately 800,000 people die by suicide yearly with many more attempting suicide. In the USA alone, there has been a 35% increase in suicides from 1999 to 2018 despite the growing body of research and continuous national effort in suicide prevention (Centers for Disease Control and Prevention [CDC], 2020; Ehlman et al., 2022). The research on suicide has been ongoing for decades with the first published research dating 1825 (Parkhurst, 1825). The understanding of suicide and suicidal ideation has evolved over time yet there is still many unknowns in how to assess, predict, and prevent suicide from happening.

Continued research on suicidal ideation and behavior is essential to understand its drivers and identify new prevention strategies. One of the main strategies of suicide prevention is related to the identification of risk factors. Risk factors are defined as personal conditions that would increase the probability of someone taking their life (American Foundation for Suicide Prevention [AFSP], 2022). Besides risk factors, AFSP also defines warning signs that are related to behavioral changes or the emergence of new behaviors, and recommends paying particular attention when multiple warning signs are present, especially when there are co-occurring traumatic or painful events. Equally important in the prevention of suicide are protective factors, which could prevent or reduce the probability of suicidal behavior and constitute positive forces in a person's life (AFSP, n.d.). According to the WHO (2019), "the identification of risk and protective factors is a key component of a national suicide prevention strategy, and can help determine the nature and type of interventions required" (p. 13).

Despite decades of research focused on identifying conceptual frameworks, risk and protective factors, most vulnerable populations, prediction, prevention, and treatment strategies, suicidality research is still considered to be in the pre-paradigmatic state (Franklin et al., 2017). Among the main critiques of the existing body of literature is the emphasis on individual risk factors, the confusion about terminology and lack of distinction between active and passive suicidal ideation, suicidal attempt, and completed suicide, lack of predictive power in existing risk factors, and a lack of a dominant theory/paradigm that would account for variation in the outcome.

A well-researched and applied theory that illustrates main contributors to suicidal thoughts and behavior is the Interpersonal Theory of Suicide (IPTS; Joiner, 2005). Joiner identified the main contributors to suicidality (see Figure 1). Accordingly, perceived burdensomeness and thwarted belongingness contribute to suicidal ideation and the addition of capability of suicide contribute to suicidal behavior.

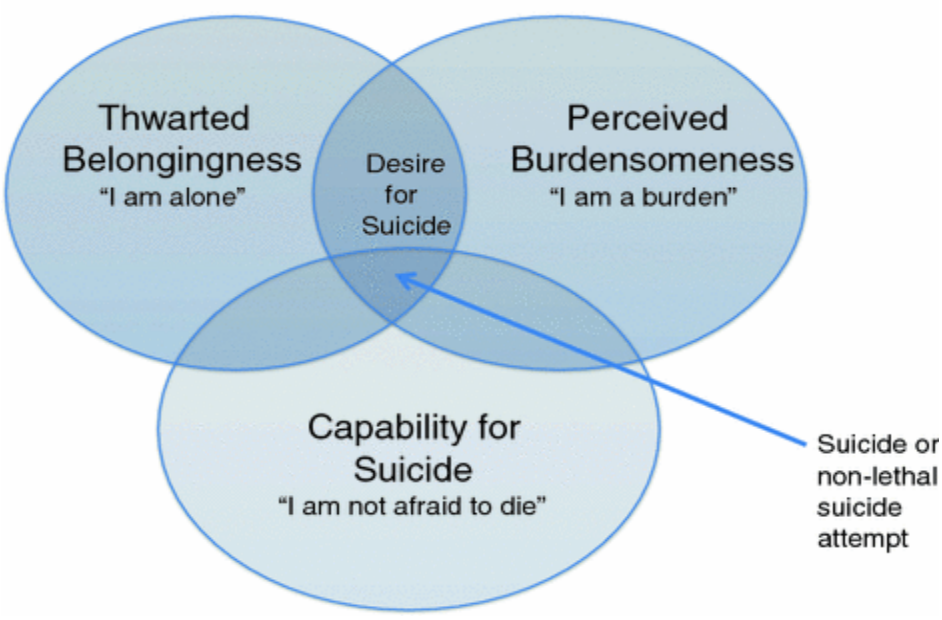

Figure 1.1. The Interpersonal Theory of Suicide (Joiner, 2005)

A recent development in the treatment of suicide, known as Collaborative Assessment and Management of Suicidality [CAMS], focuses on identifying and treating suicidal drivers, which describes patient-defined problems that make suicide compelling (Jobes, 2017). In other words, suicidal drivers are stress factors that have been internalized and that lead to the development of or elevated suicidal ideation. We propose that these stress factors could manifest as perceived burdensomeness and thwarted belongingness.

Suicidal drivers can be direct or indirect depending on their effect on suicidal ideation. As the term implies, direct drivers have a direct link to the desire to die, whereas indirect drivers serve as the springboard for suicidal ideation by increasing the vulnerability to stress (Jobes, 2017). For example, unemployment could exarcebate interpersonal conflict that could then lead to a sense of failure, which in turn could conjure the desire for death. Here, unemployment is the indirect driver while the sense of failure is the direct driver because it is linked to thoughts of suicide.

Despite efforts to identify and distinguish contributors to suicide, little is known about suicidal drivers or about how best to treat suicidal drivers that, according to CAMS, lead to suicidal ideation. To date, only two studies have examined suicidal drivers using IPTS as a framework, whereby thwarted belongingness and perceived burdensomness were conceptualized as direct suicidal drivers in the case study of two adolescents with previous suicide attempts and a quantitative study of 134 veteran service members with suicidal ideation (O'Connor et al., 2014, 2017). This study aims to explore suicidal drivers using the framework of IPTS (Joiner et al., 2009), to better understand the ways in which perceived burdensomeness and thwarted belongingness combine to lead to suicidal ideation and its drivers. It will explore how individuals

make sense of their suicidal ideation by critically applying existing theory on suicidality and could provide clinicians a better understanding of how to treat and prevent suicidality.

Definitions of Concepts

Active and Passive Suicidal Ideation

Suicidal ideation is considered one of the leading predictors for future suicidal ideation and future deaths by suicide, Hence, it is important to distinguish between active and passive suicidal ideation (Franklin et al., 2017). Active suicidal ideation is related to "the desire to kill oneself" while passive suicidal ideation is in an essence "a desire to be dead" (Liu et al., 2020). In other words, someone with active suicidal ideation would have a desire to act on their thoughts while people with passive suicidal ideation would wish for something, an outside force, to end their suffering. It is important to note that passive suicidal ideation cannot be considered as less severe and ultimately might have a deadly outcome as well as an active suicidal ideation (Liu et al., 2020). For the purpose of the study, we would consider both participants with active and passive suicidal ideation, and we would draw a distinction between the two. We would also use the terms of active suicidal ideation and suicidal intent interchangeably.

Suicidal Attempt and Suicide Plan

Suicidal attempt is defined as a purposeful engagement in an activity that could lead to a potential harm to one's well-being with or without intent to die (Franklin et al., 2017; Nock et al., 2010). In other words, suicidal attempt is a behavior that could lead to self-injury and could be either accompanied by the intention to die or the intention to affect someone else if suicidal attempt was not meant to end one's own life. In this study, some of the participants had previous suicide attempts, which is considered a second leading predictor of future suicide attempts and death by suicide (Franklin et al., 2017; Nock et al., 2010). Suicide plan is defined as a

"consideration of a specific method through which a person intends to kill oneself" (Franklin et al., 2017, p. 192).

Suicidal Drivers

Suicidal drivers were first described as issues that make suicide a desirable choice (Jobes et al., 2019). In CAMS, suicidal drivers are identified by the client and become the main focus of treatment. ***Direct suicidal drivers*** lead to the desire for death. These drivers include specific thoughts, emotions, behaviors, and themes. ***Indirect drivers*** on the other hand, are underlying factors that contribute, but do not necessarily lead, to actual thoughts or feelings of suicide. However, indirect drivers could become catalysts for the emergence of direct suicidal drivers. Some examples of indirect drivers include mental health disorders, interpersonal conflict, being homeless, and being isolated (Jobes, 2016).

Chapter 2 – Literature Review and Theoretical Framework

There are multiple theories that attempt to explain suicide from a biological standpoint that considers suicide a brain abnormality (Pandey, 2013), sociological standpoint that links suicide to societal forces and social integration issues (Wray et al., 2011), and psychological standpoint that views suicide as a complex and contextual phenomenon that is uniquely represented in different people (Franklin et al., 2017). Among psychological theories of suicide, ideation-to-action theories deserve special attention because they are among the few theories that currently exist in the field that draw a distinction between passive and active suicidal ideation, suicidal attempt and completed suicide -- terms that are distinct and should not be used interchangeably (Klonsky et al., 2016). Within this ideation-to-action framework, Joiner's IPTS is considered one of the most researched and influential (Chu et al., 2017; Joiner, 2005; Klonsky et al., 2018; Ma et al., 2016; Van Orden et al., 2010). Other theories from within ideation-to-action framework include Three-step Theory (3ST; Klonsky & May, 2015), Integrated Motivational-Volitional Model (IMVM; O'Connor & Kirtley, 2018), and Fluid Vulnerability Theory (FVT; Rudd, 2006) all of which follow the main premise that "the development of suicidal ideation and the progression from suicide desire to attempts are distinct processes with distinct explanations" (Klonsky et al., 2018, p. 38).

Interpersonal Theory of Suicide

In order to address the above mentioned needs and limitations of research on suicidality, this study will utilize the Interpersonal Theory of Suicide (IPTS) as a theoretical framework. This theory has been recognized as one of the most influential, promising, and empirically tested theories of suicide (Joiner, 2005; Joiner et al., 2009; Klonsky et al., 2018; Ma et al., 2016; May & Klonsky, 2016). Since its original creation by Thomas Joiner in 2005, researchers have tested

part of the theory, or the theory as a whole, and found its claims to be generally substantiated (Chu et al., 2017; Joiner et al., 2009; Van Orden et al., 2008, 2010, 2012). Yet, as with any theory, IPTS has been also critiqued on the basis of vague and hard to test theoretical concepts, lack of consideration for contextual factors, and reductionist thinking (Hjelmeland & Knizek, 2010).

The key assumption of the theory is that "people dye by suicide because they can and because they want to" (Van Orden et al., 2010, p. 581). In other words, in order for suicidal behavior to occur both capability and desire for suicide should be present in one person at the same time (Ribeiro & Joiner, 2009). IPTS is based on three theoretical concepts: perceived burdensomeness which entails an imaginable feeling of being a burden to people around, thwarted belongingness that is understood as inability to build or sustain connections, and capability of suicide which is an ability to implement suicidal behavior (Joiner, 2005). Joiner presents these concepts as interconnected and proposes the conditions under which the presence of these in someone's life will constitute suicidal desire or suicidal behavior: the simultaneous presence of perceived burdensomeness and thwarted belongingness could culminate to active suicide desire. The addition of capability for suicide to the feelings of perceived burdensomeness and thwarted belongingness is what leads to suicidal behavior. The distinction between active and passive suicidal desire, and suicidal behavior which has been generally overlooked in the literature, is an extremely important component of the theory.

Perceived Burdensomeness

Perceived burdensomeness is an interpersonal state that is related to the faulty feeling of being a burden to others, or "feeling so incompetent as to be a liability for others" (Joiner et al., 2009, p. 457). Perceived burdensomeness is a major risk factor of suicidal desire, especially

combined with thwarted belongingness (Ribeiro & Joiner, 2009). Multiple studies have found a strong association between perceived burdensomeness and suicidal ideation and behavior. Perceived burdensomeness was found to be a predictor of suicidal attempts in adult outpatients of a psychological hospital (Van Orden et al., 2006), and moderator and mediator between risk/protective factors and suicidal ideation and behavior in clinical samples (Hill & Pettit, 2014). Perceived burdensomeness was further found to be significantly correlated with death by suicide and choice of more deadly means (Joiner, 2005). The positive associations between perceived burdensomeness and suicidal ideation were found across demographic, occupational, and mental health states including young adults and college students (Lockman & Servaty-Seib, 2016), middle aged adults in outpatient clinical settings (Van Orden et al., 2006), people in late adulthood stage of life (Cukrowicz et al., 2011), people with chronic pain (Kanzler et al., 2012), and deployed military personnel (Bryan et al., 2012).

Some of the main contributors to perceived burdensomeness included low self-esteem, feeling unwanted, and stressful life events such as losing a job, becoming homeless, and getting sick to name a few (Ma et al., 2016; Van Orden et al., 2010). According to the IPTS, perceived burdensomeness alone can contribute to passive suicidal desire that could manifest in a feeling that someone would be better off dead, but it would require a simultaneous presence of thwarted belongingness for suicidal desire to become active (Van Orden et al., 2010).

Thwarted Belongingness

Thwarted belongingness refers to an interpersonal state of disconnection and feeling alienated from loved ones, significant others, friends, and other important people in a person's life (Joiner, 2005; Joiner et al., 2009). Thwarted belongingness causes a person to feel lonely and separated from others, and lacking meaningful connections with people (Ma et al., 2016; Ribeiro

& Joiner, 2009). Because the desire for connection is one of the most fundamental needs in a person's life, when unmet, isolation can set in (Van Orden et al., 2012). Thwarted belongingness is considered a major risk factor in developing suicidal desire that can become actualized with the presence of perceived burdensomeness (Ribeiro & Joiner, 2009). Thwarted belongingness alone and in combination with perceived burdensomeness has been found to have positive associations with suicidal ideation and behavior. In particular, thwarted belongingness has been found to be positively correlated with suicidal ideation and suicide attempts in adult patients with opiate dependence (Conner et al., 2007), college undergraduate students (Kwan et al., 2017; Lockman & Servaty-Seib, 2016), adults receiving outpatient therapy (Teismann et al., 2017), adolescents (Hill & Pettit, 2014), and older adults (Kinory et al., 2020). Some of the main contributors to thwarted belongingness were identified as living alone, low social support, and feeling lonely (Ribeiro & Joiner, 2009; Van Orden et al., 2012). Thus, even though thwarted belongingness is associated with suicidal desire by itself, the IPTS theory proposes that only combination and simultaneous presence of thwarted belongingness with perceived burdensomeness would contribute to active suicidal desire (Ribeiro & Joiner, 2009).

Thus, experiencing thwarted belongingness and perceived burdensomeness could result in active suicidal desire (Ma et al., 2016; Ribeiro & Joiner, 2009; Van Orden et al., 2010). The desire for suicide, however, is distinct from the capability for suicide (Joiner, 2005).

Capability for Suicide

According to Joiner's (2005) IPTS, all people have an intrinsic fear of death and pain. Joiner proposes that no one is born with the capability for suicide but rather it is acquired over time. In order to acquire the capability for suicide, the fear of death and pain need to be suppressed or lost prior to suicidal behavior. This fear can be suppressed through life experiences

of intense physical and emotional suffering that eventually extends the ability to tolerate pain (Joiner, 2005). The simultaneous presence of thwarted belongingness and perceived burdensomeness, along with the acquired capability for suicide, that constitutes increased pain tolerance and reduced fear of death, is sufficient for suicidal behavior to emerge (Van Orden et al., 2010). There is empirical evidence confirming that acquired capability of suicide is associated with past suicide attempts and suicidal behavior after military service and combat experiences (Bryan et al., 2010, 2012), exposure to traumatic events (Spitzer et al., 2018), increased pain tolerance and fearlessness of pain (Wachtel et al., 2015), violent video gaming experiences (Förtsch et al., 2021), restrictive eating and fasting (Zuromski & Witte, 2015), and fearlessness of death (Seo & Kwon, 2018).

It is important to note that there are two major limitations to the above mentioned studies. First, the majority of studies only tested one or two components of the IPTS and not the theory in its entirety. In addition, even though IPTS provides a clear distinction between active and passive suicidal ideation, suicidal attempts, and completed suicide, the majority of studies focused on suicidal ideation without distinguishing the terms, which can affect the results (Hjelmeland & Loa Knizek, 2020). Therefore, there is a need to examine the effectiveness and potential utility of the IPTS in its entirety (i.e., all three components) and make a clear distinction between suicidal thoughts and behavior.

The Three-Step Theory of Suicide

The 3ST (Klonsky & May, 2015) suggests a three step process of progression from suicidal thoughts to suicidal behavior. The first step incorporates the feelings of pain (emotional, physical) and hopelessness that combined would constitute passive suicidal desire. At this step, the theory views connectedness as a protective factor that could prevent a person from

progression to active suicidal desire. The second step happens when the feelings of pain and hopelessness overpower the sense of connectedness. If that happens, passive suicidal desire transforms into active desire. The third step is when active suicidal desire transforms into suicide behavior and it requires the presence of capability for suicide which includes multiple facets such as acess to means, increased pain tolerance, lack of fear of death, etc. (Klonsky et al., 2016, 2018; Klonsky & May, 2015). Its claims appear to be very promising. For example, pain and hopelessness were found to be some of the strongest drivers of suicide in adolescents (May et al., 2016) and U.S. adults with suicidal ideation regardless of gender and across different age groups (Klonsky & May, 2015).

The Integrated Motivational-Volitional Model of Suicide

The IMVM (O'Connor & Kirtley, 2018) suggests that progression from suicidal thoughts to behaviors comes in two distinct phases: motivational and volitional. During the motivational phase, feelings of defeat and entrapment result in the development of suicidal ideation. During the volitional phase, such factors as capability of suicide, access to means, impulsivity, planning, and others govern the progression of suicidal ideation into suicidal behavior (Klonsky et al., 2018; R. C. O'Connor & Kirtley, 2018). These claims were validated in several recent studies involving such diverse samples as psychiatric inpatients (Lucht et al., 2020), U.S. adults (Moscardini et al., 2022), German healthy adults (Stenzel et al., 2020), young adults in Spain (Ordóñez-Carrasco et al., 2021), and LGBTQ+ young adults in the United Kingdom (Rasmussen et al., 2021).

The Fluid Vulnerability Theory of Suicide

The FVT (Rudd, 2006) suggests that transition from suicidal ideation to suicidal behavior is dependent on unique vulnerabilities a person posessess. The interplay between risk and

protective factors in this theory is seen as a fluid and interdependent process with a general differentiation between static risk factors (genetics, race, socioeconomic status, etc.) and dynamic risk factors (level of support, stress, etc.) with static factors having a greater effect on vulnerability to suicide (Rudd, 2006; Bryan & Rudd, 2016). The theory distinguishes four risk domains: cognitive, behavioral, affective, and psychological with "transition from suicidal thoughts to behaviors occur(ing) as a result of coordinated change processes among multiple domains of risk" (Bryan & Rudd, 2016, p. 24). The FVT was used as a framework for several studies on U.S. active duty soldiers with suicidal ideation (Bryan et al., 2016, 2018; Bryan & Rudd, 2018) with its claims found to be generally supported.

Risk Factors for Suicide

Similar to the theories of suicide, the risk factors for suicide is equally broad. For example, the WHO (2012) identified risk factors that span the individual, socio-cultural, and situation. The AFSP's classification includes health, environmental, and historical risk factors along with warning signs that, if present, represent a more immediate concern for potential suicidal behavior (n.d.). According to the recent meta-analysis of 365 studies on risk factors for suicidal thoughts and behaviors, the majority of risk factors that have been studied in the past 50 years fall within the following 5 categories that account for nearly 80% of risk factors across the lifespan: prior psychiatric hospitalization, prior suicide attempt, prior suicide ideation, socioeconomic status, and stressful life events (Franklin et al., 2017). The authors concluded that there is limited predictive ability of these single risk factors when isolated from context and instead suggested utilizing a combination of different risk factors or so-called "risk algorithms." Their findings shifted the focus of research on suicide assessment and prevention (Franklin et al., 2017). This shift led to viewing suicide and suicidal ideation as a complex and highly

contextual phenomena that cannot be understood or predicted by identification of risk factors alone, but rather by "a complex interplay between risk factors" that might allow us to identify people who are in need of intervention (Correia & Jackson, 2021, p. 130). So rather than drawing a distinction between risk categories, it is important to consider them in their complexity within the context in which the suicidal thoughts and behaviors occur.

Function of Suicidal Thoughts and Behaviors

Several studies investigated the function of suicidal thoughts and behaviors for people with substantive evidence suggesting the mood regulation function of suicidal thoughts. For example, a real-time monitoring study conducted on suicide attempters (N = 43) found such effect with participants experiencing decrease in their sadness after suicidal thoughts ocurred (Kiekens et al., 2018). Another function of suicidal thoughts is to bring comfort, and relief that appeared to be prominent in people with depression, bipolar, and unipolar disorders (Crane et al., 2012, 2014; Hales et al., 2011; Holmes et al., 2007). Some studies also discovered a self-punishing function of suicidal thoughts that appeared to be closely connected with self-harm and non-suicidal self-injury (Edmondson et al., 2016; Osuch et al., 2014; Tucker et al., 2017; Paul et al., 2015). Additionally, according to a study conducted on adolescents and young adults with history of non-suicidal self-injurous behavior (which is a predictor of suicidal behavior), four distinct functions of this behavior were determined: to distract (from negative thoughts and experiences), to induce feeling (when feeling numb), to escape (pain or suffering) , or to ask for help (Bentley et al., 2014; Nock et al., 2009). As non-suicidal self-injury is considered to be "a clear marker for suicide risk", - this same functions might be considered as potential functions for suicidal ideation and behaviors (Bentley et al., 2014; Brent, 2011; Edmondson et al., 2016; Scott et al., 2015; Wilkinson, 2011, p. 741).

Vulnerability to Suicide

According to the research published in the past decade and CDC reports, the following groups are most vulnerable to suicide: American Indian/Alaska Native and non-Hispanic White populations (Xiao & Lindsey, 2021), Black adolescents (Lindsey et al., 2019), veterans and military service members (Bachynski et al., 2012; Bossarte et al., 2014), LGBTQ+ youth (Aranmolate et al., 2017), and people living in rural areas (Bertera, 2007; Judd et al., 2006). Some of the demographical risk factors include being male, being middle-aged, and being an adolescent or young adult (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Some of the most researched protective factors mentioned in the CDC and AFSP reports are positive social connections (Bertera, 2007; Doty et al., 2017; Franklin et al., 2017), limited access to lethal means (Allchin et al., 2019; Franklin et al., 2017), positive family-of-origin environment (Bertera, 2007; Franklin et al., 2017), advanced problem-solving skills (Franklin et al., 2017;McAuliffe et al., 2003), and cultural/religious beliefs that are not supportive of suicide (Lawrence et al., 2016). There is an the overall lack of distinction between risk factors and warning signs, an important differentiation (Rudd et al., 2006).

Purpose of this Study

Some authors argue that research on suicidality is in the pre-paradigmatic phase and there is a need for qualitative testing of the existing theories to determine the ones that are most accurate and effective in the treatment of suicidal ideation (Franklin et al., 2017; Hjelmeland & Knizek, 2010; Hjelmeland & Loa Knizek, 2020). As the research community still does not fully comprehend the mechanisms and risk factors that would allow us to predict and prevent suicide from happening, we should focus on understanding the phenomenon instead of trying to explain it. Conceptualizing suicide as a “highly contextual phenomenon” that needs to be studied

qualitatively could contribute to a comprehensive understanding of this phenomenon in all its complexity (Hjelmeland & Loa Knizek, 2020, p. 170; White et al., 2016). The majority of studies on suicidality have been quantitative in nature and focused on trying to explain this phenomenon instead of making an effort to understand it, which has led to "methodological homogeny" (Franklin et al., 2017; Hjelmeland & Loa Knizek, 2020; Rogers & Apel, 2010, p. 92). This study conceptualizes suicide as a phenomena.

The intent of the study is to develop a better understanding of the phenomenon of suicidal ideation, using the IPTS concepts that are widely researched and applied to determine its potential utility in comprehending drivers for suicide. Because perceived burdensomeness and thwarted belongingness together contribute to suicidal ideation (Joiner, 2005), both these concepts were used in analysis as initial themes that guided the discovery of any matching or outstanding themes. The capability of suicide, which when added to perceived burdensomeness and thwarted belongingness leads to suicidal behavior, is not relevant in this study that focuses on suicidal ideation. The following questions guided the study:

RQ1. What do participants say are their suicidal drivers?

RQ2. How do perceived burdensomeness and thwarted belongingness explain the drivers for suicide?

RQ3. What is the function of suicide for participants?

Chapter 3 – Research Methods

A qualitative inquiry utilizing a cross-case thematic analysis was used to advance the knowledge on the multidimensional and complex phenomenon of suicidal ideation.

Data Collection

This study utilized existing data from Dr. Joyce Baptist's study, "Randomized Controlled Trial for Suicidal Ideation," that was conducted in 2019/2020. The study was conducted utilizing CAMS, an evidence-based clinical approach to assess and manage suicidality (Jobes, 2012; Jobes et al., 2015, 2020). The aim of CAMS is to encourage treatment seeking. It does in itself serve as a treatment intervention. Data from the CAMS Therapeutic Worksheets was utilized for this study (see Appendix A). These worksheets were collected at the beginning of the study before the treatment began and contained information on participants' personal theory of suicidality and their direct and indirect drivers of suicidal thoughts and behaviors. The data in this study was collected before the breakout of the COVID-19 pandemic in March 2020. I personally administered the CAMS worksheets to some of the participants in Dr. Baptist's study. All participants in the study received treatment after the CAMS assessment was completed. Participants also received followed up for up to one year after treatment concluded. The data for this study was analyzed at least 6 months after the cessation of study.

Because the data saturation was not reached by analyzing some of the worksheets due to limited information written down by therapists, the decision to listen to the recordings of sessions during which the CAMS Therapeutic Worksheets were co-created by therapists and participants was made. The analysts listened to recordings of eight participants in order to obtain more information about their suicidal drivers. Two cases had to be excluded from the analysis due to unavailability of recordings and difficulty of reading the worksheets due to

incomprehensible writing. Further considerations for ensuring the data sauturation included using “in-vivo” codes and recognition (open discussion) of the bias by researcher and co-analyst to limit its presence during analysis (Fusch & Ness, 2015).

Data did not contain the names of participants, ensuring confidentiality. It is important to note that although participants’ names were not recorded on CAMS Therapeutic Worksheets, there was some identifiable information (e.g., occupation or job position) present that was de-identified to ensure participants’ confidentiality. Both the CAMS Therapeutic Worksheets and audio recordings were stored on OneDrive and password protected with exclusive access granted to Dr. Joyce Baptist, myself, and the co-analyst.

Participants

The study participants included 37 adults who were recruited using purposeful and criterion sampling. The recruitment strategy included advertisements in the K-State newsletter, announcements in undergraduate classes, and elements of snowball sampling where existing participants referred friends to the study (Creswell & Poth, 2018; Roy et al., 2015). The criterion for participation included the presence of mild to severe suicidal ideation as determined by the Mini-International Neuropsychiatric Interview (M.I.N.I.), age 18 and above, and the ability to independently provide consent to treatment. The exclusion criteria included active psychosis, and suicidal intent requiring inpatient treatment. All 37 participants who met the criteria for the study had passive and active suicidal ideation at the time of assessment and committed to not act on suicidal impulses while in the study (Sheehan, n.d.). Participants were assessed for mental health presentations, signed Informed Consent for treatment, and completed the CAMS Therapeutic Worksheets prior to receiving psychotherapy. Due to difficulties with therapists’ writing comprehension and lack of recordings for two select cases, I excluded these cases from

the analysis. Detailed demographics of the 35 participants (12 men and 23 women) are presented in Table 1.

Table 1. *Demographic Characteristics of Participants (N=35)*

Variables		*M or %*	*SD*
Age [R = 20 to 60]		33.69	11.504
Education:	High School Diploma	2.9%	-
	Some College	34.3%	-
	Associate Degree	17.1%	-
	Bachelor's Degree	17.1%	-
	Master's Degree	28.6%	-
Employment:	Full-time	34.3%	-
	Part-time	48.6%	-
	Unemployed	14.3%	-
	On Disability	2.9%	-
Race:	White	60.0%	-
	Hispanic	5.7%	-
	Native American	2.9%	-
	Black	2.9%	-
	Biracial	25.7%	
Marital Status:	Married	34.3%	-
	Single	40.0%	-
	Dating Not Cohabitating	5.7%	-
	Cohabitating	20.0%	-

Data Analysis

We utilized cross-case thematic analysis. The purpose of thematic analysis is in "interpreting and assigning meaning to a documented pattern by giving it a thematic name, a term that connotes and interprets the implications of the pattern" (Patton, 2002, p. 805).

The co-analyst and I conducted the analysis in five steps:

Step I: I first met with the co-analyst to discuss personal experiences with suicidality and familiarize her with analysis and procedures. During that first meeting, we also analyzed the first case by simultaneously listening to the recording and organizing the first participant's statements into IPTS caterogies and other emerging categories. These categories were entered into an electronic spreadsheet. After we listened to the recording and reviewed the worksheets, we checked for consistency and I answered any questions that my co-analyst had.

Step II: The co-analyst and I then independently analyzed the remaining cases. We maintained separate spreadsheets for the categories we saw emerging from the data. For all cases, perceived burdensomeness and thwarted belongingness were used as guiding themes or categories under which we organized "in vivo" codes (using participants' language to preserve authenticity) containing participants' statements (Creswell & Poth, 2018, p. 193; Joiner, 2005). For subsequent coding we searched for any emergent patterns or themes that did not align with IPTS theory (Creswell & Poth, 2018). Our codebook contained all initial coding, main categories, and developing interpretations all in one place (see Appendix B) that significantly increased the accessibility of the data for further analysis and ensured the confidentiality of the participants (Creswell & Poth, 2018).

Step III: Once initial and subcequent coding was completed, we worked on independently identifying commonality in participants' statements and putting them in groups depending on the meaning (Creswell & Poth, 2018). Throughout the analysis, I met with co-analyst (after analyzing the 4th, 9th, 14th, 19th, 24th, 29th, and 35th case) to develop a common understanding of the codes that were used and check for consistency. Once the statements were distributed in groups depending on the meaning, we separated the themes depending on the meaning into three

separate worksheets: one each for thwarted belongingness, perceived burdensomeness, and other (see Appendix C and D).

Step IV: I worked on creating a description of participants' shared experience with suicidal drivers including textural (what was the experience like) and structural (how it was experienced) description of it (Creswell & Poth, 2018). During this step, I also met with the consultant Dr. Joyce Baptist who has expertize in this area and who was able to provide valuable feedback on interpretations of the patterns we discovered.

Step V: When the description of cases was completed and common themes were merged into broader categories, we summarized and compared the cases that did not fit either thwarted belongingness or perceived burdensome. Even though we approached the data using the IPTS framework that guided our discovery of patterns in the data, we also utilized a not-knowing stance of being open to any emerging patterns that were not included in the original framework. IPTS added direction to our interpretation of participants' experiences and helped determine that IPTS can be utilized as a framework for conceptualizing the drivers of suicide. Through that work, we also discovered additional themes of suicidal ideation and unifying categories of factors that served as functions of suicidal ideation for the participants.

Enhancing credibility and validity

It is important to ensure the credibility of the findings. There are two major ways to ensure credibility during the data analysis phase -- systematic, thorough, and responsible data analysis with consideration of alternative explanations of the findings, and researcher's credibility (Patton, 2015). We ensured credibility by being open to new information as well as actively seeking alternative explanations and opposite conclusions during data analysis that in turn allowed us to consider other possibilities that might play a role in the phenomenon of

suicidal ideation in our sample. We approached the data from a not-knowing stance that allowed us to notice different patterns and sequences in the participants' assessments (de Shazer et al., n.d.). Through that continuous effort, we were able to challenge our bias and confirm the fit of our research questions that improved the credibility of the study (Patton, 2015).

Further, we dedicated time to the analysis of the exceptional cases that did not conform to the general pattern dictated by the IPTS theory. In this case, we paid particular attention to cases that did not align with the categories of the perceived burdensomeness and thwarted belongingness. By finding and analyzing such cases, we were able to gain a better understanding of the lived experience of people struggling with suicidal ideation (Patton, 2015).

Finally, I followed the advice of Patton (2015) in constantly keeping in mind my research questions and the purpose of the study as it allowed me to approach the data analysis complexity while periodically "reconnecting with the big picture…so that analysis does not become isolated from the inquiry's overall purpose and context" (p. 954). In other words, it prevented me from getting lost in the data and analysis as I had a contextual understanding of the data with which I was working.

My credibility as a researcher is supported by my experience of working with adults struggling with suicidal thoughts for the past 3 years including my role as a Research Assistant for Dr. Baptist's study. I drew from my experience of working with this population while analyzing the data. I am also a registered intern currently acquiring hours to become a Licensed Marriage and Family Therapist with more than 1500 client contact hours. My clinical expertise is directly related to working with clients struggling with past trauma and suicidal thoughts. As a therapist, I have learned how to recognize the patterns in my clients' behaviors and I am skilled in systemic thinking that allowed me to approach the data analysis non-linearly.

As a Ph.D. Candidate, I am also familiar with qualitative methodology as I took two 3-credit graduate-level courses on this subject. Further, I have previously conducted qualitative and mixed-method research.

In order to enhance the validity of this study, I ensured the trustworthiness, dependability, confirmability, and transferability of the study as they are acknowledged as qualitative equivalents of validity (Creswell & Poth, 2018). The dependability and trustworthiness was improved by allowing a continuous inspection of the process of analysis and the study in general. In other words, another set of eyes looking at the data analysis procedures and findings allowed for multiple perspectives that is crucial for any qualitative study. This process is also called "investigator triangulation" (Creswell & Poth, 2018, p. 208). I invited one of my peers who is in the same program as I am to serve as a co-analyst. In addition, Dr. Joyce Baptist who has experience with qualitative analysis and in studying suicidality served as consultant.

The transferability and confirmability of the study could be improved through a detailed and in-depth description of the study process and the participants' experiences in order to provide information for the readers to make their own judgment about the transferability of the findings (Creswell & Poth, 2018). For that purpose, I kept detailed notes of the analysis prosess and utilized the participant statements in the analysis to provide the reader with such opportunity. Even though I considered the possibility to conduct the analysis without knowing the level of suicide risk, I opted out of this possibility due to the fact that I conducted one third of the assessments in the original study and I easily recognized the participants I worked with and remembered their level of suicide risk.

Person of the Researcher

As qualitative inquiry is highly dependent on the researcher who is doing the analysis, considering this matter is very important in order to produce an unbiased high quality analysis of the data. As a researcher, I recognized that I have a great influence on the results of the analysis and that my interpretations might be dependent on my personal bias. As an observer and interpreter of the participants' experiences, I made every effort to present the findings in utmost clear form. I strived to remain continuously mindful of the effect of my strengths and limitations on the conclusions I drew from the data (Bateson, 1999).

As for strengths, I am a therapist with more than 12 years of experience both internationally and in the United States. As a result, I have a vast majority of experiences working with people struggling with the variety of mental health presentations including suicidal ideation. Thus, I was able to utilize my skills as a therapist when analyzing the experiences of the participants and telling their stories with empathy and respect. I was able to stay empathetic and sensitive to their experiences with suicidal ideation and the meaning they make of them. As a therapist, I am not afraid of opposing or challenging messages, and I welcome the difference in perspectives that allowed me to seek explanation that fit best to the data even if it was not confirming my assumptions about the phenomenon.

While my ability to reflect on the participants' experiences and utilize professional judgment when analyzing the data is a strength of mine, I was mindful of the potential bias that stems from my experiences. For example, my therapeutic orientation and my research stance can shape my interpretation of the participants' experiences. As a therapist, I conceptualize cases utilizing intergenerational theory. As a result, I pay particular attention to family-of-origin issues and parent-child relationships that I believe play a key role in problem formation. Thus, in my

analysis I tried to refrain from paying extra attention to suicidal drivers related to family history and family relationships. To address this issue, I also chose to disclose my stance, beliefs, and perspectives related to the suicidal ideation prior to when the analysis began in order to be transparent about my potential bias (Creswell & Poth, 2018).

I identify as White female raised in a middle income intact family. I was born and raised in Russia where suicide is considered a stigma and never discussed openly. My potential limitation as a researcher is related to the fact that I have been fortunate to have never experienced suicidal thoughts nor have I had friends/family who ever shared (or felt safe to share) about the presence of suicidal thoughts. As a result, I had no personal experience with the suicidal ideation until I moved to the United States. My experience of working and studying in this country has allowed me to learn more about suicidal ideation and its risk factors as well as be exposed to clients with suicidal thoughts. As someone who has not been diagnosed with a mental illness, I can only offer an outsider perspective of what the participants' experiences could be like. I was mindful about my limited experience with suicidal ideation and I let the participants tell their story while being aware of my assumptions about the participants' experiences as potentially faulty.

Another potential limitation is that I served as a therapist to some of the participants in the study. As a result, I formulated a theory or preconceived notion of why they experienced suicidal ideation that aligns closely with IPTS theory. Even though my assumptions were confirmed by some participants of the study, I was mindful of the fact that other participants might have experienced suicidal ideation in a unique or different way. Thus, I was intentional in remaining open to any alternative explanations and continuously compared cases in order to determine if this theory might be a good explanation of participants' experiences. As "there are

exceptions that prove the rule and exceptions that question the rule," I remained especially mindful of different possibilities for alternative interpretations arising through my analysis of the data (Patton, 2015, p. 954).

Chapter 4 – Findings

Data from thirty-five participants with low to high suicidal risk were analyzed to yield common themes that describe contributors to suicidal desires. Initially, 69 themes emerged from the analysis. By utilizing data triangulation (Creswell & Poth, 2018), the themes were collapsed from 69 to 7 themes that are presented here. Although these themes have distinct features, they are not mutually exclusive—many overlap with one another. Data overlap demonstrates the complexity of participants' suicidal experience.

The seven final themes were further categorized based on their origin. There appeared to be drivers that were 'self-imposed' or derived from beliefs about the self and the emotional reactions to these beliefs. These themes were perceived defectiveness (sub-themes: self-denigration, unaccomplished, and lacking control) and emotional anguish (sub-themes: hopelessness, guilt, and shame). Then there were 'other-imposed' drivers or what occurs when participants' behaviors are influenced by others' expectations of them or in other words participants' perception of the world around them and their worth in the world. These themes were being a liability (sub-themes: letting ¬¬others down, causing others to suffer, and being an impediment to others), and low self-worth (sub¬¬¬¬-themes: worthlessness, unworthiness, and not good enough). One theme, feeling alienated (sub-themes: lacking support, isolation, feeling out of place, and misunderstood/not understood), was self-imposed and other-imposed because it was possible to isolate oneself and concurrently feel isolated by others.

In addition, there were contextual drivers related to health issues (sub-themes: mental illness and physical health) and external drivers categorized as external stressors (i.e., financial health and professional/academic stress). These drivers lead to suicidal ideation that functions in one of three ways: to provide relief, as a form of self-punishment, and gain control. The themes

and their relationship to each other are depicted in Figure 2. Each theme is elaborated below with their respective sub-themes and excerpts from the data.

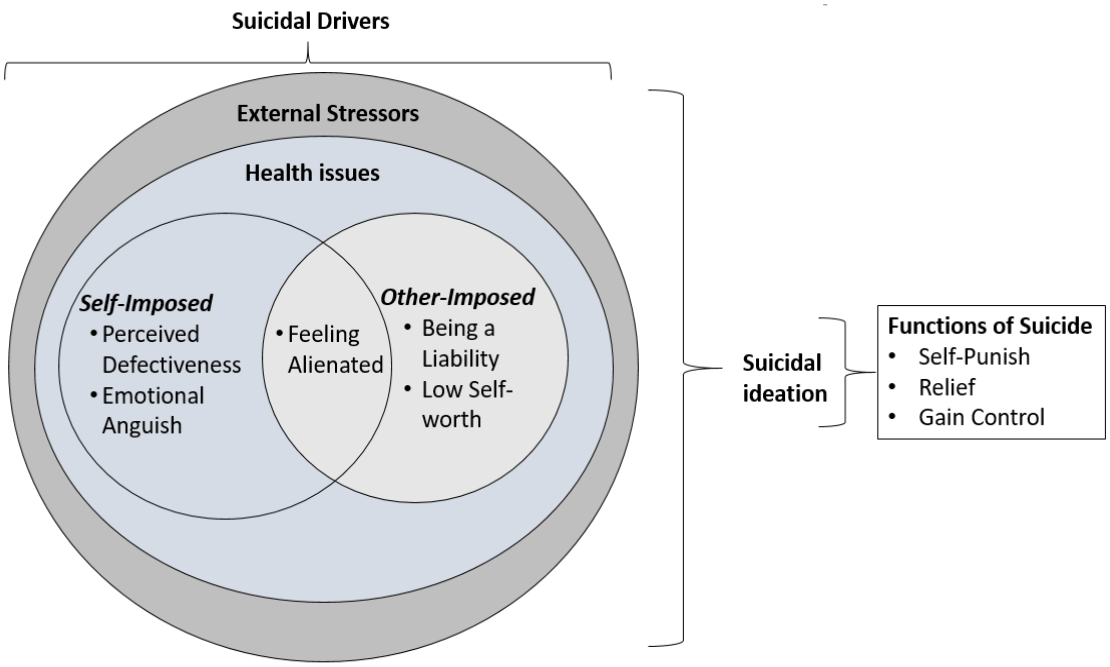

Figure 2. Suicidal Drivers and How They Inform Suicide

Perceived Defectiveness

Perceived Defectiveness appeared to be a self-imposed suicidal driver as demonstrated in the model (see Figure 2). It reflects participants' perception of themselves as defective and flawed regardless of how well they did in life or how well people perceived them. Participants who struggled with perceived defectiveness shared ways in which their poor self-perception promoted suicidality. There appeared to be a tendency to blame the self for being defective. Sub-themes that emerged were categorized as self-denigration, unaccomplished, and lacking control.

Self-denigration

The feelings and emotions related to self-denigration were intense and appeared to be a primary force that 25 participants cited as drivers of suicide. Participants struggled with intense feelings of self-hate that angered them and promoted a lack of self-compassion. Participants' narratives that reflected self-denigration were self-hate, low self-esteem, self-humiliation, self-loathing, anger with self, and disregard for own needs and desires.

Participant #10 perceived himself as "…very mediocre, lacking no skills. All I can do is walk, talk and breathe air." He shared that he lacked determination, tended to give up easily, was lazy, unable to prioritize, and had an "annoying voice and appearance." It is important to note that this participant reported a 4.0 GPA, an active academic and social life, was gainfully employed and was well-liked. Despite having what appeareds to be a fulfilling life, his self-hate was so intense to the extent he could not see beyond his perceived limitations.

Participant #1 shared how ruminating on his "mistakes" was a catalyst to a cycle that ended with thoughts of suicide. Recounting his mistakes would lead to "I hate my life," which would jumpstart a "replay…(of) potential suicide scenarios" that then led to anxiety attacks. "Feelings of anger, frustration at self, and hating self" fueled this cycle. A similar vicious cycle was shared by Participant #35, who was "fed up with self" and reported, "feeling tired, needing a break" from the self-perpetuating cycle of self-hate and self-abuse.

Being critical of one's abilities and feeling responsible for mistakes was another common theme. Participant #4 shared, "I have never been very self-confident…I do not know what is right or wrong," and as such, he believed that it would be inevitable for him to make mistakes that would be followed with guilt and regret. Participant #5, who also tended to blame himself, shared that he disliked himself enough to end his life.

The tendency to self-loathe was another common theme across participants. Participant #16 shared, “I am disgusting, revolting…Something triggers these thoughts, and it is like a flood that washes over me.” According to the participant, these thoughts would lead to shame, anger, hatred towards self, and disgust of physical self, which prompted thoughts of suicide. Participant #17 shared similar self-hate, “I am fat, I am ugly, I am old, I am tired…things are just getting worse, and then I am going to die” and said that suicide was a way to escape from himself and his life circumstances. For participant #18, self-hate was reflected in the following statement, "Seeing self makes me feel disgusted and disconnected,” which appeared to be a desire to keep a distance from self.

The inability to improve despite working extra hard was another contributor to self-hate. Participant #29 shared that he was often “amused at himself for trying to improve” because trying harder did not produce better results, which led him to hate himself. Participant #30’s self-hate was related to “getting self-sick from overwork,” which then contributed to self-denigration, "I can't even do this (overwork) and (stay) healthy....” Self-vilifying appeared common among participants who overworked themselves but did not achieve anticipated outcomes.

Unaccomplished

Thirteen participants shared that procrastinating, wasting time, feeling unproductive, and not having accomplished much promoted suicidal thoughts. Procrastination that led to unfinished work and perceiving the self as unproductive or unaccomplished triggered suicidal thoughts. For participant #1, behaviors such as “wasting time when busy, double-booking, and creating conflicting commitments” that have resulted in “having to let someone down” are what stressed her. Procrastination was what stressed Participant #8, especially when this was repetitive. Participant #11 felt the same about procrastination -- “when I am excessively a couch

potato,…when I feel unaccomplished like things are not turning out well for me, turn out negatively," I think about suicide. "Pushing things off or not meet(ing) responsibilities" was Participant #24's trigger, whereas purposefully wasting time by "driving around during lunch break" was Participant #29. For participant #35, wasting time and the opportunity to be creative led to feeling unaccomplished, which provides a reason for "pity parties" that confirmed failure.

Lacking Control

Nine participants reported lacking control as one of the factors contributing to their suicidal ideation. It included uncertainty, lack of direction, having no escape, feeling trapped, being controlled, and being caught in a cycle with no point of exit. Participant #35's marriage made her feel out of control because it appeared to be stuck in a cyclical pattern: "…everything goes fine for months, and then he will attack." This "draining cycle" as she called it contributed to her "being on edge - relax – attack." The inability to control life transitions, the uncertainties of life, an overall lack of direction were other factors that contributed to suicidal thoughts for participants. Not having direction caused some to feel lost.

The notion of being trapped when controlling one's life is not possible was another common trigger of suicidal ideation. Participant #17 disclosed that suicidal thoughts emerged when he "…feel(s) trapped" because of "…life circumstances that he cannot control (or)…escape from." Being overwhelmed was another factor that contributed to feeling out of control. Participant #34 shared that the loss of control was closely related to "…Behaviors like overscheduling, and as a result feeling the loss of control, forgetting appointments" and "not doing well on things." When overwhelmed, Participant #29 found "thinking about

suicide…relieving" because is "this is no way to live" and "if it is going to be like this, I might as well just die" she said.

Emotional Anguish

Emotional Anguish is another driver that appeared to be self-imposed. Participants were candid about how their emotional states promoted suicidal desires. The need to end emotional pain and anguish was what most participants cited as reasons for even considering taking their lives. Three prominent emotional states were identified: hopelessness, guilt, and shame.

Hopelessness

Twenty-three participants reported hopelessness -- a feeling of inevitable doom and inability to change their lives -- as a factor contributing to their suicidal ideation. Participants' hopelessness was related to the perception that their wrongdoings could not be counteracted or that their situation could not be improved in any way. Feelings of hopeless was often related to feeling helpless because they could not imagine change happening.

Participant #2's hopelessness had an existential dimension related to his "outlook on the future of humanity…." He shared his concern that people "…are getting dammer, unhealthier…consuming the earth's resources, destroying life on the planet…" that contributed to his feeling of "hopelessness" because "it is completely outside of my control." Many participants' sense of hopelessness was related to feeling stuck in their current life situation and not seeing a way out. Participant #3 shared, "No matter what I do, it is hopeless" which culminated to a sense of helplessness, "I do not want to be in this situation anymore, but I feel like it is never going to end."

Hopelessness was triggered when Participant #23 struggled to figure out her next move and asked herself "What is the point?" and "Do I have the purpose?" The weight of these

questions contributed to "…it would be easier not to exist." According to Participant #28, his "…happiest times already happened" and the prospects of nothing better awaits him made "Suicide (a) destiny, it is going to happen eventually" a remedy for "hopelessness and lack of optimism." The desire to get out of a bad situation was Participant #29's reason for suicide. He shared, "(I)was never given a chance to succeed" and hence, "…want to be free from the situation I am in."

Some participants appeared to give up and believed that whatever they did to change their situation was pointless. Participant #16's suicidal ideation was triggered when he failed to solve his problems and the exhaustion from multiple unsuccessful attempts led to despair: " I can't do nothing…(I am) trapped…no good choice or alternative" and therefore, "I do not want to exist like this…things would not be like this in Heaven." For participant #20, hopelessness triggers suicidal drivers when this thought emerges: "No way to dig me out of this, so better die."

Guilt

Ten participants shared experiences of intense guilt for being alive and felt that they deserved to be die. Guilt for past mistakes, under achievement, failing, not meeting one's responsibilities and feeling at fault were triggers of suicidal ideation. The inability to manage life when compared to with others was also guilt producing. For example, participant #4 shared the following thought: "I feel more than shame, I feel guilty for being suicidal and depressed…other people are going through harder things, and they do not feel like me..." and concludes, "Not being able to cope with things makes me feel guilty."

Participant #10 disclosed feeling guilty for being alive and a deceased relative who according to him was better than him deserved to live. Feeling guilty for mistakes was shared by a few participants. Participant #34 disclosed feeling guilty for what was done by him, for his

actions that he is not proud of. For him, a powerful interplay of his sense of wrongdoing and the feeling of guilt for his actions promoted suicidal thoughts.

Participants described how their guilt was related to failing, not meeting expectations and responsibilities/demands, feeling like it was all their fault, or being made to feel it was their fault. A few participants reported feeling guilty due to being alive and not doing enough in their lives. For example, participant #13 shared feeling guilty because she was not doing her absolute best and was troubled by the thought of not being good enough to fulfill the responsibilities she was entrusted with. “Not meeting my responsibilities so people would be better off without me, so I should not exist” was Participant #26’s catalyst for suicidal ideation.

Shame

Eleven participants described how shame was present in their relationships. For instance, participant #4 shared: "I feel shame when I talk to my parents or my mother-in-law.” For her, the experience of shame is closely related to her perception of herself as a failure that she described as “I feel hopelessness, and feeling like a failure, and I do feel shame for not be able to make my marriage work.” She connected shame to suicidal ideation that in turn fuels her shame and guilt for not managing life. For participant #8 shame is related to not fulfilling the expectations of parents that caused her “academic and interpersonal shame.”

For many participants, shame was evoked when they made mistakes. Participant # 13 described how making mistakes created feelings of “…desperation, shame, and embarrassment.” For participant #14, the intense sense of shame for mental and physical problems contributed to inadequacy. A similar message is repeated by participant #24. His depression, anxiety, and past traumas were the reason for shame and guilt because he cannot do as well as others. The failure to accomplish evoked shame too. Participant #35 shared that shame emerged when she engaged

in behaviors such as "…not stand(ing) up, …fail(ure) to protect my children,…waste huge amounts of time or not feeling accomplished."

Being a Liability

Being a liability appeared to be an "other-imposed" suicidal driver. Thirty-four participants shared an overall perception of being a disappointment and a liability to their families, friends, and loved ones, closely aligned with Joiner's (2005) concept of perceived burdensomeness. They described various troubling feelings and experiences that led them to perceive themselves as obstacles to others. Participants often concluded that the world would do better off without them. The following sub-themes emerged from the data: letting others down, causing others to suffer, and being an impediment.

Letting Others Down

Failing in relationships, being dishonest, not doing enough for and disregarding the opinion of loved ones, causing pain and discomfort, making mistakes, feeling flawed and blamed by others were ways in which 18 participants felt they let others down. The fear that they would never be forgiven or accepted after having been a disappointment to others or a disappointment to themselves was cited as a driver to suicide. For example, participant #3 shared his pain and sorrow related to "failures in relationships with (his) deceased fiancé" and felt that he "could have been such a better partner and attend to her needs more in those times when we were not as close as we could have been." Disappointment in himself and "not being able to take that (relationship) back" was his main suicidal driver.

Participant #7 shared a similar sense of having let her family down to the extent that they were not only disappointed in her but regretted having had her. She shared how she let her mother down when she defied her mother's warnings that caused the participant pain. Participant

#28 shared that she let her colleagues down when she did not get things resolved at work or when she "messed up on the problem (that) I could not figure out." The disappointment she caused at work led her to believe that she would be better "to just be dead." Participant #26 also felt that "the world would be better off without me," a thought that occurred to her every time she thought she was not doing an excellent job as a student, partner, or caregiver. These recurring thoughts were present regardless of her efforts and accomplishments. Participant #11 shared that the "pain and annoyance I caused my friends and all the mistakes I made" was what convinced him that he was let down. This sense of disappointment haunted him to the extent that they prevented him from holding down a job and keeping friends, negatively affecting his mental health.

Causing Others to Suffer

Twelve participants described themselves as being a burden or an annoyance by causing struggle and suffering for others and draining valuable resources that could be put to better use. The thought of being a burden to family and friends was unbearable for these participants, who believed ending their lives was their solution to ending the suffering of their loved ones. Participant #16 shared that the demands of his job left him exhausted and "hollow" at the end of the day, and because he had nothing left to give, he felt "like a burden to (his) partner." This sense of being depleted was what led him to believe that "the problems I create for other people would go away if I killed myself." Participant #13's feelings of burdensomeness were related to his perceived underachievement that he attributed to the high standards set by his parents. Despite his professional achievements, he believed that he could "do more," and he thought it caused family and friends hardship by not doing more. Participant #11 felt that the mistakes he

made were etched in peoples' minds -- "people (are) never going to forget" -- the suffering he caused, which led him to ponder suicide as a solution.

Being an Impediment to Others

A common theme among 11 participants was that they impeded loved ones who would be better off without them. This theme differs from the theme causing others to suffer as it is more of participants' perception that they were on a way, senseless predicament on their loved ones' way of life while causing others to suffer is a more direct and intense experience of bringing suffering to loved ones. Concerns for the well-being of their loved ones seem to be the catalyst for suicidal thoughts. These participants saw themselves as the obstacle that prevented loved ones from living happy and fulfilling lives and that their demise would bring relief. For example, participant #4 shared the following thought, "My husband would be better off, happier without me because…I am an obstacle in his way." Participant #5 believed that her "kids would be better off without" her. This participant alleged that her health issues prevented her from contributing to their lives and complicated them.

Believing that their presence or absence would not make a difference in peoples' lives made living challenging for many participants. The idea that their existence was more of an impediment than a blessing was echoed by many. For instance, Participant #27 concluded, "It would be easier on everyone not to have to put up with me or deal with me." He assumed that his temper, substance use, depression, and anxiety made him almost unbearable to live with and that his loved ones deserved a better person who would not be standing in their way. Participant #35 shared that she could never do anything right, relying on others to carry her load, causing them to strive. Like many other participants, she concluded that "It would be easier on everyone if I were dead."

Low Self-Worth

Low self-worth is other-imposed suicidal driver and it differs significantly from perceived defectiveness which is a self-imposed suicidal driver. As other-imposed, self-worth is a result of participants' experiences with people and something they have come to believe about themselves. Participants described how their sense of self-worth was linked to thoughts of suicide. It was either feeling void of value/worth, underserving or unworthy of their needs and desires or not feeling as accomplished as their peers that led to feeling not good enough. Three primary themes were identified and categorized as worthlessness, unworthiness, and not good enough.

Worthlessness

A common theme among 12 participants was feeling worthless, not of value, or regardless of how hard they tried, culminating in feeling undeserving. The ending of friendships, feeling unappreciated, and being ignored by families and friends contributed to the sense of worthlessness. For instance, Participant #7 shared that her relationship with her father was traumatizing. Yet, she longed for a relationship with him (i.e., "itching for the relationship with dad"), and not having one has led to deep sorrow and a sense of defeat -- "it is kind of not there anymore, and it would not be." The lack of relationship with her father and the break up of a romantic relationship evoked feelings of being unessential. Participant #14 shared a similar pattern of thoughts and reactions related to feeling worthless that was "triggered by social interactions that do not go well…when people do not follow through with plans with me,…whenever (I) reach out to people and (am) ignored." These interactions contributed to the assumption that "everyone hates me" or "everyone thinks I am crazy," which led to feeling worthless and embarrassed for feeling worthless. Participant #29 spoke of being useless, which

made her unworthy of the unconditional love people extend to her. The notion of "I am worthless, I am a waste of life" prevents her from embracing love.

Unworthiness

Unworthiness differs from worthlessness as it is about being undeserving of something, while worthlessness is about having no value. The sense of unworthiness was a common form of low self-worth for 16 participants. For example, Participant #20 internalized message of "I am not worthy" is preceded by thoughts such as "I do not belong" and experiences of being "rejected" by society that "make me feel shameful and not worthy of being here." Participant #16 wondered aloud, "Why would people want me around? How could I possibly add anything positive?" that reflected her low self-worth. Participant #6 believed that he was unworthy of living -- "Someone could live my life better." The death of a loved one also evoked worthiness for life as shared by Participant #10, "I do not deserve to be here; he (the loved one) deserved to be here; he was so much better." This sense of unworthiness to live was shared by Participant #24, who said, "…no one else sees worth in me being here, so I do not see worth either, hence "it would not even matter if I died."

Participants also felt unworthy of interpersonal relationships that fueled their suicidal ideation. For example, Participant #14 viewed herself as "inherently flawed" because of "family issues and past traumas." The belief that she is eternally flawed prevented her from feeling worthy of seeking companionship that was reinforced with each rejection -- failure to respond to her emails, text messages, or invitations. For the most part, feeling unworthy appeared to be a perceived internalized state. However, Participant #30, for whom receiving approval and appreciation from others is essential, was told she was unworthy. She shared that despite "going above and beyond" at work, she was "slap(ped) in the face" with "you are not worthy enough."

Not Good Enough

Perceiving themselves as not good enough was a common theme for 16 participants. Low self-confidence, feeling not as good or being different than others, not meeting expectations, being criticized despite working hard were some of the participants' shared experiences. For example, Participant #1 shared her feeling of not being good enough for her family because she continued to be dependent on them although she was an adult. Participant #7 shared that her father did not welcome her birth, making it difficult to believe she could ever be good enough for him. Participants #11 and #25, who constantly compared themselves with others, only noticed their shortfalls. Participant #13 disclosed that the unrealistic expectations of his parents rendered him feeling that he would never be good enough for them. Participant #27 attributed his sense of failure to his girlfriend, who was "not being fulfilled (by)…how things are going (in their relationship)."

Not being good enough was further linked to criticism, teasing, bullying, and manipulation. Participant #30 shared that her feeling of not being enough is connected to being criticized by others even when she was "especially productive." For participant #15, being teased, bullied, and criticized was perceived as not good enough to deserve respect, which brought him shame. Two other participants shared similar experiences of "bullying, not being respected, and being manipulated" that not only led them to feel less than but to consider suicide.

Feeling Alienated

Feeling alienated stood out because it was both self-imposed and other-imposed. A common theme across 30 participants was feeling alienated, which aligned closely with Joiner's (2005) concept of thwarted belongingness. Being alienated from friends, family, loved ones, and society, in general, promoted a lack of social connection, leading to intense suffering. The

following sub-themes emerged as contributors to feeling alienated: lacking support, isolation, feeling out of place, and misunderstood/not understood.

Lacking Support

Not being supported by family and friends was a recurring theme for 22 participants. Being rejected, judged, cut off, ignored, and doubted were some factors that were identified as contributors to feeling alone, neglected, and uncared for. Referring to her husband, Participant #4 shared, “He does not want to give me a chance…My husband always says I made so many mistakes, and I am never going to change." This participant concluded that “if I need something, I need to find a way to figure it out on my own," which left her feeling alone and unsupported. Participant #20 felt alone and unsupported when “nobody witnessed [noticed]” her, which evoked “feeling rejected and fear to act [take action/be assertive].” Participant #22 noted that “feeling cut off, left out” led her to believe that “no one likes me.” Her past and present experiences of “having no support from family...solving issues on my own even in childhood” that resulted in having “to grow up early” further fueled “feeling alone and not supported.” For participant #16, “not having anyone concerned (for them)” and the fear of not being accepted because of their sexuality promoted a sense of invalidation. Being noticed and cared for was synonymous with being accepted and supported by all these participants.

A small group of three participants struggled with trusting people as a result of past betrayals and having been doubted and unsupported by their significant other, which in turn disallowed them to seek the support they needed. For example, participant #35 attributed their recent decision to distance from family-of-origin to having been abused as a child and the inability to feel safe around family. The tendency to distance from family made it difficult for

participants to connect with their own nuclear families rendering it challenging to garner any familial support.

Isolation

Feeling disconnected from people and society fueled 22 participants' sense of aloneness and isolation. This theme was one of the most common themes related to feeling alienated. Participants shared that they felt alone even when surrounded by people, which evoked a sense of rejection and feeling omitted. Some participants intentionally isolated themselves from family, friends, and other social networks to avoid further rejection. Such seclusion exacerbated their loneliness. Participant #2 shared that they "do not have any friends" and that they "do not want any friends." Participant #7 shared how she desired a connection with people. Still, the rejection and judgment from her family left her "not being comfortable" around people and her family in particular, which led to her decision to isolate herself from people. Another reason cited for isolation was having misaligned values. Participant #3 spoke of how not identifying with the larger society's value of consumerism promoted isolation -- "I do not want to be a part of…the prevailing current (society)."

Participants trying to avoid being with people was another factor that contributed to seclusion. Participant #18 disclosed how he felt uncomfortable around people because he had trouble "hear(ing) about (the) experiences of others," especially when it was about their accomplishments that outshined his endeavors. Isolation appeared to have multiple purposes. For Participant #2, the loneliness from isolation served as a driver for suicidal thoughts, while for Participant #31, being isolated from others helped facilitate his ability "to gradually remove (him)self from people's lives so if I do kill myself, it would not impact them as much." The latter

participant deliberately deteriorated his friendships because he believed that “people do not deserve a friend like me.”

A unique situation emerged for Participant #35, who could not trust others because of previous undesirable relationships, which explained his aloneness and isolation. His inability to trust deterred him from pursuing relationships though he wanted to be in one. Hence, although he disliked being single, his distrust of others prevented him from seeking a relationship. His statement says it all, "I hate being alone and even worse to be with someone.”

Feeling Out of Place

A recurring theme under alienation was feeling out of place or not fitting in social circles and the community for nine participants. Experiences of inadequacy, worthlessness, shame, the feeling that the world is not designed for them, a lack of belonging, being criticized, feeling foreign, and misplaced contributed to participants’ sense of being out of place. For example, participant #7 described wanting deep and meaningful connections, and because all her friends are interested in “shallow friendships,” she feels out of place. Participant #20, who described himself as “a highly sensitive person,” was filled with sorrow that “there is not a lot of highly sensitive people,” which led him to conclude that “the world is not designed for people like me.” He perceived people as mean, which promoted a sense of “not belong(ing) here.” For participant #35, not fitting in appeared to be related to feelings of inadequacy resulting from feeling worthless in relationships, which triggers “the spiral” of suicidal ideation and behavior.

Misunderstood/Not Understood

Another theme related to alienation was feeling misunderstood or not understood by others. Nine participants shared feelings of being misperceived and the notion that others could not possibly understand their struggle due to the horrific nature of their experience. For example,

participant #20 shared, "I do not belong here because I feel like people do not understand me or misjudge me (because they think) that I have ulterior motives or something different." Participant #22 shared that she believed that "I think other people think I am stupid despite her professional success." She spoke of being obsessed with how people misjudged or misunderstood her to the point that it impaired her ability to enjoy life. The impairment was such that she wore "sunglasses day and night with headsets on" to distract herself from contemplating how she thought others perceived her. Participant #31 believed that no one understood "what is happening to me. (My depression) is so unique and horrible that nobody could understand." He thought that his experience was so terrifying and unusual that there was no way in the world someone could relate to him and what he was going through. These thoughts severed any sense of belonging that ultimately contributed to his attempts to remove himself from his loved ones to lessen their suffering after his demise.

Health Issues

A contextual factor that contributed to suicidal drivers was health issues. Health concerns and suffering appeared to contribute to participants' suicidal ideation. Participants shared how poor health made them more susceptible to suicidal thoughts and behaviors. Two primary health themes that emerged were mental illness and physical health.

Mental Illness

Twenty-three participants shared that symptoms of their mental illnesses (e.g., depression, anxiety, panic attacks, and past trauma) contributed to their suicidality. Participant #29 reported that his "…depression leads to sadness and worry." For him, "…suicide is the quickest way to stop these negative thoughts and feelings." Participant #20 shared that suicidal thoughts commonly occurred when he was depressed and fatigued -- "…the more I sleep, the

worse I feel," which, according to him, stemmed from "…feeling depressed" and past experiences of "high trauma." He reportedly has ruminating thoughts, memories, and flashbacks related to past abuse. The current "cycles of abuse," according to him, caused "retraumatization" and his "…past trauma being triggered" that increased his suicidal ideation.

For participant #23, the suicidal thoughts came when he realized that: "I cannot get it out of my system...I could die, and it would be better than feeling this way." He reported experiencing suicidal thoughts when he "…gets (a) panic attack, (or) gets depressed." He also reported "…getting anxious and overthink/overanalyze the situation," which usually led to a "panic attack" and subsequent feeling of being "…agitated and worked up" that together contributed to "…it would be better to die." Participant #32's suicidal thoughts emerged when "(she is) feeling emotionally exhausted" and knowing that there is "…no remedies." According to her, "…trauma in early life made me fearful - fear of failure, fear of not being accepted for who I am, fear of not being perfect," all of which contribute to her anxiety and depression and subsequent desire to die.

Physical Health

Five participants shared how their physical illnesses promoted suicidal ideation. They mentioned such issues as fibromyalgia, chronic pain, chest pain, and chronic migraines. For participant #5, fibromyalgia was one of her indirect suicidal drivers that, along with financial stress and experiences of alienation from her family, added to an intense feeling of hopelessness ("It will never get better") and a sense of liability ("Kids would be better off (without me)".

Participant #14's physical issues ("When start to hurt, medical issues") along with alienation ("When people tease me…bullying…criticism") and a sense of liability when people care for her ("The problems I create for other people would go away if I killed myself") augment

hopelessness regarding her chronic physical issues that then culminate to suicidal desire. Suicide would relief her from physical pain."

External Stressors

Some stressors that were external to participants emerged as contributors to suicidal desire. The main stressors identified were finances and professional/academic stress.

Finances

Nine participants shared that poor money management and not being able to satisfy financial obligations were some of the financial stressors that contributed to their suicidal thoughts. For example, participant #2 reported that he had a tendency to overspend, that caused him food scarcity and an inability to pay bills. For participant #5, shopping behaviors was identified as the reason for financial stress that escalated after she lost her job. Participant #27 who struggled with overspending was troubled by her irresponsibility, "I can't hold on to money, do not have a car, and can't keep a car," that promoted suicidal thoughts.

The inability to manage his finances and feeling defeated when "…everybody else can do this" was Participant #17's driver for suicidal thoughts. Participant #20 struggled with similar financial management issues stemming from his student loans. The lack of a financial "safety net" and financial obligations caused Participant #35 to "stay up all night, feel overwhelmed, and frustrated with self" that in turn triggered suicidal thoughts.

Professional/Academic Stress

For 17 participants, stress from work and school appeared to be drivers of their suicidal thoughts. Their stress was related to not achieving goals, being criticized, failing at their responsibilities, struggling with executing their plans, and the lack of hope for future success.

Not finding gainful employment and " concerns for job security" was a common trigger for suicidal thoughts. Participant #15's suicidal thoughts were related to feeling inadequate after not finding gainful employment and feeling mentally exhausted from the search. Participant #26's tendency to overschedule and take on multiple projects that she referred to as "…signing myself up for stress," was identified as a contributor to passive suicidal desire. For participant #9 suicidal thoughts were triggered by "…agitation and frustration when messing up work," and "…low achievement" that would then spiral to "I do not deserve living."

Stress from poor academic performance was another common catalyst for suicidal ideation.Participant #11 shared: "When I do not get good scores on tests or assignments, it affects my self-esteem," that elevated her stress and intensified her suicidal ideation. For participant #8, the unrealistic expectations of others and the pressures he experienced at school was what burdened him. His inability to continue under this stress is what contributed to exceptional suffering and subsequent suicidal thoughts.

Functions of Suicide

Although every participants' story was different and unique, with direct and indirect drivers intertwining in different ways, these drivers culminated in a unified desire for suicide. The reason suicide appeared to be compelling spanned three main themes: providing relief, self-punishing, and gaining control. Examples of how direct and indirect drivers are intertwined to lead to the desire for suicide as a solution are described below. Only 18 of the 35 participants answered the questions about the function of suicide.

Provide Relief

For the 13 participants who mentioned relief as the function of their suicidal ideation, the mere thought of suicide brought the sense of escape from suffering, relief of

negative self-perceptions and bothering symptoms, a way out from the cycle they found themselves encapsulated in. Thus, for the participants who felt cornered by their life circumstances, the thought of suicide was their relief as they thought they had a way out at last.

For participant #1, feeling unaccomplished and issues with mental health became indirect drivers that led to direct drivers of self-denigration, resulting in intrusive thoughts about suicide. Suicidal thoughts became "comfort, way out, escape from the cycle" for this participant.

For participant #4, indirect drivers of self-denigration and perceived burdensomeness (a disappointment, not good enough, an obstacle) along with academic stress led to the indirect driver of hopelessness ("It will never get better") and low self-worth ("I am not good enough to live"). Suicide appeared to provide relief for both himself and others -- "just to stop being me or stop being here, stop annoying people."

Participant #8's indirect drivers were perceived defectiveness (unaccomplished, self-denigration), academic stress, and emotional anguish (guilt and shame). The guilt and shame of not living up to her parents' expectations contributed to the direct driver of low self-worth (unworthiness, not good enough). According to the participant, the feeling that she is failing her parents and not doing as well as she should lead to guilt and shame "build up with no relief until it spills" into suicidal thoughts, the function of which was to "escape, get a break."

For participant #19, the indirect drivers of feeling alienated (lack of support, isolation, feeling out of place) and perceived defectiveness (self-denigration) contributed to direct suicidal drivers of feeling alienated ("I am inadequate") that was confirmed by further rejection leading to low self-worth ("I am not worthy"). Further rejection from society confirmed the feeling of unworthiness leading to hopelessness, "No way out" and suicidal thoughts of "I cannot function

in this world…This world is not designed for people like me" and "…end(ing) my life to escape the pain" served as a viable solution.

Self-Punish

For the three participants who mentioned self-punishment as the function of their suicidal thoughts, the mere idea of suicide or suicidal behavior appeared to be the way to chastise themselves, an ultimate negation and extinction of their presence as a way to get back at themselves for all that is wrong with them.

For participant #1, indirect drivers of financial burdens, health issues, school problems, and being a liability (a disappointment to loved ones) added to worry and anxiety that manifested in the direct driver of low self-worth ("I am not good enough"). Not believing that she was good enough appeared to make suicide a sensible way to punish herself. For participant #12, the indirect drivers of guilt, self-denigration, and academic stress along with feeling alienated (isolation, not essential) and being a liability (letting others down) led to the direct driver of self-denigration and being a liability (feeling not good enough) that then brought up the desire to self-punish -- "I deserve to suffer and having suicidal thoughts achieves this goal of … bring(ing) deserved suffering."

Participant #29 also views suicide as "punishment, something deserved." He shares: "Nobody else can punish me as badly as I can punish myself…it is all my fault, this will never change…so…why bother?". So, for this participant, the experiences of self-denigration, guilt, and mental health issues became precipitating factors for the feeling of overwhelming hopelessness that spilled into the suicidal desire that, for him, was a way to bring upon a deserved suffering.

To Gain Control

For the two participants who viewed gaining control as a function of their suicidal drive, life appeared unmanageable and turbulent. The thought of suicide seemed to give them temporary control because now they could end it whenever they wanted. For participant #13, experiences of shame, guilt, past trauma, lack of accomplishment and academic stress were precipitating factors that led to self-denigration ("I am crazy," "I keep messing up") and alienation that was the catalyst to her suicidal ideation. For her, suicide would help her "obtain control" over her life -- the only thing she could acquire control over.

For participant #15, experiences of alienation because she felt like a liability ("Why would people want me around?", "How could I possibly add anything positive?") were indirect drivers that led to her direct drivers of hopelessness and lacking control ("I am at a loss, without direction"). Suicide was her way to gain control and end the problems she caused others ("The problems I create for other people would go away if I killed myself"). It was her way to "give (life a) sense of order, give order to chaos" that directed her focus away from the challengeesin her life.

Chapter 5 – Discussion

This study aims to understand better how perceived burdensomeness, and thwarted belongingness, concepts from the Interpersonal Theory of Suicide (IPTS; Joiner, 2015), help explain suicidal drivers. The functions of suicide were also explored. The participants exhibited a range of suicidal drivers. The themes that emerged from this study not only aligned with perceived burdensomeness and thwarted belongingness from the IPTS (Joiner, 2005), but also the Integrated Motivational-Volitional Model (IMVM; O'Connor, 2011) and the Three-Step Theory of Suicide (3ST; Klonsky & May, 2015).

The two main concepts within the IPTS, perceived burdensomeness and thwarted belongingness appear to explain a substantial portion of participants' suicidal drivers -- liability to others and to feel alienated, respectively. According to the IPTS, the simultaneous presence of perceived burdensomeness and thwarted belongingness leads to active suicidal desire (Joiner, 2005; Klonsky et al., 2018; Van Orden et al., 2010). However, the majority of the participants (27 out of 35) who experienced both being a liability to others and feeling alienated (in addition to other suicidal drivers such as self-denigration and hopelessness) reported not only active but passive suicidal thoughts. It appears that the same drivers that lead to active suicidal ideation can be present with those with passive ideation. Importantly, passive suicidal ideation cannot be considered as less severe than active ideation because tendencies such as impulsivity from bipolar disorder (Liu et al., 2020) can quickly escalate ideation from passive to active and perhaps even to attempt. How the four broad categories of suicidal drivers – self-imposed, other-imposed, contextual, and external stressors reflect the theory and literature are illustrated below.

Self-Imposed Suicidal Drivers

For some participants, suicidal thoughts are triggered when the pain from suffering becomes unbearable or when negative reflections of the self-surface. Feeling unaccomplished, not in control, and self-loathing appear to arise from within with minimal prompting. These drivers are based on participants' perceptions of themselves, reflecting existing internalized messages.

Perceived Defectiveness

Feeling Unaccomplished

As a subtheme of perceived defectiveness, feeling unaccomplished is supported by research on burnout. Personal accomplishment is one of the three components of burnout (along with depersonalization and emotional exhaustion) that is associated with suicidal ideation in populations such as military personnel (Craig et al., 2018), psychologists and counselors (Fortener, 1999), pre-resident medical students (Frajerman et al., 2019), veterinary practitioners (Brscic et al., 2021), and psychiatric nurses (Pompili et al., 2006). According to an integrative literature review of 20 studies, feeling unaccomplished or low accomplishment is correlated with suicide risk in nursing professionals (Silva et al., 2015). Perceptions of reduced personal accomplishment contribute to burnout, which increases the risk of suicide for medical professionals, who report an already higher risk for suicide (Davidson et al., 2020; Patel et al., 2018). It appears that feeling unaccomplished is a common suicidal driver for people with diverse educational and professional backgrounds.

Lacking Control

As a subtheme of perceived defectiveness, lacking control aligns with the concepts of entrapment and defeat from an ideation-to-action framework, IMVM (O'Connor, 2011;

O'Connor & Portzky, 2018). This model conceptualizes feelings of entrapment and defeat as drivers of suicidal thoughts. To date, two studies have examined the relationship between the feelings of defeat and entrapment with suicidal ideation. The findings conclude that entrapment and defeat can predict suicidal ideation and behaviors in a sample of healthy adults (n = 1809) and university students (n = 1288) with suicidal thoughts, past suicide attempts, and no prior suicidal history (Dhingra et al., 2015, 2016). Further, lack of control as a driver of suicidal ideation aligns with the IPTS concept of perceived burdensomeness. According to Joiner, "feeling out of control and incapacity (incapacitated)…spill over to affect others besides themselves" that contributes to the feeling of perceived burdensomeness (Joiner, 2005, p. 98).

Self-Denigration

As a subtheme of perceived defectiveness, self-denigration aligns with self-hate. In the IPTS, self-hate is one of the two dimensions of perceived burdensomeness, which has positive associations with indicators such as low self-esteem, self-blame, and agitation (see Figure 2; Van Orden et al., 2010). A vast array of research connects self-hatred and self-denigration tendencies to suicidal thoughts and behaviors. In particular, self-hate was found to be a predictor of suicidal ideation and was found to be correlated to the frequency of suicidal thoughts (Jobes et al., 2009; Joiner et al., 2001; Turnell et al., 2019). Interestingly, depending on the intensity of self-hate, it was either a predictor of suicidal ideation (high intensity), or its relationship with suicidal ideation was moderated by thwarted belongingness (Turnell et al., 2019). In addition, self-hate was found to be a moderator recurrent of suicidal ideation (Conrad et al., 2009) and was determined to be one of the five markers of suicidal behavior in CAMS (Arkov et al., 2008; Jobes et al., 2009; Van Orden et al., 2010).

Emotional Anguish

Hopelessness

The idea of hopelessness as one of the main drivers of suicide was supported by ideation-to-action theories, including the IPTS (Joiner, 2005) and 3ST (Klonsky & May, 2015). According to the IPTS, hopelessness related to perceived burdensomeness and thwarted belongingness is a major threat for suicidal risks and behaviors (Tucker et al., 2015, 2018). Further, the 3ST model considers hopelessness and pain as two main motivations that drive suicidal thoughts. The studies examining 3ST concepts discovered that pain and hopelessness "accounted for substantial variance in suicide ideation" in samples of adults (n = 910) and university students (n = 665) (Dhingra et al., 2016; Klonsky & May, 2015, p. 114). Hopelessness and pain were also factors that most frequently precede suicidal attempts and completed suicide based on the analysis of reports of suicide survivors and families who lost their loved ones to suicide (Wintersteen, 2014). Thus, there is mounting evidence that hopelessness and pain are significant motivators of suicidal ideation and behaviors.

Guilt and Shame

The findings are supported by research on the role of guilt and shame in suicidal ideation and behavior. Even though guilt and shame are distinct, participants talked about guilt and shame as a single entity inseparable from the other. Both shame and guilt can exist simultaneously while conscientious evaluation of self, behaviors, thoughts, and emotions occur (Crowder & Kemmelmeier, 2018). If such evaluation is negative, feelings of shame and guilt could emerge. The difference is that shame "occurs in response to a negative evaluation by real or imagined others" due to "violating important moral or social codes of conduct." It encompasses the person as a whole, while guilt pertains to a negative evaluation of their behavior rather than the entire

person (Crowder & Kemmelmeier, 2018, p. 121; Sheikh, 2014). Thus, the difference between guilt and shame is that the first is related to behavior while the latter is related to the person as a whole.

A meta-analysis on suicides in military personnel noted that "guilt, shame, and distress about one's actions are better predictors of suicide ideation and suicide attempts among military personnel and veterans as compared to combat exposure and deployment history" (Bryan et al., 2010, 2013, 2015, p. 633). Shame is a "predominant figure in young people suicide experiences" (Fullagar, 2003, p. 291). And a recent study conducted on adult patients (n = 100) attending mental health services found a significant association of guilt with suicidal ideation and moderating effects of shame on it (Kealy et al., 2021). The feelings of guilt and shame were also strongly associated with the choice of method in female samples, particularly self-immolation that was predicted by the feelings of guilt and marital/family issues (Ahmadpanah et al., 2017).

Other-Imposed Suicidal Drivers

Being made to feel responsible for others and believing that one's imperfections cause inconveniences and problems for people is an experience shared by many participants. How participants have learned to value themselves could influence interactions that conjure feelings of being a liability and of little worth. These participants may thrive on external validation, and its absence may be perceived as confirming their lack of value, leading to a desire to atone for one's flaws in rather extreme ways.

Low Self-Worth

Feelings of worthlessness, unworthiness, and not being good enough are senses of selves that participants have come to believe about themselves over time based on their experiences. Worthlessness refers to having no value for others, while unworthiness is about not deserving

anything in life. In the IPTS theory, the sense of perceived burdensomeness is proposed to include the loss of personal and social worth (worthlessness), which incorporates the person's belief that they cannot contribute anything positive on the individual, family, and societal levels (Van Orden et al., 2012).

According to some authors, the notion of worth is one of the components of self-esteem. For example, Tafarodi and Swann (1995) view self-esteem as dimensions of self-liking and self-confidence. Self-liking incorporates the concept of social worth, while self-confidence includes the belief in self-competence (Van Orden et al., 2012). In this regard, participants' perceived worthlessness, unworthiness, and not being good enough to be worthy appear to correspond with the lack of social worth and self-competence that results in them not deserving whatever is bestowed upon them. The feeling of reduced self-worth was found to be associated with suicidal thoughts and behavior in autistic adults (Pelton et al., 2020), adolescents and street youth (Kidd & Kral., 2002; Wild et al., 2004), and psychiatric outpatients (Bhar et al., 2008). Some authors also argued that feelings of unworthiness are connected to the experiences of shame, and the perception that life is not worth living is an externalization of a deep sense of unworthiness (Sommer-Rottenberg, 1998; Thomas et al., 2002).

Liability to Others

Being a liability to others aligns with perceived burdensomeness from the IPTS (Joiner, 2005). According to the IPTS, Liability is one of two dimensions related to the sense of perceived burdensomeness. Along with self-hatred, a sense of liability to others contributes to the feeling of perceived burdensomeness that in turn leads to passive suicidal desire (Joiner, 2005; Ma et al., 2016b; Van Orden et al., 2010). In this study, feeling like a liability to others can also lead to active suicidal desire. Participants for whom being a liability to others drove them to

contemplate suicide is concerned for the well-being of others. It devastates them not to be productive or not pull their weight or fulfill their responsibilities.

The subthemes that emerged from the data (i.e., letting others down, causing others to suffer, and an impediment to others) reflects the IPTS 's indicators of liability to others (e.g., unwanted, the burden on the family, distress) which is a category of perceived burdensomeness (see Figure 2; Van Orden et al., 2010). According to Van Orden (2010), the indicator of being unwanted manifests in feeling expendable and unwelcome. It is particularly true for children and adolescents who feel rejected by their families (Woznica & Shapiro, 1990). Being a burden on the family is understood by the IPTS is a combination of "beliefs that the self is so flawed as to be a liability on others and affectively laden cognitions of self-hatred" (Van Orden et al., 2010, p. 583). In our findings, self-hatred appeared to be distinct from liability to others. Self-hatred, which was self-imposed, was more about feeling disgusted for being defective somehow, not because they were a liability. Perceiving the self as a burden on the family aligns with the subthemes of 'causing others to suffer' and "letting others down."

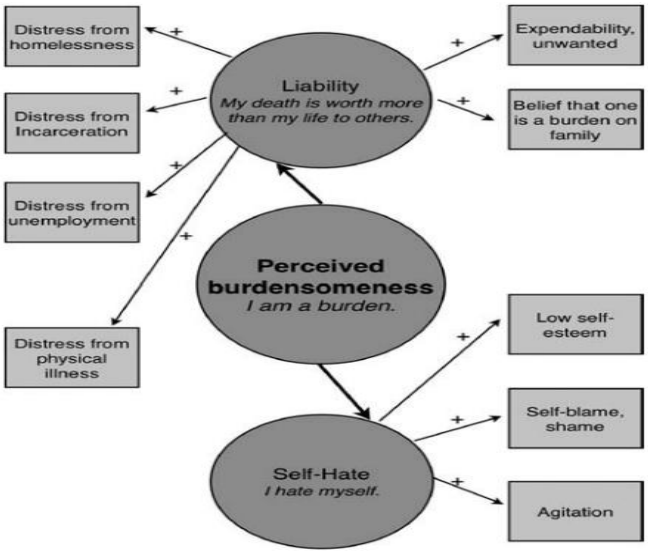

Figure 3. Dimensions and Indicators of Perceived Burdensomeness (Van Orden et al., 2010).

Both Self- and Other-Imposed Suicidal Driver

Feeling Alienated

Feeling alienated is a unique suicidal driver that exists in between self- and other-imposed suicidal drivers. As self-imposed suicidal driver, alienation can happen as a purposeful attempt of a person to distance themselves from others. For example, when someone cut ties with people before suicide so as not to cause suffering to others or when a person struggling with depression and feeling is misunderstood by society self-isolates and does not respond to phone calls or messages. For other-imposed suicidal driver, alienation can happen when a person is rejected by societal circles, family, friends, or loved ones. The experiences of alienation by a person in this case might include bullying, criticism, ignoring, etc.

Feeling alienated aligns with thwarted belongingness from the IPTS (Joiner, 2005). Participants for whom feeling alienated drove them to contemplate suicide appear to be concerned about isolation and lack of support from their families and loved ones, which reinforced their sense of lack of belonging. The subthemes that emerged from the data (i.e., lacking support, isolation, out of place, misunderstood/not understood) appear to align well with the IPTS's indicators of loneliness (e.g., self-report loneliness, few social supports) and absence of reciprocal care (e.g., social withdrawal, family conflict) which are categories of thwarted belongingness (see Figure 3; Van Orden et al., 2010). According to Van Orden (2010), self-report loneliness is related to a lack "of social connectedness and an indicator that a fundamental human psychological need is unmet" (p. 581). The indicator of self-report loneliness aligns with the subtheme of 'isolation.' The indicator of social supports is described as a factor causing further alienation from others due to either lack of support or limited support from family,

friends, and loved ones (Van Orden et al., 2010). The social support indicator aligns well with the subtheme ‘lacking support.’

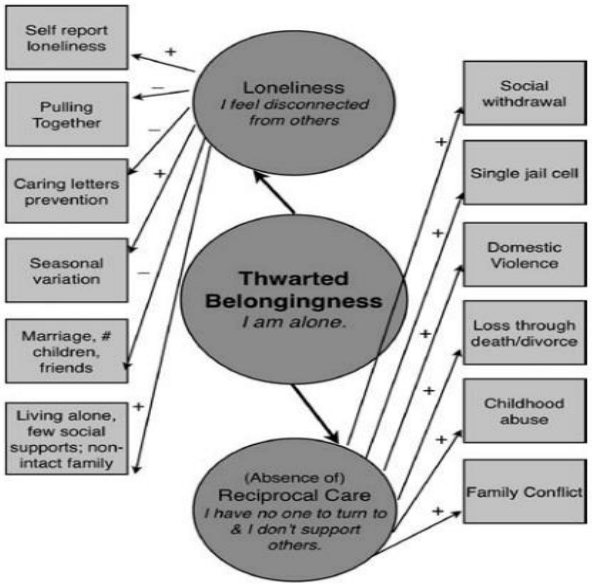

Figure 4. Dimentions and Indicators of Thwarted Belongingness (Van Orden et al., 2010).

Social withdrawal is described by Van Ordern (2010) as an individual’s deliberate low level or lacking involvement in societal experiences. The social withdrawal indicator aligns with the subtheme of being ‘out of place.’ Family conflict is understood as a disagreement and lack of understanding between family members (Van Orden et al., 2010). Family conflict indicator aligns with feeling ‘misunderstood/not understood.’ According to the IPTS, thwarted belongingness by itself leads to passive suicidal desire, but, according to our findings, it can lead to both active and passive suicidal desire (Joiner, 2005; Van Orden et al., 2010).

Contextual Suicidal Drivers

Health Issues

Both mental and physical health issues are included in the list of suicidal risk factors published by the CDC (2015), National Institute of Mental Health (NIMH, 2015), WHO (2015), AFSP (2015). Mental health issues are considered among the most vital suicide risk factors in all

age categories (Caldwell et al., 2004). All three mental health issues -- PTSD, anxiety, depression – that participants identified as drivers of suicidal thoughts are closely connected to suicidality.

The risk factors related to depression "appear useful in identifying who has developed suicidal thoughts, but they appear to have minimal utility for characterizing who has acted on their suicidal thoughts" (May & Klonsky, 2016, p.7). On the contrary, anxietyand PTSD appeared to be "more common in attempters than ideators" (May & Klonsky, 2016, p.13). PTSD was found to have - "a highly significant positive association with suicidality across psychiatric and non-psychiatric samples and PTSD populations exposed to different types of traumas" (Baca et al., 2021; Panagioti et al., 2012, p. 915). A strong association between anxiety and suicidal ideation was determined in a recent meta-analysis of 33 studies (Baca et al., 2021; Stanley et al., 2018). Major Depressive Disorder was found to be associated with suicidal thoughts and behaviors "with suicidal behavior frequently reported during depressive episodes, with a suicide risk equivalent to around 15%" (Orsolini et al., 2020, p. 208).

Even though physical health was mentioned by only a few participants (potentially because of the relatively young sample), it is strongly linked to suicidality. According to a large national study, physical health issues increase the risk of suicide if multiple health issues are present simultaneously (Ahmedani et al., 2017). According to the authors, "a robust association was found between 17 physical conditions and suicide" (p. 313). A national study of more than 8,000 adults (15 to 54 years old) found a significant association between lung disease, ulcer, and AIDS with future suicide attempts (Goodwin et al., 2003). Among the elderly, physical illness was determined to be one of the three primary factors (along with bereavement and interpersonal issues) contributing to suicidal attempts (Harwood et al., 2006). Regardless of age, a population

case-control study noted that physical illness increases the risk of suicide and has a substantially more significant effect in women than men (Qin et al., 2013).

Externally Derived Suicidal Drivers

Financial stress and academic/professional stress are subthemes of external stressors. Stress is considered one of the central factors contributing to suicidal thoughts and behaviors (Stewart et al., 2019). Among ideation-to-action theories, there is a proposed idea that stressors could add in transition from passive to active suicidal desire and then facilitate suicidal attempts when capability for suicide is present (Klonsky et al., 2018; May & Klonsky, 2016; Stewart et al., 2019). Among ideation-to-action frameworks, there is a consensus that different stressors would affect suicide ideators and suicide attempters. The results will vary in other demographics. For example, financial stress and professional stress may predict suicidal ideation in middle adulthood, while understandably, they may not predict adolescents (DeJong et al., 2010). It is also important to note that even though financial and work stress are predictors of suicidal ideation, they do not directly affect suicidal behaviors in adults as opposed to family stress, which is significantly correlated to suicidal behavior (Kim et al., 2021). Regarding academic stress, it was found to be associated with suicidal ideation in adolescent samples with depression partially mediating this relation (Ang & Huan, 2006; Jayanthi et al., 2015).

Functions of Suicidal Drivers

The findings show that drivers of suicide functioned differently across participants. For instance, a direct driver for one participant may serve as an indirect driver for another and vice versa. The unique context of each participant influenced the meaning and function of drivers. Even though there was a significant variation in participants' perceptions of direct and indirect

suicidal drivers, the role of these drivers fell into three broad categories – providing relief, a form of self-punishment, and gaining control.

Suicidal thoughts as a means to reduce suffering and bring relief is consistent with previous studies that determined suicidal thoughts can bring comfort to a person contemplating suicide and "decrease negative effect" for that person (Kleiman et al., 2018, p. 122). These findings are further supported by other studies that determined that suicidal thoughts could bring relief to patients with depression, unipolar, and bipolar disorders, with notions of comfort and discomfort being mutually exclusive in patients with suicidal thoughts (Crane et al., 2012, 2014; Hales et al., 2011; Holmes et al., 2007). There was also a qualitative study where participants shared that thinking about suicide "is comforting and makes it possible to endure suffering" (Vatne & Nåden, 2012, p. 310).

Suicidal thoughts as a form of self-punishment are consistent with previous literature on suicidal ideation and self-harm. In particular, self-punishment tendencies were positively correlated to suicidal thoughts and behaviors (Paul et al., 2015). Other studies found that suicidal ideation was positively predicted by self-punishment and considered self-punishment one of its risk factors (Tucker et al., 2017). Self-punishment was also researched in connection to non-suicidal self-injury with substantive evidence supporting punishment as a function of non-suicidal self-injury (Edmondson et al., 2016; Osuch et al., 2014).

Research has previously considered gaining control as a function of suicidal ideation. For example, it was argued that suicidal thoughts might be providing "mental control in times of distress" (Crane et al., 2014, p. 243). The notion of control as a function of suicidal thoughts was further found among participants with bipolar disorder and unipolar depression (Hales et al., 2011; Williams et al., 2008).

Overall, participants' reasons for having suicidal thoughts, although often not intentionally but rather automatic and uncontrollable, served to counter their drivers of suicide. For instance, suicide could help relieve participants of their emotional and physical suffering. Self-punishment appears to be a means to atone for being a liability or perhaps defective somehow. Gaining control may allow participants to counter their sense of lacking control over their lives. Hence, it makes sense why suicide could seem like a reasonable option or solution to those who suffer unbearable pain.

Strengths and Limitations

The demographically diverse sample is a strength. Even though this sample cannot represent the whole population, the diversity of age, professional and educational backgrounds, and mental health status add to the data's richness. Another strength is the "in-vivo" codes and participants' statements that tell the story of their experiences in the most objective way possible, considering the study design. Understanding participants' struggle with suicidal ideation and presenting them in the most "raw" and unaltered state can help de-stigmatize suicidality and aid therapists in understanding its complexity. Additionally, both inductive and deductive analysis techniques allowed us to explore the realms of the IPTS concepts as drivers of suicide and expand and broaden the model statements by including additional themes and subthemes, such as external stress and health issues.

Among the study's limitations, we utilized the IPTS's concepts of perceived burdensomeness and thwarted belongingness as guiding themes for initial search and analysis. As a result, our examination of themes was influenced by the IPTS framework. Even though we dedicated ourselves to keeping an open mind while analyzing the data and focusing on exceptions, it is essential to acknowledge that this theory-guided our discovery of themes and,

therefore, may have been somewhat limiting. Nevertheless, the widespread use and utility that the IPTS offered outweighed this limitation. Another limitation of our study includes the lack of consideration for the capability of suicide as the third dimension of the IPTS. As a result, we could not evaluate the utility of the theory as a whole. Further, the results of this study cannot be generalized to a larger population nor replicated fully due to the subjectivity of qualitative research. Another limitation is related to the fact that we cannot determine the causality of relationships between suicidal drivers and suicidal ideation. Still, we would encourage further research that would allow us to determine the relationships between these concepts.

Implications for Clinical Practice and Policy

The findings have implications for clinical practice and policies for suicide prevention. Identifying suicidal drivers and their origin can facilitate treatment goals and inform interventions. Clinicians should start with identifying the indirect and drivers of suicide. This can help with case conceptualization and help with knowing what to target first. Direct drivers should be primary target of treatment. Next, identifying what these drivers are related to (i.e., self-imposed, other-imposed, context or external stressors), can inform treatment interventions. For instance, if feeling alienated is self-imposed, this could reflect an internalized state of fear. However if feeling alienated is other-imposed, it could reflect rejection. Knowing the catalyst for the driver can inform the use of appropriate interventions. Another example is self-denigration that reflects low self-esteem. Here, treatment goals should include enhancing self-esteem. Feeling like a liability reflects maladaptive cognitions. Treatment goal should include challenging cognitive distortions.

Another important consideration is when to take suicidal drivers seriously. Active suicidal desires generally garner more attention from clinicians. However, given that passive or

active suicidal desire can be sparked by the same suicidal driver, it is recommended that the focus should be treating the suicidal driver even if the client reports only passive desires. Clients may not feel comfortable or safe to disclose the severity of their suicidal status. By treating the driver regardless of the severity of the desire for suicide, clinicians can more likely help prevent suicide. Hence, clinicians should provide the same attention to passive suicidal ideation as active ideation. By focusing on drivers, clinicians can intervene before the attempt happens, which can save lives.

The findings have implications for policies related to suicide prevention and intervention at the state level, and across various institutions, including K-12 schools, and tertiary institutions. State licensing boards should require continuing education on suicide prevention for health care professionals. Such training should include assessment and treatment of suicidal drivers. Education programs aimed at reducing suicidal drivers such as reducing alienation, normalizing failure, improving collective and individual self-worth, and improving financial literacy could be introduced in parent education programs, schools, and institutions of higher education. Educational institutions should increase efforts to develop and provide coursework and extracurricular activities that promote self-esteem and self-worth beginning from early childhood. Introducing programs that help students develop healthy social skills early on is recommended because this could help mitigate loneliness and depression among college students that is at a record time high (Lijie et al., 2022). It is also important to consider strategies for educating funders and policy makers on the importance of addressing suicidal drivers from early on by introducing them to suicide research statistics and new trends in suicide prevention and intervention. Together these programs could become a part of a solution in a global effort of suicide prevention.

Implications for Future Research

Future research with a larger and more diverse sample across various contextual dimensions such as age, education levels, racial/ethnic backgrounds, gender, sexuality, geographical location, relationship, employment, citizenship, and health status is desirable. Topics that would benefit from further exploration include distinguishing between self-and other-imposed suicidal drivers. Identifying the contextual factors that influence how drivers are derived -- from beliefs about the self or how one experiences the world around them could provide helpful information for suicide prevention. This is especially true given the rising suicide rates among Black youth (Lindsey et al., 2019; Xiao & Lindsey, 2021), Native Americans (Xiao & Lindsey, 2021), military-connected children (Williamson et al., 2018), rural centers (Bertera, 2007; Judd et al., 2006) and LGBTQ+ youth (Aranmolate et al., 2017; Xiao & Lindsey, 2021).

While it is expected that there would be an overlap in suicidal drivers, distinguishing the uniqueness of drivers would be beneficial and larger samples would facilitate this. Research should also explore differences in suicidal drivers for people with active and passive suicidal desires. Knowing how personal, contextual dimensions such as age influences the role of suicidal drivers for people with active and passive suicidal ideation could help clarify and advance theories in suicidality. Last, the functions of suicidal thoughts are not well-represented in the literature. Further research is needed to explore the notions of relief, punishment, and control as functions of suicidality in a larger sample to confirm the integrity of these findings and discover other parts of suicide.

Conclusion

This study supports the notion that suicidal ideation is a complex and multifaceted phenomenon requiring contextual understanding. Regardless of whether suicidal desire is in the

active or passive phase, indications that the drivers of suicide can exist in either phase makes it imperative that these drivers need to be identified, assessed and treated. Distinguishing between self-imposed and other-imposed suicide drivers and whether they are influenced by contextual or external factors can inform the focus of clinical interventions. This information can also be used to inform development of and policies for suicide prevention programs.

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Appendix A - CAMS Worksheet

I. CAMS Therapeutic Worksheet: Understanding Your Suicidality

Date of Session: **Session #:**

I. Personal Theory of Suicidality

"What contributes to your thoughts of suicide? What have you noticed about your patterns of suicidal thoughts? "

_____

_____

II. Drivers of Suicidality

"Now let us examine the factors underlying your suicidality or what we refer to as "drivers"." Only complete those sections that have relevance toward your participant's experience of suicide. *"Your answers may overlap with the information you provided on the Suicide Status Form earlier. However, new information may be added over the course of treatment in order to most accurately reflect your personal experience of suicide."*

"*What are the "direct drivers" that lead you to feeling suicidal?"*

"Specific thoughts like, 'It would be easier on everyone if I were dead.'"

_____

_____

_____

"Specific feelings like 'I just feel so much shame.'"

_____

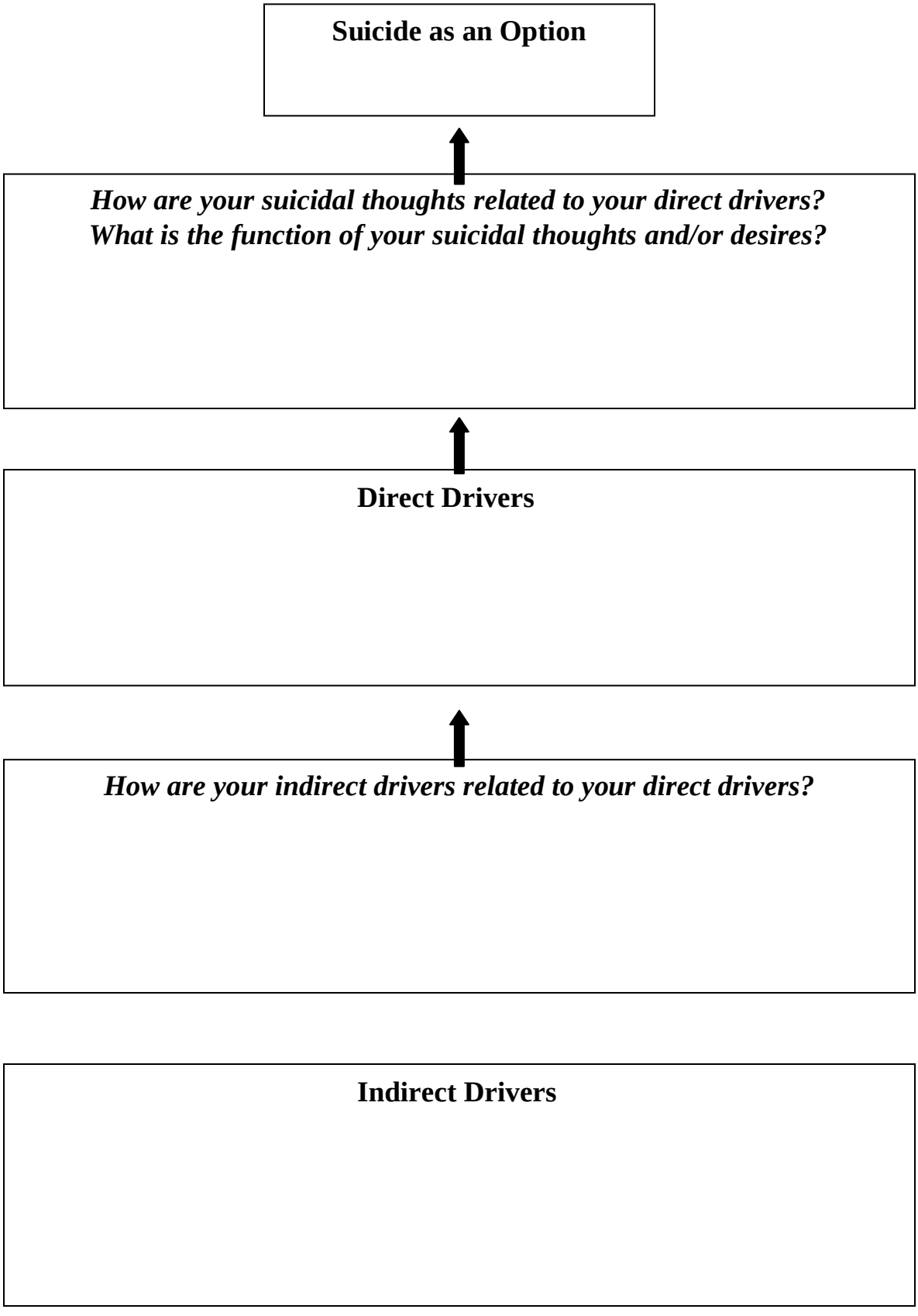
_____

"Specific behaviors like 'When I waste time all day long.'"

"Specific themes like you notice a certain recurring pattern in your relationships or self-confidence.'"

"Now we will examine the "indirect drivers" that contribute to you feeling suicidal. Indirect drivers are underlying factors that contribute, but do not necessarily lead to actual thoughts or feelings of suicide. These would include feeling depressed, experiencing trauma, being isolated, being homeless etc."

III. Suicidal Conceptualization



Appendix B - Thematic Analysis Spreadsheet Samples

Initial Coding (Step II)

#	Risk level	Participant #	Initial Coding		Subsequent Coding	
			Thwarted Belongingness	Perceived Burdensomeness	Direct Drivers	Indirect Drivers
1	High Risk					
2						
3						
4	Moderate Risk					
5						
6						
7	Low Risk					
8						
9						

Developing Common Themes (Step III)

#	Risk level	Participant #	Subsequent Coding		Hopelessness	Mental Health	Self-denigration
			Direct Drivers	Indirect Drivers			
1	High Risk						
2							
3							
4	Moderate Risk						
5							
6							
7	Low Risk						
8							
9							

Summarizing and Comparing Themes (Step IV)

#	Risk level	Participant #	Perceived Burdensomeness	Being a Liability		
				Letting Others Down	Causing Others to Suffer	An Impediment to Others
1	High Risk					
2						
3						
4	Moderate Risk					
5						
6						
7	Low Risk					
8						
9						

Appendix E - Themes and Subthemes

1. Being a Liability
Letting Others Down
Causing Others to Suffer
An Impediment to Others

2. Feeling Alienated
Lacking Support
Isolation
Out of Place
Misunderstood/Not Understood

3. Perceived Defectiveness
Self-Denigration
Lacking control
Unaccomplished

4. Self-Worth
Worthlessness
Unworthiness
Not Good Enough

5. Emotional Anguish
Hopelessness
Guilt
Shame

6. Health Issues
Mental illness
Physical Health

7. External Stressors
Finances
Professional/Academic stress