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## The role of connectedness on the paths to and from suicide

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# **The Role of Connectedness on the Paths to and from Suicide**

Thesis submitted in fulfilment of the requirements for the

PhD in Clinical Psychology,

Department of Psychology, University of Limerick

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B.A., M.A.



April, 2015

Supervised by: Dr. Barry Coughlan, Department of Psychology, University of Limerick

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## **Declaration**

I hereby declare that this project is entirely my own work, other than the counsel of my supervisors. Any contributions made by other authors have been recognized appropriately. The work herein has not been submitted for any academic award or part thereof at this or any other establishment.

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Cian Aherne  
21<sup>st</sup> April, 2015

## **Researcher's Background and Personal Interests**

I completed a Bachelor of Arts degree in Psychology in University College Dublin in 2008 and a Research Master of Arts in University of Limerick in 2011. These achievements provided the stepping stones for my placement on the Clinical Psychology Doctoral Programme in the University of Limerick for which I have written the current thesis.

As a man in my twenties, I have become increasingly aware of the frequency of suicide for this particular demographic. Learning that Ireland, in particular, has one of the highest rates of suicide for males in their twenties in the world inspired me to further investigate the phenomenon. Like nearly everyone in this country, I have been acquainted with people who have attempted suicide and who have died by suicide. I have also volunteered in Samaritans and had placements in adult mental health services where I have come in contact with suicide as a primary problem.

To make the decision to end one's life seems unnatural to me and it shocks me to see so many people choosing suicide as the solution to difficulties in their lives. There are many statistics available on suicidality but I did not find that they gave me the understanding I was looking for in relation to the decision. Having completed a thematic analysis of interviews with professional carers for my Masters, I knew that qualitative interviews with people who have worked in the area could provide me with an insight that I could not get with figures.

## **Acknowledgements**

This research piece could not have been completed without the help and support of many people. I am tremendously grateful for every effort that was made in its realisation.

Firstly, I would like to extend my sincere appreciation to my supervisor, Dr. Barry Coughlan, whose expert advice and constant support from the outset helped see this project through. His expertise and knowledge of the research methodology, in particular, contributed to the standards of the overall project.

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This project would not have been possible without the time and effort of the staff members of the host organisation - I was welcomed with open arms to each service location. I am forever thankful to the psychotherapist participants, in particular. Their insights on suicide were fascinating for me and contributed to a research project that I am very proud of. The compassion that they showed in relation to their clients will always be an inspiration for me in my clinical work. I would also like to say thanks to the people they spoke about. Whether they have died by suicide or are in recovery, their stories are vital contributions to the ongoing attempts to alleviate people's pain and suffering.

I would like to thank my parents, Jo and Declan, for supporting me throughout my academic career up until this point. Dad's wisdom in the area of suicide and psychology was of great benefit to me in formulating an original and worthwhile research piece. Mum's passion for the English language has been crucial in my development of the ability to write. My brothers, Finbar and Jack, have always been there for me to bounce ideas off. I love you all very much and your love helps me feel supported in any of my ventures, thank you.

Finally, to my wife Noelle. Words cannot express the impact you have had on my life and career to date. Nothing seems difficult when I know I have you on my side. Your work ethic and knowledge are inspirational to me and I hope we can continue to learn from each other each day for the rest of our lives. I love you with all my heart, thank you.

## **Abstract**

*Background:* Suicide is one of the most common causes of death worldwide. Research targeting an understanding of the phenomenon of suicide, however, is still in its infancy. Connectedness is a key construct of suicide that has not been previously researched in depth using qualitative methodologies.

*Aims:* The current study aims to explore the role of connectedness in the paths to and from suicide with psychotherapists working in the applied field of suicide intervention. A goal of the research is to develop a theoretical framework for the role of connectedness in relation to suicidality.

*Method:* Psychotherapists (N=12) from a suicide-specific intervention service in Ireland were interviewed in relation to their understandings of connectedness and suicide. The transcripts of these interviews were analysed using a Constructivist Grounded Theory approach.

*Results:* A tentative theoretical model for the role of connectedness in an individual's path to and from suicide was developed. The model incorporated two strands: 1) the role of connectedness on paths to suicide and (2) the role of connectedness on paths from suicide. The connection an individual has with themselves was posited as the foundation for all other connections. The quality of connections and family were seen central to one's propensity for developing suicide intent. Furthermore, the therapeutic relationship was noted as the connectedness vehicle for recovering from suicide intent. In order to develop connectedness for recovery, elements of the therapy, the client and the service required were seen as crucial to the current theory.

*Conclusions:* Connectedness and relationships play essential roles in the trajectory of suicide. The development of positive connections can be sustaining and protective against suicide whereas maladaptive connections or a lack of connection can contribute to one feeling suicidal. The therapeutic relationship can be crucial to one's recovery from suicide intent.

## **Glossary of Terms**

**Suicidality:** The likelihood of an individual completing suicide.

**Suicidology:** The study of suicide.

**Suicide ideation:** Any self-reported thoughts of engaging in suicidal behaviour.

**Suicide intent:** To have suicide as one's purpose.

**Suicidal behaviour:** Self-inflicted injurious behaviour 1) with the intention of using the appearance to kill oneself to some other end or 2) with the intention to kill oneself.

**Suicide attempt:** A self-inflicted injurious behaviour with a nonfatal outcome for which there is evidence of intent to die.

**Psychotherapy:** A form of talk therapy whereby a person with mental or emotional difficulties talks with professional in order to bring about positive change.

**Psychotherapist:** A professional who engages in talk therapy with the intention of benefitting a client's well-being. Psychotherapists, therapists, counsellors, clinical psychologists, and mental health professionals have different specific professional competencies but all commonly engage in talk therapy. For the purpose of the current study, therefore, the terms are interchangeable at times as they each serve the purpose of suicide intervention using talk therapy.

**Suicide Intervention:** A direct effort to prevent someone from taking their life intentionally.

**Suicide Prevention:** An umbrella term for the collective efforts of community organisations, mental health professionals and related professionals to reduce the incidence of suicide.

**Risk Factors:** Factors that affect the risk of suicide.

**Protective Factors:** Factors that protect people from suicide.

**Connectedness:** A sense of interpersonal closeness with the broader social world.

**Therapeutic Relationship:** The relationship between a healthcare professional and a client

## Abbreviations

<b>ETS</b>	Escape Theory of Suicide
<b>HTS</b>	Hopelessness Theory of Suicide
<b>ITS</b>	Interpersonal Theory of Suicide
<b>PB</b>	Perceived Burdensomeness
<b>TB</b>	Thwarted Belonging
<b>CBT</b>	Cognitive Behavioural Therapy
<b>DBT</b>	Dialectical Behavioural Therapy
<b>CGT</b>	Constructivist Grounded Theory

*If somebody feels connected...That kind of almost lets them know  
that they are an important human being. (P9)*

## Chapter One: Overview of Thesis

### 1.1 Introduction

Suicide is one of the leading causes of death worldwide with one person dying by suicide approximately every 40 seconds (WHO, 2014). Suicide is a unique cause of death because it is *intentional*. It is for that reason that deaths by suicide are seen as all the more tragic. Life preservation is a commonly cherished theme in modern society and methods for preserving life are constantly being researched, developed, and implemented. Finding ways to preserve people from death by suicide, therefore, is also desirable. Suicide is a complex process, however, and finding a ‘cure’ is not the same as developing a direct antidote to a singular presenting problem. Several theoretical frameworks have consequently been developed in order to explain the underlying processes of suicide and to give insight for what interventions may be most effective.

A key tenet of these theories is the theme of connectedness. Connectedness is one’s feeling of interpersonal closeness with the broader social world (Whitlock, Wyman & Moore, 2014). It is particularly relevant to suicide because it corresponds directly with one’s sense of belonging in the world. Suicide is rarely, if ever, a solitary act and is deemed a societal problem (Durkheim, 1897). Theoretical insights of the interpersonal aspects of suicide (such as connectedness) may therefore be particularly helpful in developing our understanding of the problem and methods for decreasing the rate of death by suicide.

Much of the research in the area of suicide has focussed on quantitative analyses of risk/protective factors, intervention/prevention efficacy and prevalence. There is a vast quantity of such studies including many systematic reviews and meta-analyses. The rate of suicide in Ireland (and globally), however, has not considerably decreased. Quantitative methodologies were beneficial for initial exploration of the phenomenon but now appear to

have stagnated. More qualitative research is needed that can shed deeper insight as to the specific mechanisms contributing to individuals' experiences of suicide. Several studies have explored perspectives of people who have survived suicide attempts. Such studies give access to perspectives of 5 to 20 people at a time. Psychotherapists who work regularly with people exhibiting suicidal behaviours, however, are in the unique position of having worked extensively with many people with such experiences. Research investigating perspectives of psychotherapists, therefore, could provide vital information for deepening our understanding of the phenomenon. The current study, therefore, aims to access psychotherapists' insights of the processes of connectedness and suicide.

## **1.2 Outline of Thesis**

The thesis begins with a thorough and critical examination of the literature on suicide in Chapter 2. This is particularly in relation to theoretical frameworks and research findings of connectedness and suicide. Chapter 3 explains the methodology of the study. This gives an account of the participants, the constructivist grounded theory analysis being used and the rationale for the study's approach. Chapter 4 is the results chapter that details the findings of the study. This section illustrates a tentative theoretical framework for the role played by connectedness in peoples' paths to and from suicide using themes, quotes and diagrams. Chapter 5 is the discussion. This chapter presents the results of the study and discusses them in relation to previous research. Furthermore, strengths of the study and areas for improvement are considered as well as practical implications and suggestions for future research. A conclusion section is presented as Chapter 6 in order to summarise the study's key points.

## **Chapter Two: Review of Literature**

### **2.1 Chapter Introduction**

This chapter begins with an account of the current perspectives on suicide. The chapter then gives a comprehensive critical overview of the research literature pertaining to suicide including an exploration of prevalence, epidemiology, and aetiology. Risk factors, protective factors, and prevention and intervention methods and their efficacy will also be investigated. The various theoretical constructs that are guiding the global understanding of suicide will then be discussed. The role of connectedness in suicide will be explored in relation to theoretical frameworks along with the most up-to-date research and findings on suicide worldwide and in Ireland. The chapter concludes with a review of our current understanding of connectedness and suicide and how the current study aims to contribute to further this understanding.

### **2.2 Perspectives**

The World Health Organisation (WHO, 2014) defines suicide as the act of deliberately killing oneself (this is also the definition utilised in the current study). Having a death registered as a suicide, however, can differ from country to country. For example, suicide statistics in Ireland only include deaths classified under determined intent (WHO, 1992) whereas other countries may include deaths with undetermined intent (such as some single car motor vehicle accidents; Scowcroft, 2014). Suicide is also legal in most Western countries (suicide was legalised in Ireland in 1993) but remains illegal in many countries still (such as most Muslim-majority nations). Furthermore, the right to die is interpreted differently in various countries. The definition of suicide can be interpreted differently from case to case too, depending on a variety of circumstances and motives (e.g. physician-assisted suicide or the

perpetrators and victims of the 9/11 attacks; Joiner, 2005). The current study, therefore, focuses on suicides that are within a person's control, are un-assisted and are generally resulting from difficulties in one's life.

### **2.3 Suicide Research**

The majority of research in the area of suicide has included prevalence rates, exploration of risk/protective factors and efficacy of prevention/intervention strategies. There is a vast amount of empirical studies related to suicide (the term 'suicide' is in the title of over 75,000 papers from the databases of academic journals used in the current study). The current study, therefore, utilises systematic reviews and meta-analyses where available.

In performing a review of the literature, electronic databases were searched for related articles. The databases utilised included: Academic Search Premier (EBSCO), Applied Social Sciences Index, PsychINFO, Psychology + Behavioral Sciences Collection (EBSCO), PubMed, ScienceDirect, Web of Science, Google Scholar, and Wiley Interscience Journals. Combinations of the following search terms were used: suicide, suicidality, suicidology, connectedness, interpersonal, relationships, attachment, intervention, prevention, qualitative, theory, systematic review, and meta analysis. Articles were screened for relevance to the current study and the reference lists of the articles were also screened for any additionally relevant studies.

#### ***2.3.1 Prevalence***

It is acknowledged that the validity of suicide prevalence statistics can be problematic at times (Tøllefsen, Hem & Ekeberg, 2012) but the current study will use them for an insight into the general rates of suicide in Ireland and other countries (which have been shown to be reliable over time Birt et al., 2003; Värnik et al., 2011).

WHO reported that over 800,000 people die by suicide worldwide each year. Bertolote and De Leo (2012) note that global suicide mortality rates have decreased somewhat over the past 20 years although it is still in the top three ranked causes of death for people aged between 15 and 44 years (WHO, 2014). In Ireland, media headlines relating to suicide rates can be misleading. National news headlines in recent years have included “Number of suicides rises to highest on record in 2011” (Cullen, 2014) and “Suicide rates hit an all-time high as 554 take own lives” (Hade, 2014). The most recently released statistics for suicide in Ireland, however, report relatively stable rates of suicide in Ireland, per 100,000 of the total population per year, over the past 20 years (National Office for Suicide Prevention; NOSP, 2013, Scowcroft, 2014). These range from 10.3 to 13.5 per 100,000 per year for the past decade. Suicide rates, therefore, are not hitting “all-time highs” as has been reported in the media. Historically, on the other hand, suicide rates since the beginning of the 1990s are considerably higher than they were in the previous twenty years (Walsh & Walsh, 2011). Furthermore, suicide rates for young males in Ireland have increased threefold in the past three decades (Murphy, Kelleher & Malone, 2014); a trend that warrants concern.

The most recent data on suicide prevalence in Ireland report 475 deaths by suicide in 2013 (a rate of 10.3 deaths by suicide per 100,000) with a male to female ratio of approximately 5:1 (Central Statistics Office, 2013). This gender ratio has widened from 2:1 in 1980 (Corcoran, Keeley, O'Sullivan & Perry, 2004). Figure 2.1 presents the triangle of suicide prevalence in Ireland.

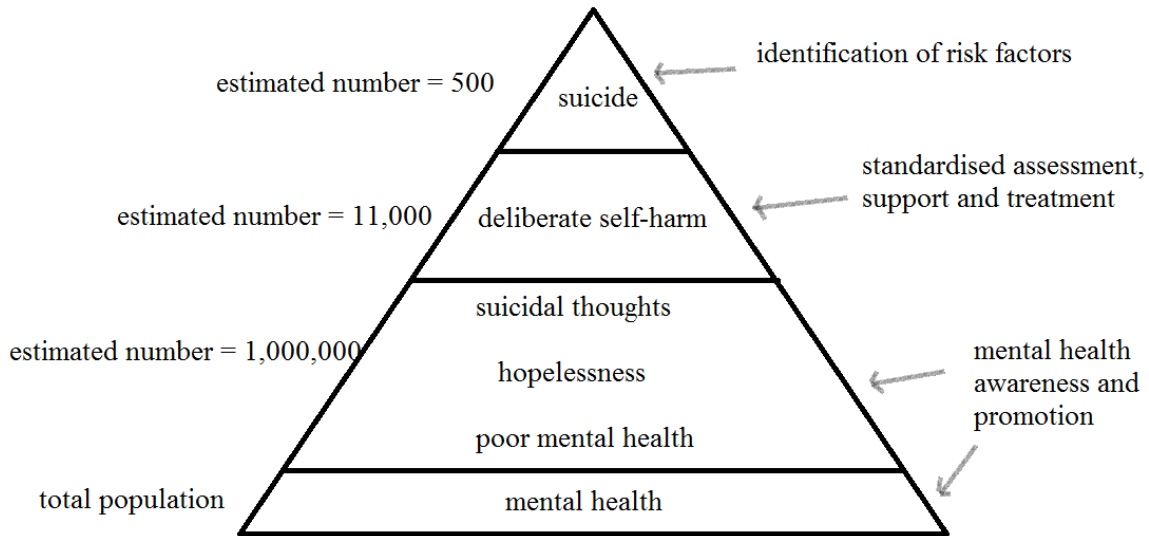


Figure 2.1 The triangle of suicide prevalence in Ireland (Health Service Executive, 2007).

There were 5,981 deaths by suicide in the UK in 2012 (a rate of 11.6 per 100,000) with a male to female ratio of about 4:1 (Scowcroft, 2014) and there were 41,149 deaths by suicide in the USA in 2013 (a rate of 12.6 per 100,000) with a similar male to female ratio of roughly 4:1 (Xu, Kochanek, Murphy & Arias, 2014). The comparisons presented in Table 2.1 should be interpreted with caution given the differences in definitions for registered suicide in these countries.

Table 2.1:

*Most Recent Suicide Rates in Ireland, UK and USA*

Country	Year	Rate (per 100,000)
Ireland	2013	10.3
UK	2012	11.6
USA	2013	12.6

In WHO's (2014) global report on suicide, Ireland ranked 58<sup>th</sup> highest out of 172 nations in terms of suicide per 100,000 (17<sup>th</sup> in the EU). In Ireland, the age groups for males that have the highest rates of suicide are 20-24, 40-44 and 60-64 years where prevalence is approximately 30 per 100,000. For females, the highest rate of suicide is seen between the ages 25-29 (approximately 9 per 100,000). Of note, Ireland ranks 4<sup>th</sup> highest in Europe in terms of death by suicide of people between the ages of 20 and 24 (31.9 per 100,000; NOSP, 2013). Suicide is thus the leading cause of death for that age group in this country (Murphy et al., 2014).

### **2.3.2 Risk Factors**

WHO's (2014) document 'Preventing Suicide – A Global Imperative' details the main suicide risk factors considered on a global scale. These include 1) health system and societal risk factors, 2) community and relationship risk factors, and 3) individual risk factors. They state that no specific risk factor or combination of risk factors can be accurate predictors of suicidal behaviour but that an accumulation of different risk factors can contribute to an individual's vulnerability to suicide. Some of the societal risk factors indicated by WHO include barriers to accessing health care, access to means for completing suicide, inappropriate media reporting of suicide-related behaviour (Sisask & Värnik, 2012) and stigma (Schomerus et al., 2015). Community and relationship factors listed include disaster, war and conflict, stresses of acculturation and dislocation, discrimination, trauma/abuse, sense of isolation and lack of social support, and relationship conflict, discord or loss (Yip, Yousuf, Chan, Yung & Wu, 2015). In addition WHO cite individual factors such as a previous suicide attempt, mental disorders (Arsenault-Lapierre, Kim & Turecki, 2004), substance abuse (Yoshimasu, Kiyohara & Miyashita, 2008), job/financial loss (Milner, Page & LaMontagne, 2013), hopelessness (Hawton, i Comabella, Haw & Saunders, 2013), chronic

pain/illness, family history of suicide, and genetic/biological factors (Voracek & Loibl, 2007). These risk factors have been supported by extensive research as can be seen by articles referenced above.

### *2.3.2.1 Risk Factors in Ireland*

The Suicide Support and Information System (SSIS) was set up in Ireland in 2008 to provide descriptive information of cases of suicide. It is currently in its pilot phase whereby information has been tracked from cases of suicide in County Cork. Arensman et al. (2013) completed a comprehensive report on the SSIS looking at risk factors for suicide between 2008 and 2012. Of over 300 cases of suicide in the area in that time, they found similar risk factors to those listed above in the WHO (2014) report. For example, previous suicidal behaviour, psychiatric diagnoses and substance abuse were all common in those who had died by suicide in Arensman et al.'s report. Their study is based on one county of Ireland and may not be generalisable to the country as a whole but it is the most up to date detailed account of suicide risk factors specific to an Irish sample.

In addition, the following were noted as risk factors in studies of specifically Irish samples: particular days of the week and months of the year (Mondays, April, June and August for men and August for women; Corcoran et al., 2004); recent loss of relationship, physical inactivity and social inactivity (Surgenor, 2014); marriage separation (Corcoran & Arensman, 2011; National Suicide Research Foundation, 2007); psychiatric diagnoses (O'Neill, Corry, Murphy, Brady & Bunting, 2014); ageing towards 21 years (Malone, Quinlivan, Grant & Kelleher, 2012); alcohol consumption (Walsh and Walsh, 2011); poor problem-solving abilities and the attitude that suicide behaviour is normal (McAuliffe, Corcoran, Keeley & Perry, 2003); drug use (Brennan & McGilloway, 2012); and childhood

adversity (Corcoran, Gallagher, Keeley, Arensman & Perry, 2006). These risk factors hence may be important to consider for suicide intervention and prevention programmes in Ireland.

### ***2.3.3 Protective Factors***

Many of the protective factors against suicide include opposing elements to risk factors (e.g. married versus divorced). WHO (2014) also reported that personal resilience, strong personal relationships, religious or spiritual beliefs and positive coping strategies are protective factors. In an Irish context, Surgenor (2014) noted engagement with health services, physical activity and social activity as protective. Another Irish study, ‘The My World Survey’, found that low risk alcohol behaviour, talking about problems and having at least one supportive adult in life were protective factors for well-being and mental health for Irish young people (Dooley & Fitzgerald, 2012). Furthermore, the Department for Education and Skills’ (DES) guidelines on suicide prevention in secondary schools lists developing a sense of belonging, staying in school, social and emotional learning, positive relationships and extra-curricular activities for students as protective factors (DES, 2012).

### ***2.3.4 Efficacy of Prevention and Intervention Methods***

WHO’s (2014) report recognises effective interventions for suicide prevention. These include 1) universal prevention strategies maximising health and minimising suicide risk for entire populations, 2) selective prevention strategies for particular vulnerable groups within populations, and 3) indicated intervention strategies for specific at-risk individuals in the population. The report presents a clear depiction of the risk factors associated with suicide and the relevant interventions for each (Appendix A).

#### *2.3.4.1 Prevention*

Strategies to prevent suicide are desirable as people can be supported and equipped with skills before suicide ever becomes an issue. Van der Feltz-Cornelis et al. (2011) completed a review of 6 systematic reviews on suicide prevention strategies. They maintained that general practitioner training on identifying people at risk, improved accessibility to professional care and restricted access to lethal means are the most effective suicide prevention methods with sufficient scientific evidence bases. The finding that general practitioner suicide risk assessment training is effective for preventing suicide may be of particular relevance in Ireland as people often tend to make contact with health services in the month prior to suicide completion in this country (O'Neill et al., 2014).

Social media platforms can be appropriate arenas for strategic suicide prevention but they are difficult to manage (Robinson et al., 2015). For example, the internet provides supportive forums and a coping mechanism for people who are isolated but can also normalise suicide behaviour through images, content and bullying (Daine et al., 2013). Furthermore, Sisask and Värnik's (2012) systematic review of media reporting and suicide found that all research studies completed since 1990 (40+ studies) have noted at least some association between media coverage and rates of suicide. The Samaritans suicide support service provides detailed guidelines for media reporting of suicide in Ireland (Irish Association of Suicidology, 2013) and research has supported the premise that when media reporting of suicide is modified, it can be successfully preventative (Niederkröthaler & Sonneck, 2007).

#### *2.3.4.2 Intervention*

Ougrin, Tranah, Stahl, Moran and Asarnow (2015) completed a systematic review and meta-analysis of therapeutic interventions for people who are suicidal. They explored all existing

research for psychological, social and pharmacological interventions. Interventions that were found to be effective, with the strongest evidence bases, included dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), and other forms of psychotherapy such as mentalisation-based therapies and problem-solving therapies. Similar results were obtained by Donker et al.'s (2013) systematic review of psychosocial treatments for people with schizophrenia and psychosis who were suicidal. Furthermore, Mujoomdar, Cimon and Nkansah (2010) and TARRIER, Taylor and Gooding's (2008) systematic reviews of DBT and CBT efficacy respectively were found to be effective in reducing suicidality. Robinson, Hetrick and Martin (2011), on the other hand, completed a systematic review of therapeutic intervention for suicide for young people and concluded that evidence of effectiveness is limited (although there were some encouraging results for CBT). Psychotherapeutic intervention, therefore, may not be as effective for young people as it is for adults or may need to be modified.

Pompili and Goldblatt (2012) reported encouraging effects for an antipsychotic medication, clozapine, in reducing rates of suicide. They note, however, that medication for treating suicide is not generic and is dependent on the specific symptoms of the individual. An example of this is seen in McKnight et al's (2012) systematic review and meta-analysis that found lithium treatment to be more effective than placebo at reducing number of suicides specifically for people with mood disorders. Furthermore, Vita, De Peri and Sacchetti (2015) found that increased lithium in drinking water is linked with decreased population suicide risks. Joiner (2005) listed fluoxetine as the most desirable antidepressant medication for treating suicidality. Joiner also mentioned, however, that the field of medication intervention for suicide provides inconclusive evidence for its effectiveness. Furthermore, Linehan (2008) posits that a different approach from the medical model to suicide intervention is required.

### ***2.3.5 Stagnation in the Literature?***

From the numerous research pieces, systematic reviews and meta-analyses described above, it is clear that there is a wide range of knowledge available for what suicide consists of. Research has shown a wide variety of risk factors associated with suicide, factors that can protect people from suicide and what intervention and prevention methods are effective or ineffective. On the other hand, with all these thousands of research projects completed, suicide rates have not decreased dramatically. This may relate to the fact that our *understanding of why* the above results exist is still in its infancy. To truly be able to relate to someone who is suicidal and to understand their experience from their perspective, it is vital to develop a knowledge base for *why* they feel how they feel. It is also important to increase our awareness of *why* intervention and prevention strategies work or do not work. This would conceivably improve the efficacy of intervention and prevention strategies.

To develop a scientific understanding of this phenomenon, qualitative research is the necessary next step (Lakeman and Fitzgerald, 2008). A paradigm shift to qualitative and mixed methods research is needed in order to bring the fields of suicide research, prevention and intervention to the next level (Hjelmeland and Knizek, 2010). The current study aims to develop a theoretical framework, using qualitative methods, to help better understand the ‘why’ questions mentioned above. It is important first, therefore, to explore previous theoretical frameworks of suicide in order to reveal the relevant areas and themes that may be worth researching in this regard.

## **2.4 Theoretical Frameworks for Understanding Suicide**

The following section explores and critically evaluates the extant theories of suicide in the literature.

#### ***2.4.1 Le Suicide (Durkheim, 1897)***

Durkheim's "Le Suicide" is one of the first major texts providing an explanation for the phenomenon of suicide. He posited that suicide is a societal fact and claimed that greater social control leads to lower rates of suicide. He looked at suicide on a macro level and stated that breakdown in social cohesion contributes to higher suicides rates. It is noteworthy that Durkheim cites social cohesion (or social connectedness) as pivotal to this theory. Durkheim has been criticised because the data that his theory derived from were spurious and his idea that social capital leads to social cohesion does not necessarily hold true (Kushner & Sterk, 2005). Durkheim's theory is also sociological rather than psychological and does not explain individual differences in suicide. Valid tests of Durkheim's theory are difficult to complete (Lester, 1999) although there have been some studies to support his premise that societal factors such as marital status, offspring and political oppression (Stack, 1979; Tartaro & Lester, 2005) play a role in suicidality.

#### ***2.4.2 Dialectical Behaviour Therapy (Linehan, 1987)***

Marsha Linehan (the creator of Dialectical Behaviour Therapy; DBT) approaches suicide from a behavioural angle. Her work is based on the premise that people who are suicidal have biological deficits, experience/s of trauma and a lack of adaptive mechanisms for handling emotional pain (Linehan, 2008). DBT, therefore, focuses on one's ability to regulate emotions as a buffer to suicide. DBT emphasises the supportive role of more frequent professional contact (increased connection) with the individual who is suicidal. Linehan's approach works well for suicide intervention and DBT has been shown to be effective in reducing suicidal behaviour (Mujoomdar et al., 2010). DBT is more of a framework for approaching therapy rather than a theory for explaining suicide and its constructs. On the other hand, its underlying premises hold true for individuals receiving treatment.

### ***2.4.3 The Escape Theory of Suicide (Baumeister, 1990)***

Baumeister (1990) hypothesised that suicide is brought on by ‘cognitive deconstruction’ (irrationality and lack of meaning) in the face of painful self awareness. Suicide, therefore, is seen as a means of escaping from the self when one’s self awareness is consumed by perceived failings and self-blame. The Escape Theory of Suicide (ETS) has received some research support (Dean & Range, 1999; Lester, 2013; Wolford-Clevenger & Smith, 2015) but does not include relationships and other people in its appraisal of the phenomenon. The current study posits that suicide is an interpersonal construct and a theory that does not investigate the link between suicide and relationships is limited and cannot adequately explain the phenomenon.

### ***2.4.4 Psychache (Shneidman, 1993)***

Shneidman (1993) developed one of the first widely accepted psychological theories of suicide. He maintained that suicide is the result of specific psychological distress (“psychache”) becoming so unbearable that a person sees it as the only viable option for escaping their pain. Shneidman believed that each individual has a different threshold for psychache but that this uniquely psychological pain is present in all suicides. Recovery from suicidal intent, therefore, would come from easing the psychache and meeting the emotional needs that the individual feels are not being met (Shneidman, 1996). Shneidman’s theory has been substantiated by numerous studies where psychache has been shown to be the predominant predicting factor for suicide (DeLisle & Holden, 2009; Holden, Mehta, Cunningham & McLeod, 2001; Patterson & Holden, 2012; Troister, Davis, Lowndes & Holden, 2013). Shneidman’s theory, however, is quite general. He listed 20 separate thwarted emotional needs that can constitute an individual’s psychache. This does not provide us with

an over-arching understanding of the specifically predominant mechanisms involved in the development of suicide intent or how such mechanisms interact with each other.

#### ***2.4.5 Attachment and Suicide Trajectory (Kaplan and Worth, 1993)***

It has been acknowledged that the history of an individual's attachment pattern with their caregivers may play a critical role in suicide trajectory (Bowlby, 1973; Kaplan & Worth, 1993; Sheftall, Mathias, Furr, & Doherty, 2013) and that insecure attachment patterns are related to suicidal behaviour (Mandal & Zalewska, 2012; Wright, 2005). Adaptive connections from infancy, therefore, may play a critical role in the potential for becoming suicidal. Furthermore, survivors of suicide attempts have cited the development of positive attachments as being central to recovery (Bostik & Everall, 2007; Bostik, 2009). People who have had seemingly healthy attachment patterns, however, still die by suicide. Attachment theory, therefore, offers some insight as to what may contribute to suicide vulnerability but maladaptive attachments do not fully explain the path to suicide and may be merely a risk factor.

#### ***2.4.6 Hopelessness Theory (Abramson and Alloy, 2000)***

Abramson et al.'s, (2000) Hopelessness Theory of Suicidality (HTS) posits that certain individuals have a specific vulnerability to thinking negatively and therefore are vulnerable to suicide ideation and intent. They maintain that this vulnerability is triggered by negative events in an individual's life over time that lead to feelings of hopelessness and suicide. The cognitive response pattern described by HTS has some empirical support (Abramson et al., 1998; Cornette, 2002) but other research has demonstrated that hopelessness itself is not a significant predictor of suicide (Holden et al., 2001). Williams, Van der Does, Barnhofer, Crane and Segal (2008) thus suggested a differential activation model of hopelessness and

suicidality. They proposed that previous experiences of suicidal ideation may trigger thoughts of suicide in future low moods (of differential intensity). Hopelessness, therefore, plays a critical role in suicidality but may not offer a full explanation or insight of its mechanisms.

#### ***2.4.7 The Interpersonal Theory of Suicide (Joiner, 2005)***

Joiner postulates that the sense of meaningful belonging to a relationship, group or to the world mitigates suicide intent. According to Joiner, when a person does not feel this belonging (thwarted belongingness; TB) and/or feels like they are a burden to others or the world (perceived burdensomeness; PB), they see suicide as desirable. Joiner recognises that either of these entities by themselves can be enough to trigger suicide but that both of them together increase the likelihood further. It is notable that both TB and PB place a strong emphasis on maladaptive connections. In addition, Joiner upholds that an acquired capability to complete suicide is also required. He notes that this ability is developed through particular kinds of experiences (such as previous self-harm behaviour). See Appendix B for diagram of the Interpersonal Theory of Suicide (ITS; adapted from Van Orden et al., 2010). Van Orden et al. (2010) also graph the different elements of ITS and the roles played by TB, PB and acquired capability to die by suicide (Appendix C).

ITS is the most widely researched and substantiated theory of suicide. Studies relating to people's levels of suicidality have shown ITS to fit well with large samples of people who have psychiatric diagnoses, university students and community populations (Christensen, Batterham, Soubelet & Mackinnon, 2013; Silva, Ribeiro & Joiner, 2015; Zhang, Lester, Zhao & Zhou, 2013). Some research findings have not quite matched with ITS. For example, analyses of suicide notes for elements of ITS found that ITS did not offer a reasonable explanation for the themes of the notes (Gunn, Lester, Haines & Williams, 2012; Lester and Gunn, 2012). Slis (2014) also found that ITS did not predict suicide ideation and behaviour

over time. Some studies may not have found that ITS maps directly onto their results but its framework is still general enough to offer an explanation for almost all suicides (Joiner, 2005).

#### ***2.4.8 Genetics***

Some constructs emphasise the biological and genetic aspects of suicide. For instance, Roy (1992) found that monozygotic twins were far more likely than dizygotic twins to die by suicide. Furthermore, Tomassini, Juel, Holm, Skytthe and Christensen (2003) found that biological relatives of adopted people who died by suicide had an increased likelihood of having died by suicide. Joiner (2005) further discusses the roles of genetics and neurobiology in suicide and how they can discern the possible trajectory of a person's vulnerability to suicide.

#### ***2.4.9 Theories Fit Well Together***

Many of the theories discussed above have several overlaps and tend to fit well when viewed together. In fact, research has shown that a number of these theories can be merged together to form further integrated frameworks. Cornette, Abramson and Bardone (2000) effectively integrated ETS and HTS with self-discrepancy theory to form a reconciled understanding of suicide. HTS is also strongly linked with ITS as Joiner (2005) explains how PB and TB are what contribute to one's hopelessness and despair. Joiner also gives quite a comprehensive overview of how several other theories are incorporated in ITS. For instance, he reports that Shneidman's 20 elements of psychache can be integrated in the two main strands of ITS. Moreover, Joiner maintains that Linehan's approach is also incorporated into ITS. He explains that one's emotional dysregulation can contribute to the acquired capability for self-harm and can also lead to interpersonal strain (PB and TB). In addition, Joiner claims that

ETS can be explained by ITS as it is PB and TB that lead to one's negative self-awareness. Acknowledging that theories on suicide tend to fit well together, the current study aims to further add to the theoretical research base by examining the construct of connectedness in suicide using a constructivist grounded theory approach (CGT).

#### ***2.4.10 The Emergent Theme of Connectedness***

Through exploration of the theories discussed above, the theme of connectedness and relationships appears to play a prominent role in many of them. For example, Durkheim proposed that a lack of group connections in society contributes to greater levels of suicide, DBT maintains that consistent adaptive therapeutic relationships are required in recovery from suicide behaviours, and several of the thwarted emotional needs named by Shneidman (1996) include needs for positive connections (e.g. affiliation, deference, exhibition, nurturance, shame-avoidance, succorance). Sperber (2011) also remarked how psychache is linked to alienation and one's sense of disconnection from the world (i.e. low levels of connection). Furthermore, secure relationships described by attachment theory can be protective against suicide by giving people acceptance of themselves, the assurance of a permanent relationship, encouragement and feelings of intimacy and closeness (Bostik & Everall, 2007). In addition, Abramson et al. (2002), the proponents of HTS, suggest that understanding of the psychosocial factors (including positive connections) contributing to suicide is crucial. Finally, ITS has interpersonal relationships at its core as TB and PB are examples of failed connections on some level. It is noteworthy that ITS, the theory that puts the largest emphasis on interpersonal connections, is the most widely researched and empirically supported theory on suicide. The role of these relationships and connections in people's lives is referred to in the current study as connectedness. The current study aims to

encapsulate the uniquely interpersonal aspect of suicide, expressed in each of the above theories, by investigating the role played by connectedness in its process.

## **2.5 What is Connectedness?**

Connectedness can be defined as a sense of interpersonal closeness with the broader social world (Whitlock, Wyman & Moore, 2014). Stone Luo, Lippy and MacIntosh (2014) described connectedness as the link between the known influences on suicide (such as developmental, environmental, psychological, social, cultural, physiological and genetic factors). They cited social support, social cohesion and social integration as key mechanisms of connectedness that can help prevent suicide. Barber and Schluterman's (2008) literature review of connectedness for young people revealed four common elements to the construct. These were 1) the quality of the relationship, 2) how much one likes the relationship (or environment), 3) a feeling/attitude of belonging and 4) feeling close to other people. Furthermore, Sanger and McCarthy Veach (2008) completed a grounded theory analysis of 138 suicide notes and found that each note referenced at least one interpersonal (or connectedness) theme. The themes unearthed from their study included positive relationships, relationship reconciliation, concern for others, negative relationships and acknowledging the end of a relationship. They also acknowledged that suicide is rarely, if ever, a solitary event, and often involves connections failing on some level. Joiner (2009) also notes, however, that all people who die by suicide experience isolation in some form before their death. Connectedness may be the link between these two positions (of connection and isolation) as people may perceive themselves to be totally isolated but they generally have connections on some level that will be affected by their death. As can be seen from the above literature, connectedness is a wide-ranging and dynamic concept that involves relationships with other people, the environment and the world. People's sense of connectedness seems to depend on

their perception or feeling of belonging and negative connections may also exist that contribute to suicide.

### ***2.5.1 Risk Factors and Connectedness***

Several connectedness themes were found to be related to risk factors for suicide. For example, individual characteristics or difficulties with relationships, such as unwillingness to be helped, avoidance of conflict resolution, PB and interpersonal difficulties have been cited as contributory to suicide (Buhnik-Atzil, 2015; Li & Phillips, 2008; Opperman, Czyz, Gipson & King, 2015; O'Reilly, Truant, & Donaldson, 1990). Furthermore, the absence of connectedness, such as loneliness, low sense of belonging, low sense of social connectedness, social withdrawal, absence of friends and loss of relationships, has also been shown to relate to suicide (Bonnewyn et al., 2014; Cui, Cheng, Xu, Chen & Wang, 2011; Donald, Dower, Correa-Velez & Jones, 2006; Fässberg et al., 2012; Hatcher & Stubbersfield, 2013; O'Reilly, Truant, & Donaldson, 1990; Purcell et al., 2012).

Difficulties with connections or relationship conflict are seen as risk factors for suicide as well. For example, intimate relationship difficulties, such as peer relationship difficulties, romantic discord and marital conflict, have been cited as playing a role (Cui et al., 2011; Donald et al., 2006; Li & Phillips, 2008; Purcell et al., 2012). In addition, family strife such as parental discord, difficulties with family relationships and low family connectedness have also been described as risk factors (Donald et al., 2006; Opperman et al., 2015; Li & Phillips, 2008; Purcell et al., 2012; Ratnarajah, Maple & Minichiello, 2014). Finally, negative connections such as ones that involved peer victimization, delinquent behaviours, bullying and discrimination were linked to suicide in several studies (Cui et al., 2011; Logan, Crosby & Hamburger., 2011; Peter, Roberts & Buzdugan, 2008; Stone et al., 2014).

### *2.5.1.1 Unemployment in Ireland*

Lucey et al. (2005) suggested that trends in suicide rates in Ireland were not related to socio-economic changes between 1968 and 2000. Their study is 10 years old but, given the relative stability in suicide rates since that time (following the 2008 economic recession), it appears that their conclusions have held true. On the other hand, Walsh and Walsh (2011) and Corcoran and Arensman (2011) reported that unemployment (a key element of socio-economic changes) was a risk factor for suicide between 2000 and 2006. Both studies, however, predicted a rise in suicide rates (due to the recession) following their research whereas that has not been the case. The relatively low numbers of completed suicide and the dynamic nature of the phenomenon make the prediction of suicide rates difficult. It may also be difficult to capture this dynamic and uniquely personal experience through statistical analyses. For example, a person who is unemployed may feel a lack of worthiness and meaning to his/her life because they view employment as purposeful. A different individual, however, may see unemployment as common in their social network and therefore feel comfortable with their situation. Exploring their qualitative feelings of connection, in this instance, may be more illuminating than simply identifying their risk factors.

### *2.5.2 Protective Factors and Connectedness*

A sense of connectedness acquired in early life is noted as a protective factor against suicide (WHO, 2014). WHO also acknowledges that the development of connectedness at an early age is a theoretically valid upstream approach to protecting people from suicide. The protective elements that connectedness provides have been noted as a sense of emotional closeness, resilience, encouragement to seek help during difficult experiences, and social support (Di Fulvio, 2011; Purcell et al., 2012).

There are a number of examples of connectedness that have been reported as protective against suicide in the literature. These include close family and friendship ties such as being married, having children, living with family, having close relatives, having a sense of family connectedness, positive relationships with parents, positive peer relationships, and being a twin (De Luca, Wyman & Warren, 2012; Duberstein et al., 2004; Gooding, Sheehy & Tarrier, 2013; Kaminski et al., 2010; Oliffe, Ogrodniczuk, Bottorff, Johnson and Hoyak, 2012; Purcell et al., 2012; Stone, et al., 2014; Tomassini et al., 2003). Examples on a societal level include community involvement, sense of social connectedness, regular social interaction and social supports (Donald et al., 2006; Duberstein et al., 2004; Purcell et al., 2012). In addition, a sense of belonging has been linked to protection from suicide. Examples include cultural belonging and school connectedness (Buchman-Schmitt, Chiurliza, Chu, Michaels & Joiner, 2014; Stone et al., 2014). Interestingly, a reduced amount of suicides occur in the US during major sporting events (i.e. The Super Bowl; Joiner, Hollar & Van Orden, 2006). Joiner (2005) also postulated that when a team that is particularly important to a locality has sporting success, it can contribute to a community's interpersonal connections during times of success and be a protective barrier against suicide. The practice of religion may be a further element of interpersonal community connection that protects against suicide (Duberstein et al., 2004; Oliffe et al., 2014).

### ***2.5.3 Prevention and Connectedness***

One of the priority goals of the American National Strategy for Suicide Prevention has been to encourage the development of connectedness among people, families and communities (National Center for Health Statistics, 2001). Furthermore, the Centers for Disease Control and Prevention in the US had connectedness as its core theme for suicide prevention in 2009. Other examples that include connectedness in recommendations for suicide prevention

include MacDonald's (2014) focus on the construct as the initial point for developing suicide prevention protocol in the US Airforce. He states that "connectedness is truly the key to meaningful and effective suicide prevention (p. 31)." Fässberg et al. (2012) also recommended aiming prevention strategies at building social connections and enhancing a sense of community for those at risk of suicide. Furthermore, Logan et al. (2011) posited that building positive connections with children through parental affection and positive reinforcement were the most important aspects of parenting for preventing suicide in young people. There is a dearth of research on the efficacy of prevention programmes, such as the ones listed above, but it is noteworthy that connectedness is thought to be a worthwhile concept for prevention.

Jigsaw is a programme that has been set up by the National Centre for Youth Mental Health in Ireland targeting improvements to youth mental health with an indirect aim to lower levels of distress and prevent suicide. Jigsaw engages Irish communities in connecting young people's support networks (family, peers, school, services, and neighbourhood) in order to support their well-being (Illback et al., 2010). Jigsaw offers brief intervention to people at the service which is a form of positive connection that has been shown to be effective in reducing long-term rates of suicide cross culturally (Fleischmann et al., 2008). They have used other elements of connectedness, such as co-ordination of local community resources, in attempts to support young people. The programme itself, as of yet, has not been evaluated in terms of suicide prevention efficacy but the amount of young people engaging (over 1,000 since 2008; Jigsaw Infograph, 2015) is encouraging.

#### ***2.5.4 Intervention and Connectedness***

Lakeman and Fitzgerald's (2008) systematic review of 12 qualitative papers on suicide reported that people can turn away from suicide quite quickly through experiencing the right

kind of connection with others. Health professionals may be in the ideal position to provide this positive connection and help an individual to recover (Olliffe et al., 2014). Help from health professionals, for instance, has been seen as strongly related to the cessation of suicide plans (Gooding et al., 2013). Gooding et al.'s findings seemed to point to the therapeutic relationship as the most protective aspect of interventions.

Psychotherapy in particular offers a person the space to experience one-to-one positive connection with another person for a prolonged period of time (Gooding et al., 2013). The connection in therapy may be particularly helpful because it is an opportunity for the modelling of healthy relationships. Bostick's (2009) grounded theory study of adolescents who were overcoming experiences of suicide found that the building of secure attachments, through therapy, as part of recovery can help people to open up, develop self-agency, develop understanding of themselves and create a life worth living. Bostick concluded that the development of secure attachments in therapy is closely linked to the development of resiliency that was lacking previously. This resiliency involves sources of support, encouragement of interpersonal communication and further close relationships. She also maintained that positive self-perceptions, hope, empowerment and changes towards reasons for living developed as a result of the positive therapeutic relationship. Fostering worth and belonging and targeting improvement of interpersonal relationships may also be crucial aspects of psychotherapeutic suicide intervention that develop an individual's sense of connectedness (Boccio & Macari, 2013; Van Orden, Talbot & King, 2012).

Pieta House is a suicide-specific intervention service that has been established in Ireland since 2006. They have a 'barrier free' service whereby people who are suicidal can access psychotherapy without needing a referral and without having to pay. These aspects of the service conceivably add to the ease of connection. Preliminary data for the efficacy of this service is encouraging (Surgenor, 2014).

## **2.6 The Research Gap**

Connectedness is a predominant element of previous theories and research that warrants more detailed exploration. It is understood that maladaptive connections can contribute to vulnerability to suicide and that adaptive connections can be protective but there is little research available that explains *how* this happens and *why* it might be the case. Previous theories have worked well together thus the development of further theory on suicide frameworks can add to the research base in a meaningful way. Moreover, there has been a vast amount of research completed in relation to the quantitative aspects of suicide. These quantitative research pieces are no longer adding to our understanding of the phenomenon. On the other hand, there is a dearth of qualitative research in the area. Lakeman and Fitzgerald (2008) have encouraged further qualitative research that can contribute to our understanding of suicide and the routes to recovery. The current thesis therefore aims to address this research need by using qualitative methodology (i.e. CGT analysis of interviews) to develop further understanding of the role of connectedness in suicidal processes and the route to recovery.

### ***2.6.1 Need for more Qualitative Research***

Quantitative analyses of suicide are no longer adding to our understanding of the subject or its processes. For instance, following the vast amount of quantitative research available, it is remarkable that the number of suicide fatalities has not decreased substantially in recent years. Furthermore, a full understanding of suicide is not possible based on risk factors alone and there is no evidence to suggest a cause-effect relationship between risk factors and completed suicide (Harré & Moghaddan, 2003; Mathias et al., 2012). Moreover, there is a lack of scientific research exploring *how* people develop suicidality, *why* people are choosing suicide as a solution to their difficulties, and what the best methods are for supporting the

lives of people with suicidal intent. It is important to develop adaptive methods of raising suicide awareness and preventing further suicides but a more in-depth exploration of the processes of suicide and recovery is needed in order for such development. Qualitative research methodologies, therefore, may be particularly appropriate in expanding our understanding of suicide.

There is a scarcity of qualitative research available pertaining to suicide. For example, Hjelmeland and Knizek (2010)'s plea for more qualitative research in suicidality noted that only 3% of studies published in the main international suicidological journals (between 2005 and 2007) were qualitative in nature. Hjelmeland and Knizek postulate that quantitative research is important for *explaining* suicidal phenomena but that it does not go into the depth of *understanding* needed in order to inform intervention. A qualitative study in an Irish context noted that young Irish males' difficulties with talking about suicide and lack of knowledge of its processes were barriers to supporting their friends who died by suicide (Sweeney, Owens and Malone, 2015). Without understanding the processes that relate to risk factors, therefore, simply knowing the risk factors that correlate with suicide attempts does not particularly inform intervention (Deuter, Proctor & Rogers, 2013). Hjelmeland and Knizek argue that linear quantitative studies of suicide are somewhat reductionist and do not take individual experiences into account. To bring the field of suicide research forward, more qualitative studies that develop our understanding of suicide and the processes related to suicide are necessary. In addition, a number of articles concur with the view that there is an over-emphasis on quantitative methods (in terms of risk factors in particular) and encourage a research shift towards qualitative methodologies and mixed methods approaches for studying suicide (Kral, Links & Bergmans, 2011; Niner et al., 2009).

### ***2.6.2 Themes from Interviewing Survivors of Suicide***

Examples of valuable insights gained from qualitative studies include research that has involved discussions with survivors of suicide. These individuals are in a unique position of being able to offer insight of suicide from personal experience. Vieira, Freitas, Pordeus, Lira and Silva (2009) completed a qualitative analysis of interviews with 12 Brazilian teenagers and found that a “broken heart” was a contributing factor to their suicide attempts. They noted that difficulties in family bonds also played a role. In interviewing 10 people who had experiences of suicide attempts/ideation about their experiences of health care professionals, Vatne and Naden (2013) found four salient themes. Survivors discussed 1) the difference between experiencing and not experiencing openness and trust, 2) being met by and not being met by someone willing to address the issue of suicide, 3) feeling met and respected and 4) feeling embarrassed and humiliated. Orri et al.’s (2014) interviews of suicide survivors unearthed themes of feeling negatively towards the self, having a need for control, perceived difficulties in interpersonal relationships, elements of communication and the use of suicide as revenge. Vatne and Naden’s (2012) study revealed themes of losing touch with the world, life history, ambivalence between life and death, the option of suicide as sustaining and feelings of shame and guilt. Vatne and Naden explained that people who are suicidal seem to be struggling with wanting to escape from suffering and wanting love, safety and dignity. They talked about how people need meaning in life and that is why life history may play a role. Themes of Irish suicide survivors included culmination of earlier life struggles, unfulfilled needs, negative emotional experiences and sense that life was uncontrollable (O’Connor, Coughlan & Meagher, 2012).

There is richness in the above findings whereby the participants have been able to describe the experience of suicide and recovery over time. A more detailed insight and understanding of the phenomenon is therefore obtained. Another notable aspect of the

findings is that the sense of connectedness and maladaptive connections play prominent roles in people's experiences of suicide. It will be important for the current study to elaborate on these understandings and offer a deeper exploration of what connectedness consists of and the role it plays in suicidality.

### ***2.6.3 Experiences of Professionals***

The qualitative research that has been completed has focussed on suicidal people and survivors of suicide. An understanding of suicidal processes and recovery from suicide from expert professionals' points of view, however, has not yet been obtained. Qualitative research completed with suicidal people or survivors of suicide can only investigate the experiences of a relatively small number of people. Professionals, however, may have worked with several suicidal people and may therefore be able to provide richer data in relation to the processes of suicide. Furthermore, people who have experienced suicidal intent may not have been coming from a stance of understanding their experiences. Mental health professionals working in the field, on the other hand, may be experienced, have more understanding of the subject, and be better able to offer a more grounded perspective. The current research aims to interview mental health professionals working in the applied field of suicide to gain an added insight that has not been previously explored.

Some of the research that has been completed with professionals has investigated the effect that clients' suicidal behaviour has had on them (Fox & Cooper, 1998; Kapoor, 2002; Kapoor, 2008; Ting, Sanders, Jacobsen & Power, 2006). Other research has focussed on professionals' attitudes towards suicide (Gagnon and Hasking, 2012; Knizek, Kinyanda, Akotia & Hjelmeland, 2012; Rogers, Gueulette, Abbey-Hines, Carney & Werth Jr., 2001; Srivastava & Tiwari, 2012) but these have been mostly quantitative in nature.

Professionals in the mental health field have been interviewed regarding the impact of clients' suicidal behaviour on their well-being and on their attitudes towards these clients. It seems, however, that very little research has investigated professionals' understandings of suicide, their perspectives on the processes of suicide and how they work with suicide in practice. Lindner and Briggs (2010) attempted to form the "ideal types" of suicidal males through interviews with professionals. They analysed discussions of two sets of mental health professionals in relation to the written materials and records of 20 suicidal males. The focus of their study, however, seemed to be more on the comparison between the two groups' understandings rather than focussed solely on the understanding of suicide. Furthermore, Lindner and Briggs developed a model based on clients' suicidal experiences whereas the processes of their work with suicidal people were not explored. Moreover, the notion of "ideal types" of suicidal people may not contribute to an understanding of how people get to the point of being suicidal and the processes behind their recovery and may be more of a reflection of previous quantitative results. In addition, professional counsellors' insights were used to good effect in Whisenhunt et al.'s (2014) exploration of the relationship between suicide and self-injury. Again, however, this study did not explore the construct of suicide itself and gave an understanding of its links with self-injury rather than a specific aspect of suicide. Studies, therefore, have shown the usefulness of interviewing mental health professionals about suicide but the current study may be the first to interview them about their understanding of its processes.

## **2.7 Bridging the Gap**

Connectedness has been a predominant theme in the literature of suicide. Its specific intricacies and the roles they play in suicidality, however, have not been extensively explored. There is an established need for further qualitative research to assist in the

understanding of particular aspects of suicide in order to inform interventions and give mental health professionals further insight of its constructs. Mental health professionals may be ideal candidates for exploring the phenomenon as they have conceivably more contact with people who are suicidal than any other profession. The role of connectedness is particularly prominent in psychotherapeutic intervention for suicide as psychotherapists spend prolonged periods of time with people who are suicidal in order to build adaptive connections in efforts to help the individual recover. The current research, therefore, aims to build on previous suicide theory by using CGT of interviews with psychotherapists (working in suicide-specific intervention services) to develop an understanding of the role played by connectedness in the development of and recovery from suicidal intent.

## **2.8 Research Objective**

The theme of connectedness has been cited in several important research studies related to suicidality (Hill, 2009; Purcell et al., 2012; Whitlock et al., 2014) and has been linked to previous theories on suicide (Abramson et al., 2002; Bostik & Everall, 2007; Opperman et al., 2015; Sperber, 2011). Previous research has noted the significance of connections (or lack thereof) in suicide trajectory (Fässberg et al., 2012; Hatcher & Stubbersfield, 2013; Logan et al., 2011) and there is evidence that the development of adaptive connections can be helpful for alleviating suicidality (De Luca et al., 2012; MacDonald, 2014). An explanation of the role that connectedness plays in relation to suicide, however, may be a useful framework for understanding suicide and suicide intervention that has not yet been developed.

Research Objective: To develop a preliminary theoretical framework for understanding the role of connectedness in relation to suicide.

- The goal is for this framework to incorporate the role that connectedness plays in a person becoming suicidal and the role it plays in a person recovering from suicidality.

## **Chapter Three: Method Chapter**

### **3.1 Chapter Introduction**

The following chapter provides a comprehensive account of the research methods used in the current study and the rationale for its approach. The design of the study, the procedure of the study, the participants, and data management will be outlined in the following sections.

### **3.2 Rationale for Choice of Qualitative Approach**

The aims of the current study were to develop a theory for how the dynamics of connectedness play a role in someone becoming suicidal and play a role in their recovery from suicidal ideation and/or intention. The current study employed a CGT approach to analysing qualitative data in relation to this topic (Charmaz, 2014).

Qualitative research generally obtains data through interviews or focus groups whereby discussions are recorded, transcribed and analysed for patterns and trends (Burnard, Gill, Stewart, Treasure & Chadwick, 2008). Such methods can be used to gain insights into human experiences in natural settings and to scientifically explore these insights. Human beings' lived experiences, in particular, can be researched using qualitative methods (Fossey, Harvey, McDermott & Davidson, 2002). This form of research focuses on individual perspectives and it aims to capture the elements that provide meaning to the participants.

Qualitative analysis was particularly relevant to the present study as therapists' insights and understandings of suicide were being researched. An investigatory qualitative approach was necessary to gain an in-depth view of the dynamics involved in connectedness and suicide. Utilising a qualitative methodology in exploring this area may facilitate the development of rich data that can give us further understanding of people's real and holistic

experiences of the subject. Such subjective and human experiences related to suicide may be difficult to expand upon using quantitative approaches.

Interviews with therapists, who work in a suicide-specific intervention service, were deemed the most appropriate method for gathering data in the current study. Interviewing is the most common form of qualitative data collection and offers a unique opportunity to research people's individual stories (Donalek, 2005; Knox & Burkard, 2009). There are criticisms regarding the reliability, trustworthiness and generalisability of qualitative research interviews (Kvale, 1994) but the current research aimed to gain a unique understanding of suicide from the subjective participant-researcher perspective and interviews offered an adaptive and appropriate method for doing this. Focus groups of therapists and of survivors of suicide were also considered in order to further enrich the data. The individual interviews utilised, however, were comprehensive in nature and reached saturation point in terms of the themes uncovered. It was therefore felt, in accordance with the overall scope of the project, that they provided rich enough data for wide-ranging analysis of the phenomenon of connectedness and suicide without having to undertake additional focus groups.

### **3.3 Grounded Theory**

Grounded Theory (GT) proposes a systematic research methodology whereby theory is generated from qualitative data (Glaser & Strauss, 1967). GT puts an emphasis on understanding certain phenomena by developing codes, categories and theories from qualitative data. This understanding is developed by constructing theories that can offer insight and meaning through descriptive and explanatory analyses (Rand, 2013).

GT has been dubbed "the constant comparative" method because of the requirement of the researcher to constantly compare the qualitative data throughout the analytical process (Glaser & Strauss, 1967). As part of GT, similar data are grouped together before being

formed into conceptual categories. These categories are then linked in accordance with the different relationships and conditions present and a theory explaining the phenomenon at hand emerges (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). GT attempts to develop theory based on the importance that people place on issues in their lives and how they experience events (Corbin & Holt, 2005; Glaser & Strauss, 1967). One of the main advantages of the GT approach is that the theory is rooted in the data; this is important as it adds rigour to the scientific validity of the method.

### ***3.3.1 Constructivist Grounded Theory***

CGT is an innovation of Glaser and Strauss' original principles and has been developed, in principal by Kathy Charmaz (2014). Original GT proposed developing theories from an objective stance from the "ground up" whereas CGT recognises the subjective role of the researcher and takes a more reflexive stance (Mills, Bonner & Francis, 2006). This subjectivity has been an important aspect of the current research methodology. The researcher had already performed a literature review before beginning the research and had a personal insight of the subject matter that was bound to have an impact on the research analysis. CGT was therefore a more appropriate method of analysis than original GT for this research.

Other qualitative methods, such as Interpretative Phenomenological Analysis (IPA) were considered for the current study. The current study was exploring therapists' lived experiences of connectedness and suicide which is a key tenet of IPA. The aim of the current study, however, was to develop a theory explaining the processes of connectedness and suicide rather than to investigate therapists' experiences of connectedness and suicide. For this reason, CGT was deemed a more appropriate method of analysis.

### **3.3.2 Social Constructionism**

Social constructionism is an approach to research focused on human meaning making and is deemed fundamental to CGT. Rather than focusing on *what* people know, social constructionism centres on *how* people know (Raskin, 2002). For instance, the human involvement in research is acknowledged as playing a role in the findings. This is opposed to historical psychological research that has maintained the possibility of an objective science where variables are controlled for rather than recognising that the human interaction with research is a crucial component of its findings. The social constructionist stance posits that knowledge is a result of human-made constructions and fleeting interactions within particular time contexts. Human involvement, therefore, is critical to research results. The existence of inherent human nature across different people is also rejected by social constructionism as people and interactions are fluid across contexts (Raskin, 2002). For these reasons, the interactions of the interviews in the current study, including the participants' dialogue and the researcher's reactions and observations, are all acknowledged as integral to the resultant theory.

### **3.4 Data Collection**

Semi-structured individual interviews were completed by the researcher with therapists from a suicide intervention service. A reliance on semi-structured interviews is particularly appropriate for CGT (Duffy, Ferguson & Watson, 2004) as they encourage two-way communication and mutual dialogue.

Data were gathered with therapists employed in a suicide intervention service in three separate service locations in Ireland. Therapists were recruited for the study through email and phone contact. Twelve psychotherapist employees volunteered to take part and arranged interview times with the researcher. Data collection took place in the form of individual

interviews between the researcher and the 12 participants. These interviews ran for 40 minutes to 1 hour 20 minutes in duration and the total time of the interviews was 695 minutes ( $M = 58$  minutes;  $SD = 12$  minutes).

### **3.5 Suicide-Specific Intervention Service**

The service that participants were employed by, in the current study, offer intervention and treatment for people with experiences of suicide ideation, suicide intent and deliberate self-harm. The intervention service is a charitable organisation that is partly funded by several corporate sponsors. Psychotherapists work in the intervention service and provide one-to-one solution-focussed psychotherapeutic support for clients with experiences of suicide. Clients tend to be seen for up to 15 sessions in order to help decrease suicide ideation and crisis and they are sometimes seen for longer if required. All therapists employed by the service have had extensive training and their qualifications are recognised by the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), the Irish Association for Counselling and Psychotherapy (IACP) or the Psychological Society of Ireland (PSI).

### **3.6 Participants**

All of the participants in the current study were psychotherapists working in the suicide intervention service. They all had at least one year's experience of working in the service. The participants included 5 males and 7 females. The age range of the participants was 38 to 56 years of age, the mean age ( $M$ ) was 48 years 8 months and the standard deviation ( $SD$ ) was 6 years 6 months. All participants had psychotherapy qualifications recognised by IAHIP, IACP and/or PSI. Throughout the course of the interviews, participants revealed that they had been working in the field of psychotherapy for different time spans between 2 and

28 years. Participants also approximated the amount of clients they had worked with who had been suicidal. This ranged from 60 to 1,000 clients per participant ( $M = 255$ ;  $SD = 263.59$ ).

### **3.7 Semi-Structured Interviews**

Individual interviews are the most commonly practised method of data collection in qualitative research (Sandelowski & Barroso, 2002). They can be problematic, however, in terms of balancing the power dynamic, the authenticity of participants' responses and difficulties with participants being able to withdraw consent mid-interview (Nunkoosing, 2005). On the other hand, participants' insights, attitudes and beliefs in relation to particular phenomena can be collected through individual interviews and were deemed appropriate in the current context (Speziale & Carpenter, 2003). Furthermore, participants in the current study were qualified psychotherapists who have significant training in terms of one-to-one contact, individual power dynamics, and interpersonal responses. Such a background was deemed to contribute to participants' comfort levels in the interview situation and to the authenticity of their responses (Erskine, 2013; Reiter, 1995). Individual interviews, therefore, were considered the ideal method of data collection for therapists in particular.

The principles of CGT assume an emphasis on semi-structured interviews rather than structured ones (Mills et al., 2006). Semi-structured interviews were concurrently preferred in the current study as they gave the researcher further opportunities to follow the participants' trails of thought and to develop areas of relevance to the topic. The semi-structured interview schedule (Appendix D) for this study was designed by the researcher to explore the participants' knowledge of suicide and connectedness from their experiences with clients throughout their careers. The open-ended questions were developed from previous research to identify therapists' understandings of connectedness, how connectedness (or the lack of

connectedness) plays a role in a person becoming suicidal and the role of connectedness in recovering from suicide ideation and/or intent.

### ***3.7.1 Interview Procedures***

All participants chose to be interviewed in their individual services as they felt that would be most convenient and comfortable for them. The services were located in three different counties in Ireland (the breakdown of participants per service was 6, 4 and 2).

At the beginning of each interview, the researcher reminded the participants of what the research was about, how confidentiality and anonymity would be adhered to, and how the interview would be structured. The researcher also reminded participants that they could cease their participation at any stage and that they could withdraw from the study at any time. Participants then gave their informed written consent on the consent sheet (Appendix E) before the interview began. Interviews were recorded using a digital recording device.

## **3.8 Consent & Ethical Issues**

Ethical approval was sought and obtained from the UL Ethics Research Board. The suicide intervention service agreed that ethics approval from the university would suffice for the service. The following sections detail the ethical considerations that were included in the current study.

### ***3.8.1 Initial Contact***

The service's Director of Research was contacted via email and phone calls enquiring about interest in the study and appropriateness of implementation. When ethical approval was confirmed, contact details of different service locations were provided to the researcher by the Director of Research. Service staff were then sent a recruitment letter (Appendix F) and

an information sheet (Appendix G) detailing what the study was about and what their participation would involve should they wish to take part. The researcher also visited the service locations in order to meet with any potential participants. Therapists were informed at each point of contact before participation that they were free to withdraw at any point and that they were not obliged to take part.

### ***3.8.2 Data Storage and Management***

Each interview was recorded using a digital recorder device. They were uploaded to the researcher's laptop and immediately deleted from the recorder. Once each interview was transcribed, the audio file was then deleted. All identifying information from the data collection was completely anonymised by the researcher so that participants and the clients they talked about would not be identifiable. The transcripts were typed and stored on a password-protected memory stick. They were then transferred to the principle investigator's password-protected hard drive that will be locked in a filing cabinet for 7 years before being destroyed in accordance with UL's data management procedures and protocols.

### ***3.8.3 Risks and Benefits***

The interviews required discussion of clients who had been suicidal, had attempted suicide and had died by suicide. The topic of suicide can provoke difficult emotions and the researcher was aware that it may have been distressing for participants to recount some experiences. Participants in this study are expert professionals in the area of suicide intervention, however, and work in the area on a daily basis. Nonetheless, they were informed of the sensitive nature of the interviews before taking part. They were also encouraged to seek support/supervision in relation to the interviews if they felt that was necessary. Regular supervision is already a requirement for professionals employed by the intervention service.

The purpose of the study was to develop further insight into the processes of suicide and to add insight to the area that may not have previously been researched. The understandings of professionals in the area are a resource that has not yet been investigated qualitatively in relation to suicide. Participants were informed that their participation in the current study would provide valuable information to the ongoing prevention and intervention strategies for suicide in Ireland.

Researching suicide can be a difficult process for the researcher considering the amount of hours engaged with such a harrowing topic. The researcher for the current study was aware of this risk and attended personal therapy on a regular basis throughout the process where any difficulties with the subject matter could be discussed and resolved.

### **3.9 Analysis**

The current study utilised CGT analysis. This involved repeated reading of transcripts and development of organized codes and themes. Each interview was read repeatedly with theoretically relevant questions (e.g. “What does this say about connectedness and suicide?”) and linking questions between interviews (e.g. “How does this piece on early childhood relate to what the other participant had said about early childhood?”). This process allowed for categories and themes to develop that hence informed the theory.

The analytical process was non-linear. This means that each step of the analysis was discrete from the others. This allowed for the researcher to move forward and backward between each step throughout the process of analysis. The researcher was therefore constantly comparing data (i.e. codes with categories, categories with themes, themes with theory and vice versa). The comparative procedure was repeated in this way until saturation was reached with relevant categories and themes.

### 3.9.1 Line-by-Line Coding

Analysis began with line-by-line coding of the transcripts. This involved labelling each line of the 12 transcripts with a meaningful code that could be understood in the context of the research. Coding is a method of defining data that systematically gives each line a label.

Below is an example of how a Microsoft Word table was used to assist in coding transcript data:

Table 3.1.

#### *Example of Line-by-Line Coding*

<b>Transcript</b>	<b>Line-by-Line Coding</b>
It's been my experience that when people come in, they can almost sequentially show how they've disconnected from...maybe their own community and then the community within their own family and then often times what brings them to a point of deciding maybe to go ahead with a plan of suicide is that maybe the death of a loved one or maybe an argument with a mother or father who up until this point had been their last kind of like connection to another is lost. So they come in and they're adrift..so adrift in the sea of pain and darkness you know...	<p>Clients have sequentially disconnected.</p> <p>Clients have disconnected from their community.</p> <p>Clients have disconnected from their family.</p> <p>The death of a loved one can bring one to the point of deciding to die by suicide.</p> <p>An argument with a parent can bring one to the point of deciding to die by suicide.</p> <p>The loss of a last connection with another can bring one to the point of deciding to die by suicide.</p> <p>People attend the service who are adrift in pain and darkness.</p>

### 3.9.2 Focussed Coding

Focussed coding involved reading through the line-by-line codes and noting commonly occurring chunks that clustered into larger sections of data. Where chunks of coding made analytical sense, more focussed codes were developed.

Table 3.2.

*Example of Focussed Coding*

<b>Transcript</b>	<b>Line-by-Line Coding</b>	<b>Focussed Coding</b>
<p>It's been my experience that when people come in, they can almost sequentially show how they've disconnected from...maybe their own community and then the community within their own family and then often times what brings them to a point of deciding maybe to go ahead with a plan of suicide is that maybe the death of a loved one or maybe an argument with a mother or father who up until this point had been their last kind of like connection to another is lost. So they come in and they're adrift..so adrift in the sea of pain and darkness you know...</p>	<p>Clients have sequentially disconnected.</p> <p>Clients have disconnected from their community.</p> <p>Clients have disconnected from their family.</p> <p>The death of a loved one can bring one to the point of deciding to die by suicide.</p> <p>An argument with a parent can bring one to the point of deciding to die by suicide.</p> <p>The loss of a last connection with another can bring one to the point of deciding to die by suicide.</p> <p>People attend the service who are adrift in pain and darkness.</p>	<p>People who are suicidal tend to have disconnected from meaningful relationships.</p> <p>The loss of meaningful relationships can bring one to the point of deciding to die by suicide.</p> <p>People who are disconnected from meaningful relationships experience pain and darkness.</p>

**3.9.3 Categorising**

The final stage of the transcript analysis was in selecting groups of focussed codes and developing meaningful categories for them in observing emergent patterns. These core categories are seen as central themes to the data and thus directly inform the theory (Charmaz, 2014). An example of a category that the above tables fit into would be “The Effects of Disconnection.”

### ***3.9.4 Memo-writing***

Memo-writing is seen as a critical aspect of CGT as it is a method for keeping track of conceptual and theoretical development throughout the analytical process (Lempert, 2007). Memos were written as part of the current analysis to permit the researcher to be fully involved in the analysis from early in the process. Memo-writing involved writing out insights, thoughts and ideas as they emerged throughout the entire research process. These insights related to each step of the coding, ideas generated from discussions, and theoretical reflections. Written memos make the research process more transparent for the reader as they reflect the researcher's thought processes and analytical frameworks at different points throughout the analysis. Several of the memos written are included in the Chapter 4 to illuminate the researcher's analytical process for the reader.

### ***3.9.5 Theory Development***

With the use of memos, the different core categories were compared and linked to form the emergent theory. Theories can be outlined in different fashions using several diagrammatic systems. A number of different frameworks for the theory were considered before the model of best fit was chosen.

During each phase of the theory development (line-by-line coding through to the theory itself), the researcher was conscious of maintaining a closeness with the actual words of the participants. This was considered a key emphasis as it helped to keep the participants' voices alive in the data. The participants' exact words, therefore, were used to detail the properties of the themes in the theory.

### **3.10 Validation of Analysis**

In order to uphold the trustworthiness, reliability and validity of the current research, a number of methods were employed.

#### ***3.10.1 Inter-Rater Reliability***

Inter-rater reliability refers to a triangulation of the analysis whereby multiple researchers are involved in the process (Armstrong, Gosling, Weinman & Mareau, 1997). It has been reported that inter-rater analysis can increase validity and reliability of more complex qualitative analyses whereby codes, categories, and themes can be cross-compared and integrated as they emerge for different researchers (Gwet, 2014). Following the transcription of the first 5 interviews, they were sent to the principle investigator who read through them. The suitability of the interview questions and the emergent data were discussed between the principle investigator and the researcher. The remaining 7 interviews were tailored from these discussions (e.g., Some areas that had emerged, such as ‘disconnection from oneself’, would be further probed as part of the semi-structured schedule).

The 12 interview transcripts were initially coded and categorised by the researcher. The field supervisor then also coded and themed the transcripts, without input from the researcher, so that inter-rater coding and comparing of categories could occur. The majority of the themes and categories were similar across raters. Where there were differential perspectives, they were discussed and included fittingly so that there was coherence for the emergent theory.

Given the scope of the current study, the researcher did not have the resources available to complete follow-up meetings with the participants for further validation of the data. This is an inherent weakness of the current study’s data validation methods.

### ***3.10.2 Reflexivity***

Semi-structured qualitative interviews and their subsequent analysis can be subject to bias as the researcher is the main ‘measurement device’ in qualitative research (Miles & Huberman, 1994). The interviewer is a subjective person with a particular background, belief system and way of being with other people. The interviewer’s inherent individuality could, therefore, lead the interviews and analysis in a biased manner. To increase validity, the interviewer developed the interview questions firstly in accordance with the existing research and theory on suicide. Secondly, questions were relayed with the principle investigator, field supervisor and other researchers in attempts to refine them from multiple perspectives.

The researcher was conscious of the natural bias that may occur in the research from the beginning and made every effort to put aside any previous assumptions when interviewing participants and to maintain an open stance throughout the questioning. The use of memos was a useful tool for reflexivity and added to the transparency of any biases that may be present in the research. While acknowledging the researcher’s role in the theoretical outcomes of the study, the inter-rater coding and theming of data added to the project’s scientific rigour.

## Chapter 4: Results

### 4.1 Chapter Introduction

The following chapter provides an overview of the results from the CGT analysis. The theory that has been proposed will be described in this chapter and illustrated through relevant themes and sub-themes (and their properties), quotations, memos, and a diagram.

As the theory developed, two major strands emerged. Participants spoke about (1) the role of connectedness on paths to suicide and (2) the role of connectedness in therapy on paths from suicide.

#### Memo Box 1

Initial objective wasn't to have two strands to the theory but it's making more sense as the analysis goes on. It doesn't make sense to describe the two sides of the coin as one side. This also gives more insight to both paths rather than trying to compress them together.

### 4.2 Strand 1 – The Role of Connectedness on Paths to Suicide

This strand incorporated participants' views on what connectedness is and how it plays a role in people becoming suicidal. In this section, the over-arching theme of Connectedness and Suicide was identified. The over-arching theme was complex and sub-themes were therefore required in order to explain the characteristics of connectedness and how people need connection. The over-arching nature of this theme meant that it was an umbrella under which the core themes in this strand were placed. The core themes of "Connection with Oneself", "Quality of Connections With Others" and "Family and Other Close Connections" were identified. These core themes were also explained using sub-themes (similar to the sub-theme format for the over-arching theme). The sub-themes and their properties are in the table below. The properties of the sub-themes are titled with direct quotes from participants.

Table 4.1. Themes and Sub-Themes for the Role of Connectedness on Paths to Suicide

<b>Over-Arching Theme: Connectedness and Suicide</b>					
<u>Sub-Themes</u>		<u>Sub-Theme Properties</u>			
Connectedness Characteristics		<i>'Human Contact is Really Important'</i> <i>'Suicide is a Community Problem'</i>			
People Need Connection		<i>'No Man is an Island'</i> <i>'If the Whole World Tells You You're Well, Get Up'</i> <i>'Adrift in the Sea of Pain and Darkness'</i> <i>'It's the Vital Link'</i>			
<b>Core Theme: The Connection with Oneself</b>		<b>Core Theme: Quality of Connections with Others</b>		<b>Core Theme: Family and Other Close Connections</b>	
<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>	<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>	<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>
A Protective Buffer	<i>'The Connection With Themselves is the Most Important One'</i> <i>'It Does Start from Within'</i> <i>'Lack of Connection With Oneself is What Ties in With All of the Other Stuff'</i> <i>'To Be Suicidal, it is All Inward-Focused'</i>	Lifespan	<i>'How That Extends into our Relationships in the Now as Adults'</i> <i>'A Healthy Blueprint'</i> <i>'It's Harder for Them to Connect With Me'</i>	Family	<i>'Your Template for Living'</i> <i>'The One Community That Loves Them ... Unconditionally'</i> <i>'Quite Often the Family is the Problem'</i> <i>'The Parents - How They Interact With the Child'</i>
Lifespan	<i>'There's Layers and Layers There'</i>	Toxic Relationships	<i>'And the Relationship Turns Abusive'</i>	Almost Everyone has Something to Connect to	<i>'Everyone Has Potentially Relationships That Can Be Important'</i>

### **4.3 Over-Arching Theme – Connectedness and Suicide**

The over-arching theme in relation to the role of connectedness on the paths to suicide involved participants' explanations of what connectedness is and why it is linked with the path to suicide.

#### ***4.3.1 Connectedness Characteristics***

The following section outlines the sub-theme of Connectedness Characteristics by exploring the different aspects of connectedness discussed by participants and why it is important in relation to suicide.

##### **4.3.1.1 Human Contact is Really Important**

Participants explained that *how* human beings connect with each other is particularly important. A description of this type of human contact was offered by one participant:

*P11: "So it might be even that 'I have a niece and I take her to the swings and last Saturday I took her to the swings and I really enjoyed it'... And then there's a moment where there's at least been a connection with somebody..."*

Further characteristics of human contact that were listed included feeling heard by other people and feeling useful to and needed by others:

*P8: "Maybe for some a sense of being valued you know? That...what they say is being heard, they might actually have an opinion on something. They might feel useful you know?..."*

Four of the twelve participants spoke about a spiritual aspect to human connection and how this is important to keep in mind when discussing suicide. The following is an account of a story related to suicide and spiritual connection:

*P10: "I had one guy here....he actually had a rope around his neck. He was swinging because he was fairly convinced that his mother and girlfriend were safely out of the*

*way. They for some reason mysteriously woke up in the middle of the night and cut him down. So I don't know why that would have happened, I'd like to think it was soul...ya."*

#### **4.3.1.2 Suicide is a Community Problem**

Participants discussed how human relationships on a societal level are linked with suicide and how it is a community problem. The role of society in Ireland, in particular was mentioned by eight of the twelve participants as they listed education, government, community, and stigma as playing roles in how people connect and how people become suicidal:

*P6: "...I would say we're not talking about it...We need to do more of that...It doesn't happen to other people, it can happen to any one of us..."*

*P2: "I think quite a good bit of it is through our education system as well. It's not ok to make a mistake...people can be ridiculed, shamed, embarrassed by it...It's ok to be able to say 'I don't know' but quite often young people come in and they feel they should know..."*

Participants also spoke about the roles being set up for people through societal norms and how these roles can contribute to suicide:

*P5: "For men it's about achievement... 'I need to make money, I need to be strong. I need to be attractive to women, I need to show that I'm able to provide them with a home and a house and a car'...Like who's looking for that? And they'll say 'Everyone'...they've swallowed down this dream that (is) a poisoned pill actually."*

What communities place a value on from person to person, therefore, can affect levels of suicidality.

#### **4.3.2 People Need Connection**

Participants discussed how humans have an innate need for connection and how not having connections is related to not wanting to live.

#### 4.3.2.1 No Man is an Island

Participants emphasised that human beings are inextricably linked to one another:

*P1: “Well I think connectedness is at the root of everybody... we need people, no man is an island so like your life is about relationships really I think you know either relationships to work colleagues or at home or to yourself...”*

Seven of the twelve participants named connection as being vital to human life.

#### 4.3.2.2 If the Whole World Tells You You’re Well, Get Up

Participants spoke about the effect of connecting with others and how it can have a positive impact on one’s emotional well-being:

*P12: “...You can see that those issues of friendships and family and...the broader sense of community, how important that is to your sense of well-being and your sense of being connected.”*

Participants described how connectedness is important as a buffer against suicide. Some of the key constructs that illustrated the positive effects of connection included hope, resilience, support, and a sense of belonging:

*P1: “...I mean it’s all about relationships really you know...if people have a lot of support and a lot of love...and feel that they belong, then generally they can overcome an awful lot of problems...”*

#### 4.3.2.3 Adrift in the Sea of Pain and Darkness

In direct contrast to speaking of the positive effects of connection, participants also described isolation and disconnection and their detrimental effects. They reported how the loss of relationships/connections can lead to suicide:

*P7: “I think they’re (relationships) probably the...main reason why people consider taking their lives. Be it relationships with family, parents or the loss of a relationship. I have found as well you know...That sense of loss of a relationship does bring somebody to a dark place...”*

Participants listed a number of specific effects of disconnection and isolation such as feeling alone and unlovable, becoming trapped, and feeling shame and despair:

*P5: "...It's (isolation) in all of them. Every person I've ever seen. It is the sense of shame...not wanting to burden anybody else with this awful despair. So then they just lock it all inside. And that becomes very dark....and it's like treacle."*

*P11: "They may have lost contact with family and friends...or be in a house with people but not be talking about what's going on for them...and the more lonely they feel, the more awful they feel, the harder it is to put words on any of that..."*

Memo Box 2

I had initially coded this property in terms of 'disconnection.' Following inter-rater feedback, however, the term 'isolation' jumps out from the data a lot as well. I think that both disconnection and isolation are interlinked and part of each other and that is important to name them both here.

A sequential domino effect was also noted. This involves one big disconnection leading to other ones until a person becomes totally isolated:

*P7: "A domino effect because one disconnection can cause other disconnections...one client...separated from his wife...lost his home... he didn't know anybody. He used to like to garden but...he didn't have a garden...so many disconnections because of one relationship breaking down..."*

The metaphor of a buoy at sea for illustrating how isolation looks for someone who is suicidal was used:

*P8: "I can see...a swimming buoy literally just heading off down the river on its own....and while people on the bank might be looking on and be really concerned, the person whose heading off kind of feels nobody cares because they feel they can't reach out or people won't reach out."*

#### 4.3.2.4 It's the Vital Link

Participants described suicide and connectedness as juxtaposed. They expressed that connection is the vital link between being suicidal and finding reasons for living:

*P5: "I've never met a person with suicide who (has) a strong sense of connection to others – never. I think...it's the vital link."*

*P6: "When one reaches I suppose a place in their life where... they can only see reasons for dying...all of that connectedness is no longer in their vision..."*

One of the reasons named for the link between disconnection and suicide was that being disconnected from others makes it easier to die by suicide as one does not have to consider one's impact on others:

*P4: "...That isolation if that isn't there then it's harder to justify taking your own life. It means you've to consider impact..."*

### **4.4 Core Theme – The Connection With Oneself**

The connection with oneself emerged as a core theme from the interviews. Participants acknowledged how the connection with oneself plays a role in whether one can connect with others. In this regard, the connection with oneself plays a primary role in connectedness and suicide.

#### **4.4.1 A Protective Buffer**

The following sub-theme explains how having a connection with oneself can be a protective factor against suicide and that the disconnection from self can act as a catalyst towards suicide.

#### 4.4.1.1 The Connection With Themselves is the Most Important One

Nine of the participants stated that the connection with oneself is vitally important for people:

*P1: "...They need more, they need to have a strong connection with themselves like to feel good about themselves...where they can be themselves and they can be open to other people."*

They also mentioned how imperative it is in protecting someone from suicide:

*P9: "When the grim reaper comes, that's the only relationship that matters really, your relationship with yourself..."*

#### 4.4.1.2 It Does Start from Within

Participants spoke about the effect of having a connection with oneself and how that can protect someone from suicide. Namely, participants reported that to connect with other people, one must first have a connection with oneself:

*P5: "I think that without that connection with yourself, it's extremely difficult to connect with anybody else because a lot of people who are suicidal either withdraw or become angry and if you withdraw or become angry, then most other people...might not know how to cope."*

From this, it was also explained that having a connection with oneself can help a person to see more clearly and hence see their supports:

*P9: "What I see is that when I start to love myself and start being gentle with myself...for some reason...other people tend to all of a sudden be there..."*

#### 4.4.1.3 Lack of Connection With Oneself is What Ties in With All of the Other Stuff

The lack of connection with oneself was seen as detrimental to well-being and a contributing factor to suicide. Some of the effects of this disconnection included self-criticism, an inability to connect with others, and a move towards self-isolation:

*P10: “I mean it’s all of those self relationships...then they become their own critics...and the critic then absolutely, unmercifully criticises them...”*

*P7: “They don’t have a relationship with themselves and then as a result of that they’re disconnected from family, disconnected from their wider peer group and society as a whole.”*

#### 4.4.1.4 To Be Suicidal, it is All Inward-Focused

Ten of the twelve participants discussed the effects of disconnecting from oneself, gave descriptions of this disconnection, and linked it with suicide. These descriptions tended to involve a narrow focus of cognition, cognitive distortions, and an inability to view the positive relationships in their lives:

*P6: “It’s like looking through a very very I suppose dense fog...Cognitively they may be aware that there is still a lot in their life – maybe work, loved ones, all of this but they find it very difficult to be able to engage in that.”*

*P2: “Everything is black, there’s no room for hope....the whole world is against them....there is no way other than taking their own life...”*

Participants used words such as ‘fragmented’, ‘splitting’, and ‘dissociating’ when illustrating the disconnection from oneself.

#### **4.4.2 Lifespan**

The sub-theme of how people connect with themselves across the lifespan materialized in the interviews. This included looking at the connection with oneself across different stages of life from infancy to old age.

##### 4.4.2.1 There’s Layers and Layers There

The connection with oneself was discussed across several life stages. A maladaptive environment during infancy and childhood, in particular, was associated with contributing to disconnection from oneself:

*P 10: "Where the child was shamed, constantly...that's emotional abuse really...I suppose the toxicity would come from the child not becoming aware of themselves as an individual. That they're just solely dependent on their carer..."*

*P3: "If a child or an adolescent is being...abused by an adult...there may be fear and there may be anger...the inward direction of these emotional energies which are inappropriately placed...that's informing relationships and people slip away from them... those negative forces driving inwards will actually...inform the self to destroy the self."*

Participants also spoke about the difficulties of adolescence and trying to connect with one's identity at that point in life:

*P12: "An adolescent finds themselves...talking about their values, they're talking about what the core of their personality is, how they relate to people...their interests...who they see as heroes in the world... They struggle with 'this is who I am, this is what I represent'..."*

Furthermore, participants discussed the disconnection from oneself for many years through adulthood and how difficult it can be to connect with oneself after many years of disconnect:

*P1: "If they've been thinking this way for 40 or 50 years, you're not going to change their thinking and their behaviour over night, it's going to take a long time to kind of unwrap everything, it's like an onion. There's layers and layers there that you have to get through."*

#### **4.5 Core Theme - Quality of Connections**

A core theme from the data involved the quality of connections. This theme included how the quality of connections one has throughout their life plays a role in whether or not they become suicidal.

##### **Memo Box 3**

Changing core theme of 'Toxic Relationships' to 'Quality of Connections.' Toxic/abuse relationships came up a lot in the data but not enough to constitute a core category. Of the

initial 9/10 core categories, the Toxic Relationships codes have come up the least (< 5%).

Furthermore, I think toxic relationships fits in well with the quality of people's relationships across a lifespan as they are being mentioned in the context of life stages (i.e. childhood, marriage etc.).

#### **4.5.1 Lifespan**

This sub-theme details the quality of connections people tend to have with others from infancy across the lifespan. The quality of connections at each major life stage seems to play a role in whether or not someone becomes suicidal. Furthermore, the barriers to healthy connections across the lifespan are encompassed in this sub-theme.

##### 4.5.1.1 A Healthy Blueprint

Participants had a particular focus on infancy and childhood. They discussed early attachments and how they lay the foundation for later connections in life:

*P9: "This goes back to, I would contend, to you know kind of formative years and childhood and even...that sense of attachment and... being with our primary care giver and whether that was a good enough relationship..."*

*P7: "The importance of attachments and that if we don't have early attachments, how that can manifest in adult relationships."*

Healthy and nourishing relationships earlier in life were recognised as contributing to one's ability to receive support from other people later in life and thus protecting people from suicide:

*P11: "...somebody who comes in who up until 6 months ago had... good relationships during their family years...and everything ticking along fairly nicely...(then) they lost a friend to suicide and then suddenly there's the low mood and there's the beginning to isolate themselves because the kind of turning the tide on that...is likely to be easier. Because they have blueprint for relationship...."*

This description was given in contrast to people who have not had a healthy blueprint and who may find developing connections much more difficult as a result.

#### 4.5.1.2 How That Extends into our Relationships in the Now as Adults

In discussing the quality of relationships across the lifespan, participants went on to discuss how different relationships can be important across different life stages:

*P1: "If you're working with a young teenager then their connection with their parents is the most important thing...if the communication is open it will help the kids an awful lot..."*

*P4: "It's what relationships are important you know?...If someone is married with children then their wife and children. If they're separated, it might be just their children...Some people it's friendships, some people it's their dog..."*

Participants regularly spoke about loss of relationship being difficult for people. This became especially salient in old age as that is where people tend to have experienced the most loss. When someone loses their close relationships, at any life stage, it can contribute to feelings of suicide:

*P3: "...Sometimes people don't have the strength to start again.....They might want it, to wish they'd company but the loss of the loved one is too much you know and that grief is huge and they may be in the autumn of their lives..."*

#### 4.5.1.3 It's Harder for Them to Connect With Me

In discussing the quality of connections across the lifespan, participants also described a number of barriers to connection. These included trauma and bullying:

*P1: "With people who've had traumatic backgrounds and or traumatic childhoods...it's harder for them...to connect..."*

*P8: "Bullying...exclusion, name calling....as in quite derogatory about the way they dress outside of school...exclusion would be the biggest. Hearing about events that have happened. That they've all met up and they haven't been included..."*

In addition, some participants spoke about technology. Technology was seen as helpful in making initial contact with people and in staying in touch with people in other countries. It was also, however, seen as a barrier to genuine human connection at times:

*P2: "It's interesting with younger people...The onslaught of Xbox and mobile phones and Facebook. They find it really difficult just to sit and do what we're doing. Just to actually make contact with somebody but of course what they're also doing is they're breaking contact with themselves because it's all through electronic modes."*

#### **4.5.2 Toxic Relationships**

Participants initiated conversation on the concept of toxic relationships when talking about the quality of connections and how they relate to suicide. These were emphasised as important to consider when discussing one's ability to develop adaptive relationships.

##### 4.5.2.1 And the Relationship Turns Abusive

Relationships were deemed toxic if they had elements of physical, emotional or sexual abuse. Participants reported how being the victim in a toxic relationship can cause a person to direct negative emotions on themselves and can contribute to them blocking out other people and positive connections:

*P5: "In that person's case, it was a very traumatic rape at a young age that resulted in a pregnancy and an abortion that she has never told anybody...she just made a decision and that was it. Nobody's ever ever getting near me again and she more or less shut down."*

One of the main outcomes of toxic relationships in terms of connection was mistrust.

Participants described how people's trust in relationships becomes skewed from previous experiences of toxic relationships and they subsequently find it difficult to form supportive connections:

*P8: “You go into a relationship with somebody...the starting point is you get into it because you trust them and you feel something for them....and the relationship turns abusive....your sense of self, of value...trust goes out the window because this isn’t what it was supposed to be...”*

Other toxic relationships were also mentioned such as co-dependency and submissiveness.

Participants stated how toxic relationships can have a negative impact on one’s sense of self and sense of connection with others:

*P9: “...Co-dependency or...emotional abuse or just not being heard sometimes by the other and them being a bit more directive and me just being submissive...and your needs not getting met effectively...because toxic relationships obviously over time then impinge on our own sense of self and our self worth...”*

#### **4.6 Core Theme – Family and Other Close Connections**

The connections that emerged as most influential for people who encounter suicide were those with family. Family was not always limited to biological relationships, however, and participants explained that the relationships that are closest and most intense for people are deemed familial and have the highest impact.

##### ***4.6.1 Family and Parents***

The core construct of family and parents emerged as a sub-theme whereby participants spoke about the importance of family to people in general, the benefits of having positive family support, the detrimental effects of maladaptive familial relationships, and the role of parenting.

##### ***4.6.1.1 Your Template for Living***

Participants spoke about how family is where most people learn how to relate to others and form their first real connections. The intense closeness of family was seen as an important aspect of learning how to connect with others:

*P8: "I suppose family is...what you're born into...family is where you hope to get your nurturing and I suppose your template for living...you would hope that that's where you get your sense of...communication skills, social skills...These are the closest you have..."*

*P1: "Oh family is really important I think...because that's where the closest relationships are really that's...where we're more intimate...with families you know we go deeper..."*

How one's role in family can play a part in suicide was discussed:

*P12: "I find with people who are suicidal, what's being negotiated is your role in this family...where parents don't take responsibility, where it's passed to children...and that's too much...so it's even for older people...you're still playing this role and now it's impossible to escape this role...and the intensity that's applied through the family system."*

#### 4.6.1.2 The One Community that Loves Them...Unconditionally

The benefit of having positive family relationships was acknowledged. Participants spoke about how having supportive family members can be a buffer against suicide and has positive effects on connecting in general:

*P7: "...Recovery is probably more heightened when the family are on board."*

The effect of a supportive family is so noteworthy because of the unconditional love that there tends to be:

*P3: "That's the one community that loves them, you know, unconditionally."*

#### 4.6.1.3 Quite Often the Family is the Problem

Conversely, participants spoke about how maladaptive familial relationships can be the source of the problem for people who are suicidal and can act as a barrier to positive connections and recovery. When family relationships are not balanced, for example, suicide appears to increase in risk:

*P7: "...For some people it's because of bad relationships...and their only way out of it is to take their own life in their mind...there's an awful lot of that that runs through...with families..."*

*P2: "Sometimes they (clients) are in relationships that they shouldn't trust... these are relationships that we've been told that we should trust, you know parents, other siblings...and quite often the family is the problem..."*

#### 4.6.1.4 The Parents - How They Interact With The Child

Participants described how parents play a pivotal role in their children's emotional well-being. In particular, participants noted that maladaptive parenting can play a major role in a person's tendency to become suicidal. One participant described how children are not born with connection deficits and that it is something that must be learned from their parents:

*P10: "There's nothing wrong with a child usually. Nothing wrong with a child when it's born d'you know? That's apart from some physical you know mental you know that that's a condition but there's nothing...why would a child need help under 18?"*

Another participant gave a story that illustrated the negative effects of maladaptive/uncaring parenting:

*P5: "...one fella came into me... when I went into the waiting room...the mother was sitting there and she had her iPhone and she was clicking it...and he was sitting there and he was just looking devastated...and when I walked in I greeted him first and she still didn't look up... And I went into the room and the first thing he said... 'She doesn't give a sh\*t, I'm completely invisible to her, if I was dead in the morning she wouldn't give a damn.'..."*

#### **4.6.2 Almost Everybody has Something to Connect to**

Another sub-theme here comprised of the premise that most people have something to connect to. Participants maintained that there are very few people in the world, if any, who do not have an inherent desire to connect to something. They talked about how that connection to another person, animal or hobby can be what saves them from suicide.

#### 4.6.2.1 Everyone Has Potentially Relationships That Can Be Important

Participants gave long lists of adaptive connections that can support people in times of distress and can bring them back in touch with the world:

*P 3: "...To connect with...maybe teachers in schools...mentors within clubs...workplaces, volunteering agencies even you know religious orders...could be a local GP... your local gardener... getting involved in charitable work you know sometimes seeing (people)...in the community that have stories, maybe worse than themselves can give them hope...family, belief in god or some kind of spiritual aspect as well is often useful...hobbies..."*

This connection with something other than oneself was described as a buffer against suicide and provides people with meaning in their lives. In addition, five of the twelve participants mentioned having a connection with a pet or some form of nature as being protective against suicide.

### **4.7 Strand 2 – The Role of Connectedness in Therapy on Paths from Suicide**

For this strand of the theory, the over-arching theme of Connectedness and Recovery was identified. This over-arching theme was complex and required sub-themes to explain the connection experienced by the client in therapy and how it helped them to form other connections and overcome their experiences of suicide. The over-arching nature of this theme meant that the emergent core themes were understood in the context of connectedness in therapy and recovery. The three core themes that emerged as fundamental to connectedness in therapy and recovery were: “The Therapist”, “The Client” and “The Service Required”. In a similar fashion to the over-arching theme, these core themes were explained using sub-themes. The sub-themes and their properties are also displayed in the table below. The properties are titled with direct quotes from participants.

Table 4.2.

*Core themes and sub-themes for the role of connectedness in therapy on paths from suicide*

<b>Over-Arching Theme: Connectedness and Recovery</b>					
<u>Sub-Theme</u>			<u>Sub-Theme Properties</u>		
The Therapeutic Relationship			<i>'There's No Therapy if There's No Relationship'</i>  <i>'They Start to Heal a Little Bit'</i>  <i>'You're Looking to Reconnect Them With Life'</i>  <i>'Building a Network of Support'</i>		
<b>Core Theme: The Therapy</b>		<b>Core Theme: The Client</b>		<b>Core Theme: The Service Required</b>	
<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>	<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>	<u>Sub-Themes</u>	<u>Sub-Theme Properties</u>
Therapist Characteristics	<i>'If You're Grounded, You Can Help to Ground the Client'</i>  <i>'With a Heart and a Half'</i>	Client Characteristics	<i>'It Depends'</i>  <i>'The Real Power Lies With the Client'</i>  <i>'People at Different Stages in Their Life'</i>	The Model	<i>'That's Just Beyond Reproach'</i>  <i>'It Wouldn't Be Appropriate'</i>
Therapy Dynamics	<i>'Even the Initial Contact by the Door'</i>  <i>'It's an Eclectic Mix'</i>  <i>'We'll Go at Their Pace'</i>	Connection Barriers	<i>'Mental Health Difficulties are the Most Challenging'</i> <i>'It's Like a Script Their Writing in Their Heads'</i>  <i>'A Very Good Mask'</i>	Liaison	<i>'The More Variety We Have'</i>
Therapeutic Difficulties	<i>'It's Not Safe'</i>  <i>'Here Are Your Tablets'</i>				

## **4.8 Over-Arching Theme – Connectedness and Recovery**

The over-arching theme in relation to the role of connectedness on the paths from suicide to recovery involved participants' discussions of how connectedness plays a role in helping people to recover from thoughts of suicide and suicide intent. This was mostly discussed in relation to connectedness in therapeutic intervention. Ten of the twelve participants acknowledged that the connection in therapy is the most important facet of the intervention. They talked about how, in their role as psychotherapists, they helped clients to recover through the therapeutic connection.

### ***4.8.1 The Therapeutic Relationship***

This sub-theme explored the relationships built between therapists and clients. Participants explained the intricacies of the therapeutic connection and how that helps a client to move from feeling suicidal to wanting to live.

#### ***4.8.1.1 There's No Therapy if There's No Relationship***

Participants frequently spoke about the importance of the connection between them and clients in therapy. They maintained that this was a vital cornerstone to the therapeutic process and the client's recovery:

*P3: "Without that...life buoy being thrown to them...where they can reconnect and have the therapist you know pull them out of the mire almost...I don't think we're going anywhere really."*

They explained that this can give people a reason to live but that if the connection does not exist between the therapist and the client then the client is more likely to lean towards suicide:

*P11: "I sometimes think that connection is what keeps someone alive...If there isn't a connection in the room, I get very very worried. That means that there's a very high risk. If there's even a single moment of a real connection, it's much more likely the person is safe. It's essential."*

#### 4.8.1.2 They Start to Heal a Little Bit

The effect of the therapeutic connection in helping clients to overcome their thoughts of suicide was illustrated:

*P10: "The value of the therapeutic relationship would be energetically connecting with the client so that they feel safe or nourished and maybe sometimes that would be first stage of therapy that they feel actually that they may be just getting some sort of attention that's not threatening. That they start to heal a little bit."*

*P9: "...we're actually showing them that 'you will never be totally disconnected from the world because there is somewhere that you will feel connected.'...Sometimes that's enough."*

Participants spoke about how the therapeutic relationship can give clients feelings of hope, love, company, and support and that these are vital components of the healing process:

*P7: "...For clients just being actually heard in the first place and not being judged and not being told what to do and how to do it can be very very moving...and empowering...and clients saying 'God, you know, thank you so much for this...it means a lot that there is somebody that actually genuinely cares.'..."*

*P3: "...Nourishment, sustainment, holding, hope and to let them have a sense of it then... and then just by offering those very simplistic pieces around the nourishing and the holding aspects, the switch in their behaviour in maybe a short period of maybe 2 or 3 weeks is phenomenal..."*

Participants emphasised that the connection built in therapy is something that clients have really needed but up until now may not have received:

*P2: "The one thing that...any of us need is to be connected with someone. I have (clients)... the fact that somebody will give them 50 minutes, some of them are actually dumbfounded by it...it's like 'Oh! So this is what it's like to talk to somebody?!'... I think at least here they can begin to feel that somebody cares."*

*P9: "Because maybe for the first time in a long time maybe they actually recognise then 'Oh Jesus, I'm not alone...there is at least one person in this world who actually cares enough that they want to hear what it's like to be me and to hear what my pain*

*is...I didn't believe that was possible. '...'*

#### 4.8.1.3 You're Looking to Reconnect Them With Life

Participants mentioned that the connection in therapy is used as a unique tool for helping clients to take the initial steps away from suicide outside of the therapeutic environment.

They noted that it can help the therapist to understand how the client connects:

*P4: "Connectedness in therapy...often that's the place people can come back to...The first connection (a client) can experience that is non-threatening is the connection to therapist and I think any step out of isolation is a step away from suicide..."*

*P11: "...My work would be about just coaxing them into a relationship with me ya as a primary starting point...and how they are with me in that gives me a lot of information about how they are possibly in their other relationships..."*

In taking the first steps away from suicide, participants explained how clients then develop hope. They reported that the therapeutic connection can give clients hope for further connections and a better future:

*P4: "You're working with them around hope...that's the key thing in relationship...is hope. That we have to hold the hope because the person has lost hope..."*

In this regard, participants explained how the therapeutic connection can help clients to find out something about themselves that they did not already know. This new found insight can act as a means for recovery:

*P9: "If somebody feels connected...if they feel heard in their pain...if they feel that they're not being judged in that...That kind of almost lets them know that they are an important human being. That they are worth something that maybe they didn't even acknowledge themselves..."*

#### 4.8.1.4 Building a Network of Support

One of the salient aspects of the therapeutic relationship that was noted as being helpful in a client's recovery was that it helped them to start building connections outside of therapy. The

connection in therapy was seen as a model for how the client could connect outside of therapy:

*P7: “I think it’s important that I model to them what a connection could be like within the safe boundaries of client-counsellor relationship...I think if they’re here with me and they’re attending every week, they’re making a human connection and hopefully that filters out then into other areas of their lives.”*

*P8: “Some have actually kind of reconnected with family like...it’s something that I’d encourage to maybe make contact with people...Meet for a quick cup of coffee, just say you have a half an hour...a friend that you haven’t seen for awhile...”*

In helping clients to build connections outside of therapy through the therapeutic relationship, participants acknowledged that there was a knock-on effect of positive experiences for clients in their lives. The mechanisms of such connections are described here:

*P1: “...And so she’s (a client) going to a school that runs courses for adults and just trying to get her to do something, to go out and to meet people...so you’re being distracted...You’re interacting and that helps to get you out of yourself...and she was even saying she met somebody with similar experiences to her and she discussed it and it made her feel good...”*

*P3: “They’re making new friends, new connections...It’s very hard to be depressed when you’re in good company...or it’s hard to be depressed when you’re out in the middle of a field and you’re about to be set up to score maybe the winning goal in the match you know ‘oh I scored a goal but I still feel very depressed and suicidal right now’ absolutely not...”*

#### **4.9 Core Theme – The Therapy**

The following section outlines the core theme of The Therapy. Within this theme are a number of sub-themes that relate to psychotherapy as an intervention for people who are suicidal. They include factors related to the therapist, the dynamics of the therapy and barriers to effective therapy.

##### **4.9.1 Therapist Characteristics**

This sub-theme explores the different aspects of the therapist that have an adaptive role in the

therapeutic connection. The therapist is seen a central figure to a suicidal individual's recovery. A therapist's grounding, training, openness, and compassion for the client all play important functions.

4.9.1.1 If You're Grounded, You Can Help to Ground The Client

Participants spoke of the importance of their supervision, extensive training, and the therapy that they have received through training. They believed these were crucial components for being able to connect with a client and to keep the relationship safe in the therapeutic space:

*P5: "When it's shared and the person opposite you has enough training and...groundedness within themselves and you don't look like you're going to fall over from the weight of this distress...it lightens the experience for them. They seem to see more clarity or something..."*

*P7: "I think that's the first thing is if you're grounded you can help to ground the client...I have to understand who I am, what I am about, what my triggers are and what my blind spots might be you know and I suppose that's where personal therapy comes in for me and my supervision comes in as well. It helps me to be fully present with my clients."*

Eight of the participants noted that it was important for the therapist to be connected to themselves in order to be able to do the work.

Memo Box 4

I had initially considered linking the categories of Therapist's Connection to Self, Client's Connection to Self and Client's Connection to Therapist as part of the model but bits were sticking out from each category that didn't quite link up together. In the end they are on different strands of the theory and have different weight – I think it makes more sense and works better this way.

#### 4.9.1.2 With a Heart and a Half

The openness of the therapist was evident in the interviews as an important facet in developing a therapeutic connection. Participants' compassion for their clients was clear to see:

*P3: "Ultimately, you know, unconditional love is being offered from one human being to another. That's what we are at a base level and they can feel that and they can connect with that."*

*P9: "The one thing that I can promise I can offer you is...I will hear you. I will actually with a heart and a half, look to sit with you and really try and...have an opportunity to walk with you through this time. That I'm not gonna let go because it's getting tough or because ...I don't like you or anything like that..."*

#### **4.9.2 Therapy Dynamics**

The various dynamics that occur as part of the therapeutic relationship formed a sub-theme discussed by participants. These involved how the initial connection is developed, specific therapeutic techniques, and different models of therapy used by therapists.

##### 4.9.2.1 Even the Initial Contact by the Door

The very first meeting with a client was noted as an important opportunity for developing the connection. The dynamics of the initial interaction are seen as significant:

*P12: "You only have that 15 minutes to get really grounded and to really open that up for the client is so important... And you can have your glitches and it's not always perfect and you can recover but there's so much information in that first piece..."*

*P5: "...Even the initial contact by the door is very important. To make eye contact with them, shake their hand...the whole thing of valuing them even as they sit down..."*

The participants viewed the coupling of themselves and the environment as important factors here:

*P11: “A lot of that is in the room...making sure it’s well lit and all of that and warm then it’s about me and my manner... The person is offered tea and coffee so...as they come in and sit down, it’s about making sure that I’m making eye contact with them but not glaring at them...watching my tone of voice, watching the language that I use...welcoming them in ...”*

#### 4.9.2.2 It’s an Eclectic Mix

Participants described a number of therapeutic techniques that they engage in with clients in order to help them in their recovery from suicide ideation and intent. They maintained that they use a range of different approaches and techniques in order to suit the client in whatever situation they are in. In this respect, participants claimed that working with suicide comes from a person-centred perspective where their techniques are utilised to fit the client:

*P3: “...I think it just rises and falls as appropriate you know? A bit of a model, a bit of feeling, a bit of positive feedback...Back into the model again maybe irrational thoughts have been erected now, challenge them with a bit of CBT. Ok client’s getting lost in the past, time to solution-focus so it’s an eclectic mix so it’s always changing just like the client from moment to moment so it’s about maybe matching that...”*

*P9: “...the kind of person-centred approach where you actually make the connection with the client and try and build that relationship first and foremost...positive regard and non-judgemental and empathy... let them trust this space...they will be met where they are...then you start to...work on moving them away from the crisis...”*

Furthermore, in describing their role in the therapy, participants stated that they were there to facilitate change and that the connection allowed them to do that:

*P7: “I’m more of a vehicle that directs them along the road but they do the driving.”*

#### 4.9.2.3 We’ll Go at Their Pace

Within the dynamics of the therapy, a prominent property named by the participants was meeting the client where they are. Eight participants mentioned that it was important to understand where the client was coming from in order to meet them and affect change:

*P7: "I just go with the client's frame of reference really...I'm not directive...I start with like 'tell me your story, what brought you here? What's going on for you?' and then I ask them what they actually want and what they expect from me so it's like...they've got the power...and we'll go at their pace."*

A metaphor used by one participant to depict this property was the notion of clients and therapists having to meet at the edge of the cliff:

*P4: "...I felt working here was a bit like standing on the Cliffs of Moher and people going to the edge and we meet them there and if we can form a relationship of some sort they can choose to come with us away from the edge or if they chose not to engage in that it's much more difficult for them to choose to move away you know?"*

### **4.9.3 Therapeutic Difficulties**

Participants spoke about a number of difficulties that can emerge in therapy when trying to build a connection with a client. These included mistakes by the therapist, maltreatment of the problem, and the lack of connection between the therapist and client.

#### **4.9.3.1 It's Not Safe**

Participants noted that mistakes can happen in therapy. A number of participants recalled when they felt therapy 'went wrong' for some reason:

*P3: "I've had experiences with clients where you know, I've made mistakes in the past and maybe been too challenging to them. I've had clients maybe saying 'I'm not coming back again' and you know, realising I made a mistake on this session...and you know I was too caught in the early days maybe in the models."*

It was also reported that mistakes are not always detrimental to the therapy or the connection and that it can help to name the problem if there is a feeling of discord. Participants also mentioned, however, that sometimes the connection in therapy does not emerge and the intervention can falter as a result:

*P12: "...The relationship between the therapist and the client is huge and quite often when therapy doesn't work, that's why it hasn't worked because that connection hasn't been made. It's not safe to come in here..."*

Participants discussed the maltreatment that exists in suicide intervention and how people are not always given what they need in order to recover:

*P2: "I think there's a lot of plasters being put over an awful lot of wounds and it's not what people need. They need support, they need somebody...that will listen, who will help them to rebuild their lives..."*

They acknowledged that this can be down to lack of resources and lack of knowledge.

#### 4.9.3.2 Here Are Your Tablets

One of the most frequent barriers to connection in therapy reported by participants was the use of high levels of medication. It was reported that medication is essential at times in keeping clients safe but six of the participants named it as problematic when attempting to engage with someone who is suicidal and to get to the root of their difficulty:

*P5: "...I find that the hardest part of the whole feckin job, working with people who are feckin medicated. You know and it's very difficult when you're told... 'you have depression, you'll have it for life, you're never going to get better, here are your tablets, you come off and you're going to die.'..."*

*P3: "The client is just so, so disconnected from the self that...if you ask them say 'how are they feeling?' and they say 'P3, I've no idea what you're talking about' and it's just because of the medication that they're on..."*

### **4.10 Core Theme – The Client**

One of the major aspects of the therapeutic relationship is the client themselves. There are certain characteristics and dispositions of clients that play key roles in building a connection and recovering, and in barriers to connection.

#### ***4.10.1 Client Characteristics***

This sub-theme deals with unique aspects of the clients that play a role in the therapeutic connection. They include the individuality of each client and their responsibility in therapy.

##### **Memo Box 5**

‘The Client’ was not a core category initially. Different aspects of the client were being fit as part of other categories (e.g. ‘Clinical Diagnoses’ had been under a separate core category of ‘General Barriers.’) With the theory emerging the way it has, however, a core category negotiating the elements of the client in theory (including personal barriers) appears to fit and link perfectly with the themes of ‘The Therapy’ and ‘The Service Required.’

##### **4.10.1.1 It Depends**

Participants spoke about the individuality of the clients that experience suicide and how no two clients are the same. They found it difficult at times to speak in general terms and described how each person that is experiencing suicide ideation and intent is uniquely different from the other and has uniquely different experiences:

*“P7: Everybody comes in here because they’re suicidal or self harming but their reasons are absolutely very different...”*

Some of the particular individual characteristics mentioned that may relate to suicide, connectedness and recovery were age, type of trauma experienced (if any), capacity for pain, values, ability to self care, and ability to form previous relationships.

##### **4.10.1.2 The Real Power Lies With the Client**

The responsibility of the client in developing the connection in therapy was mentioned on

several occasions. This included the fact that the client must be willing to engage in order to be able to form a therapeutic relationship:

*P12: "The real power lies with the client because you're not going to go anywhere that the client won't take you so the reality is you're not going to do anything...unless the client really wants to engage and has taken responsibility to engage."*

Other aspects of the client's role in the therapeutic connection included the ambiguity they face in attending therapy for suicide and how difficult it can be to talk about such experiences. Participants maintained that if clients can get in touch with the part of themselves that wants to live then the connection comes a lot easier:

*P1: "...There's a part of them that still wants to live and it's that part that when they can get in touch with that part then that takes them in here."*

#### 4.10.1.3 People at Different Stages in Their Life

A client's particular age or life stage played an important part in how participants formed therapeutic relationships and implemented intervention. In particular, participants spoke about the difference between working with clients who were under and over 18 years of age. Participants discussed how a lot of the work with clients under 18 (children) requires work with their parents and that such clients may not have the capacity to form connections in therapy the same way that adults would:

*P7: "I do a lot of work with under 18s so it can be a little bit slower you know than working with adults..."*

Participants also explained that building a connection with someone who is under 18 can be tricky because their parents must be kept informed of the therapy progress:

*P8: "If you're any way sort of feel that trust is an issue, if you see your counsellor linking up with your parents every single session which is what we have to do when they're under 18, ya it can be a little bit difficult I'd say for the client."*

In addition, participants also spoke about old age and how connection with elderly clients can be different as well:

*P3: “A client can have a desire to be connected but mightn’t have the wherewithal to follow through on it...I’ve seen this a lot with the elderly clients that we’ve had here...Given their age, they’re not in a position where they have the energy to go out and find a new partner or the interest...”*

#### **4.10.2 Barriers**

The sub-theme of individual barriers to therapeutic connection materialised. This sub-theme incorporates the client’s personal characteristics that can be challenging for the therapist in trying to form a connection in therapy.

##### 4.10.2.1 Mental Health Difficulties are the Most Challenging

Having a clinical diagnosis was reported as a barrier for connection in therapy. Participants acknowledged that diagnoses, such as Borderline Personality Disorder, made it difficult to establish a connection in therapy:

*P3: “I suppose sometimes with maybe a borderline personality or a client with maybe the likes of schizophrenia...I think the connection there can be very fragile...working with very long term mental health patients...It can be very difficult to form a relationship there...”*

Six of the twelve participants reported the presence of various clinical diagnoses or long-term mental health difficulties in clients as being possible barriers to connection. These included Borderline Personality Disorder, Schizophrenia and Autism Spectrum Disorder.

##### 4.10.2.2 It’s Like a Script Their Writing in Their Heads

A prominent characteristic of clients experiencing suicide ideation or intent was that of difficult thought processes. Participants explained that many clients experience some sort of

cognitive distortion that can make it difficult for them to think clearly. Having a negative view of the self and a negative world view were related to difficulties with connection in therapy:

*P4: "...To justify completing, you have to justify your lack of value and lack of worth to the people around you that love you, that care about you...The more you pull away from them and the more hopeless you feel, the more isolated you feel, the more useless you feel or pointless then the more you can justify..."*

Participants explained that this pattern of thinking is part of the process of suicide and that the connection in therapy is required for the therapist to be able to help clients to change these thought processes.

#### 4.10.2.3 A Very Good Mask

Participants described the mask that clients can put on as particularly challenging to work with when trying to establish a connection. People who are suicidal may try to disguise their level of despair which can make it exceedingly difficult for a therapist to connect with them and realise their needs:

*P5: "...she had social connection...she had a really good family...She ticked all the boxes and she took her life after 1 session...She never shared how deep her despair was. She had a very good mask up...There was a full hiding away of that despair..."*

*P2: "They may have family members or are living with a family but they're so disconnected from themselves and from other people, they can be sitting in the same room and have suicidal thoughts and nobody around them knows that they're suicidal!"*

### **4.11 Core Theme – The Service Required**

All participants worked in the same type of suicide-specific intervention service. Each participant spoke about specific aspects of this service that contributed to the connection developing between the therapist and client and to the client developing a sense of

connectedness in general. As such, a core theme for this section of the therapy revolved around the service required for developing a suicidal client's sense of connectedness.

#### ***4.11.1 The Model***

Participants discussed specific aspects of the model of the service that they felt were vital in supporting a person who is suicidal in making connections. They also spoke about things that the service cannot do and cannot cater for. In addition, some participants offered suggestions for suicide-specific intervention services to consider in attempting to develop a client's sense of connection.

##### ***4.11.1.1 That's Just Beyond Reproach***

An aspect of the service that participants mentioned frequently was the provision of more than one therapy session per week for clients initially. They stated that this was helpful in developing a therapeutic connection and providing the client with a holding:

*P4: "...The twice a week is about the relationship, it's about...really connecting with the person...so that they feel that they're being held. We also give an option of holding sessions so if a client is very suicidal we can see them 6 days a week if needs be...the purpose of that is that initial holding to try and get some light into the darkness..."*

Participants reported that the connection between the therapist and client is paramount to intervention. They maintained, therefore, that giving the client the option to change therapist (if they felt the connection was missing) was particularly useful:

*P6: One of the things that we say at assessment here...is 'if you don't feel connected to your therapist, will you say so? You know you'll cause no offence whatsoever and we will look to refer you to somebody else.' Because the connection is crucial..."*

Furthermore, offering support sessions to family members, involving parents for clients under 18 years of age, and having a next of kin as a necessity were all seen as helpful factors for the client's sense of connectedness:

*P2: "When we're actually doing an assessment, we will check to see do they have a next of kin. If we don't have a next of kin...I would stop the interview and say ok I can't work with you unless we actually have a next of kin..."*

*P7: "...actually we all need to be together doing this work as part of a team because...nobody heals in isolation...recovery is probably more heightened when the family are on board and are learning as well..."*

In addition, participants maintained that the ethos of the service in general makes a difference to the client in putting them at ease. The aspects of the ethos mentioned included the fact that it is a suicide-specific service, that it is free of charge, and that one does not need to be referred in:

*P9: ...To create a barrier-free service for people in crisis who actually know that there is a space that they can come to where they don't need a referral from a GP...They can just actually arrive here and be seen within 24 hours...by someone who ultimately opens the door with a smile and addresses them by name and brings them in and offers them a tea or a coffee and they're gonna be met as they are with compassion and love...that's just beyond reproach in my mind..."*

Finally, participants made a number of suggestions that they felt would help a service in terms of connection and recovery from suicide. These included training in becoming more in tune with clients' body language, group therapy for suicide survivors, and having a component of basic education on relationships and emotion for young people.

#### 4.11.1.2 It Wouldn't Be Appropriate

There were a number of things that participants were concerned that a suicide-intervention service should not do when looking at connectedness and suicide. These included "in-depth" work with people who are currently suicidal:

*P11: "I wouldn't be doing any in-depth work during an actual crisis so I wouldn't be doing any trauma work or anything like that until the person is stable..."*

Participants stated that such work should be completed in long-term therapy rather than suicide intervention. Participants also cautioned about working with people who were not motivated to engage in the work. When attempting to support someone who is suicidal through a therapeutic connection, it can be dangerous if they do not have the motivation to engage:

*P3: "There had been times when you know the intervention has flagged a bit and clients have...maybe attempted suicide during the contract time and... you know... 'let's have a conversation about what your intentions really are as opposed to what you're...declaring they might be you know?' Because then if I'm not actually clear then I can't actually you know navigate along this journey with this person."*

#### **4.11.2 Liaison**

The need to have means for effective liaison between the service and other services was outlined as a sub-theme for connectedness and recovery.

##### 4.11.2.1 The More Variety We Have

Participants outlined how the more follow-on services they have at their disposal, the easier it is to connect clients with the outside world and with the supports they need to continue their recovery:

*P7: "I think it's important to have many different connections with different organisations cause people's desires or interests in different organisations may be different...So the more variety we have, we might find the one that suits."*

The liaison referred to by participants included services that clients could avail of if needs be such as education centres, homeless support services, and long-term therapy services. They also stressed the need for effective liaison with medical services and how that can play a role in the client receiving the treatment they require.

## 4.12 Results Overview

Results of the CGT analysis of participants' understandings of connectedness and suicide unearthed a theory for the role of connectedness in the paths to and from suicide. This tentative model had two strands: 1) The Role of Connectedness on Paths to Suicide and 2) The Role of Connectedness in Therapy on Paths from Suicide. The first strand explains the role of connectedness in the trajectory towards suicidality and the second strand explains the role of connectedness in therapy for recovering from suicidality.

### 4.12.1 Explaining The Theory

The first strand of the theory incorporates an over-arching theme detailing the characteristics of connectedness in relation to suicide and explaining the nature of the innate human need for connection. The theory posits, therefore, that the absence of positive connections can add to suicide development. The foundation of this over-arching theme involves the core theme of an individual's connection with themselves. The connection with oneself is seen as a protective buffer against suicide and the absence of a positive connection with oneself is deemed contributory to the development of suicide ideation. Furthermore, the ability to connect with oneself is required in order to be able to connect with others. The dynamics, propensity and importance of connecting to oneself are variable across the lifespan.

There are two further core themes of connectedness that stem from the "Connection With Oneself" theme. The first involves the quality of one's connections with others. The quality of connections at different stages of the lifespan can either contribute to or protect from later development of suicidality. In addition, if the quality of one's connections is toxic or abusive it can influence their development of suicide ideation/intent. The second includes family and other connections. For instance, one's relationships and role in what they perceive to be their 'family' plays a part in their susceptibility to suicide. Furthermore, it is postulated

that everyone has the potential to have meaningful connections of some kind. The development of these connections can help negate the development of suicide and the absence of meaningful connections can contribute to suicide development.

Figure 4.1 outlines how these core themes are encompassed in the over-arching theme section of “Connectedness and Suicide”. The core theme of “Connection With Oneself” is represented by the figure in the centre of the box. The other core themes are pictorially related to the “Connection With Oneself” theme by the lines depicting the nature of the relationships. Figure 4.1 depicts how the first strand of the theory explains the role of connectedness in the paths to suicide. This is outlined by the arrows leading towards the words “Possible Suicidality.” These arrows then lead to the second strand of the theory explaining the role of connectedness in therapy on the path from suicidality.

The over-arching theme of the second strand incorporates the role of connectedness in an individual’s recovery from suicidal ideation/intent. The therapeutic relationship is seen as the connection that is paramount to recovery. The over-arching theme is split between three core themes. These themes are all interconnected in the development of the therapeutic connection and eventual recovery.

Therapy itself is one theme and involves the characteristics of the therapist, the dynamics interplayed in therapy, and the difficulties that arise in therapeutic intervention. The client and what they bring to the relationship is another theme. This theme involves the client’s characteristics and the individual client-specific barriers to connection in therapy. The final theme is that of the ideal service required to assist the development of adaptive therapeutic connection. This incorporates the service’s model and effective liaison between the therapy service and other services.

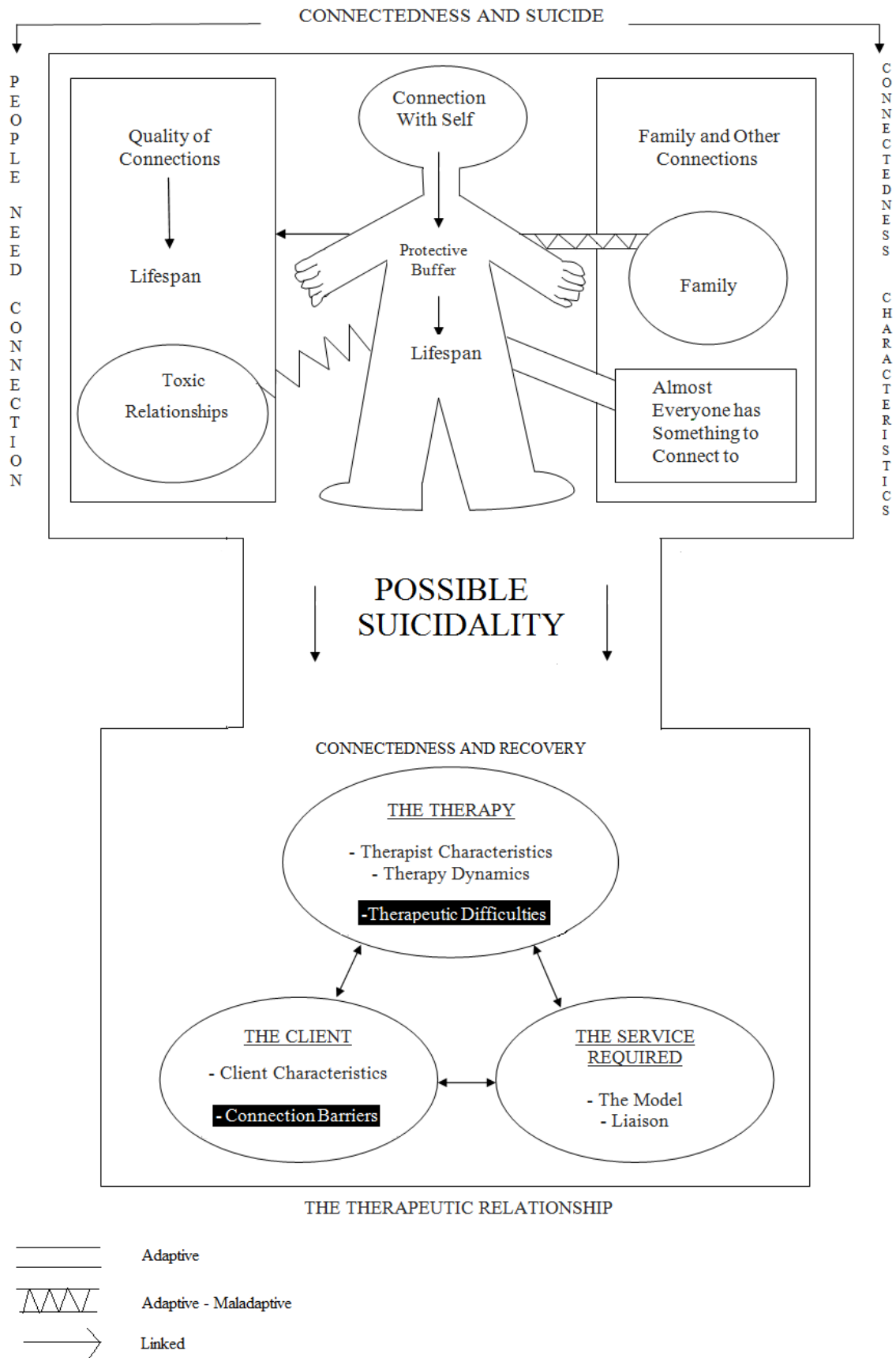


Figure 4.1 Tentative model explaining the role of connectedness on paths to and from suicide

## **Chapter Five: Discussion**

### **5.1 Chapter Introduction**

This chapter will discuss the main findings of the current study and compare them to previous findings and theoretical frameworks in the area. The strengths of the study and areas for improvement will then be examined. This will be followed by the practical implications for the current research and suggestions for future research in this area.

### **5.2 Key Findings and Practical Implications**

Overall, the main findings include 1) the link between connectedness and suicide, 2) the importance of connectedness with oneself, 3) the role played by the quality of connections one experiences, 4) the significance of the family connection, 5) the link between connectedness and recovery, 6) the key characteristics of the therapy that contribute to or are a barrier to connection, 7) the key characteristics of the client that contribute to or are a barrier to connection, and 8) the service that is required for developing connectedness with someone who is suicidal. These results form a tentative model explaining the role of connectedness in suicide and recovery. The results for the model proposed are preliminary but, given the multitude of research supporting many of its claims, the relevance of the theory seems valuable. The findings will be discussed here with reference to previous research and their practical implications.

#### ***5.2.1 Connectedness and Suicide***

The current theory posits that connectedness is particularly important for human well-being and that the absence of connection can contribute considerably to the development of suicide ideation/intent. This is also a common theme in existing literature (Buchman-Schmitt et al.,

2014; Sanger & McCarthy-Veach, 2008; Stone et al., 2014). Furthermore, the importance of supportive and positive connections fits well with existing theories on suicide (Joiner, 2005; Kaplan & Worth, 1993; Linehan, 2008; Shneidman, 1996). It is unsurprising, therefore, that two of the only interventions that have been shown to reduce rates of suicide are based on connectedness. The first is that of Motto and Bostrom (2001). This has been described as a “belongingness” intervention whereby people at risk of suicide are sent caring letters post-crisis over a prolonged period of time. The letters have been shown to reduce suicide in comparison to people who received no letters post-crisis. The second is that of Fleischmann et al., (2008). This was a WHO driven project completed in five different countries over a two year period. It encouraged increased contact between people at risk of suicide and clinical staff. This included a one hour information session and up to 9 follow up contacts via phone calls or visits. An increase in interpersonal contact was shown to decrease rates of suicide. On the basis of this previous research and the current findings, further implementation and development of effective connectedness interventions for suicide is desirable.

One of the main characteristics of connectedness in this model is that one-to-one human contact is a requirement. This is an interesting finding given that human contact has changed dramatically in recent years with increased use of the internet and technology. Furthermore, online counselling and therapy has demonstrated high rates of efficacy (Andersson, 2009; Cook & Doyle, 2002; Kiropoulos et al., 2008). The reality is that human contact is ever-changing and now operates across a variety of different media. Furthermore, online counselling may also be a more popular option for younger generations (King et al., 2006). With that in mind, a suggestion made by one of the participants in the current study may be most appropriate: keeping in contact with people online or via technology devices

may be beneficial for initial contact or to keep in touch but, to truly feel connected in relationships with others, face-to-face contact is necessary.

In addition, the current theory sees connectedness as an innate human need that is vital for living. The mechanisms of connectedness that make it vital to life and contribute to protection against suicide acknowledged in this theory included hope, resilience, support, and a sense of belonging. These elements have received substantial support as being protective against suicide in previous research and it could be worthwhile to promote them in suicide intervention and prevention protocols (Davidson, Wingate, Rasmussen & Slis, 2009; Hatcher & Stubbersfield, 2013; Kleiman & Riskind, 2013; Kleiman, Riskind & Schaefer, 2014). The absence of connectedness, on the other hand, can lead to distress and subsequent suicidality. Disconnection, loneliness, and/or isolation are also key components of the human need for relationships. A variety of previous studies have supported this claim (Olfiffe et al., 2012; Oulanova, 2014; Schomerus et al., 2015, Vatne & Naden, 2012). The loneliness that is at the core of existential philosophy has been posited as playing an important role in the dynamics of suicide. Lakeman and Fitzgerald (2008) and Benson, Gibson and Brand (2013) suggest that the feeling of being suicidal is related to the existential realisation that, while one's life can be shared with others, one's existence is felt by oneself alone. Sun and Long (2012) have developed a theory on recovery from suicide whereby acceptance of the value in existence is the core theme for recovery from suicidal intent. The current research offers further support for the worth of such intervention and theory.

Finally, the current theory states the connectedness can be the vital link between someone wanting to live and wanting to die. Psychiatrist, Jerome Motto, gave a poignant example of this link from a note of a person who died by suicide from the Golden Gate Bridge: "I'm going to walk to the bridge. If one person smiles at me on the way, I will not jump." The person may have had objective connections but, for him up until the point of his

death, perceived connection was an entity he was yearning for. Connectedness being seen as the critical link between life and death has also been supported in previous research (Fässberg et al., 2012; Hill, 2009; MacDonald, 2014).

### *5.2.2 Connectedness with Self*

The theory developed in the current study places the connection to oneself as the foundation for being able to develop other connections. For instance, the connection to oneself is deemed as the most important connection one can have when looking at a person's suicide trajectory. The current research describes the connection with oneself as a sense of self-compassion and self-awareness. Some previous research suggests that the relationship an individual has with themselves plays an important role in the development of suicide ideation. For example, Kidd (2004) and Orri et al. (2014) reported that a negative understanding of oneself could contribute to suicide development. Furthermore, Benson et al. (2013) noted that losing coherence with one's sense of self and experiencing a disruption between one's sense of self and the environment can result in increased suicidality. They concluded that feeling suicidal should be understood in the context of one's sense of self. Moreover, actress Muriel Hemmingway (close relative to 7 people who died by suicide including grandfather Ernest Hemmingway), when trying to make sense of her relatives' deaths, concluded that "There's no one outside of yourself that can help you or love you the way you need, except you." (Winfrey & Copple, 2013). Studies on suicide do not seem to have focussed on how the relationship with oneself affects one's relationships with others. The importance of having an adaptive connection with oneself for being able to connect to others, therefore, may be a novel finding from the current study and may be an important focus for suicide intervention and prevention. For example, promoting the notions of self compassion and personal development may be beneficial to highlight in suicide prevention campaigns.

Furthermore, the current theory proposes that it is a disconnection from oneself that results in a negatively-oriented and inward-focussed suicidal mind. When a person is disconnected from himself or herself or their self awareness is negative, their cognitive pattern is narrowed and their thoughts become self-critical and dark. This style of thinking is common in the mind of someone who is suicidal (Shneidman, 1996; Williams et al., 2008). This finding may be particularly relevant to the efficacy of CBT when supporting someone who is suicidal.

Connection with oneself also seems to tie in appropriately with self awareness. Self awareness and being aware of one's needs have been noted as helpful in recovery from suicide intent (Chi et al., 2013; Preven, 1981). Baumeister's (1990) ETS, however, posits that suicide is an attempt to escape from self and negative self awareness. Suicide as an escape from painful self awareness has received considerable support in the literature (Pompili et al., 2011; Wallack, 2007). Furthermore, it has been hypothesised that self awareness experienced by humans is a reason that suicide exists (as compared to animals; Maltzberger, 2003). Further investigations of the ETS, however, show that its intricacies may fit well with the current theory. Support for the ETS has shown that increased self awareness increases one's ability to access suicidal thoughts (Chatard & Selimbegović, 2011; Selimbegović & Chatard, 2013). If one's self awareness is developed in an adaptive manner, therefore (e.g. using appropriate psychotherapy), one may be in a better position to confront a difficulty and overcome it. If this self awareness is developed in a maladaptive fashion, however, suicide can be a definite risk (Freckelton, 2011). The current theory concludes, therefore, that one's self-connection alone does not contribute to protection from suicide but that the connection with oneself must be adaptive if it is going to be helpful. Increased self awareness is conceivably difficult to develop by oneself. Psychotherapeutic intervention, where a mental

health professional can assist with the developing one's self awareness, therefore, may be the perfect arena for developing this adaptive self-connection (Parloff, Kelman & Frank, 1954).

In addition, an individual's propensity to have a relationship with themselves is dynamic across the lifespan and can be affected by different variables at different stages. This may be of particular relevance to experiences of abuse in infancy. Maladaptive connections from a young age, therefore, can have an effect on one's connection with themselves as their experiences inform them that they are unlovable and that positive relationships are not possible (van Harmelen et al., 2010). Adolescence may also be a difficult stage for connecting with oneself as this may be the life stage within which one is forming their individual identity. When this identity is a negative one, a person may be at risk of suicide (Orri et al., 2014). Finally, a negative relationship with oneself has also been seen as complicit in suicide attempts for older adults specifically related to their life stage (Bonnewyn et al., 2014). This finding may offer beneficial information for professionals training in the field of suicide intervention.

### ***5.2.3 Quality of Connections***

The current theory explains how the quality of a person's connections may play a role in whether or not they become suicidal. The quality of one's connections, like a person's connection with themselves, is a dynamic mechanism across one's lifespan. How people relate in early life informs how they relate later in life. For example, having secure attachments in infancy can have a positive effect on the quality of one's connections throughout their life. This aspect of the theory is supported by previous research on the role of attachment patterns in later relationship style (Venta & Sharp, 2014). Much of the theoretical underpinning of psychotherapy centres on developing secure attachments with clients through a positive therapeutic alliance (Connors, 2011; Gelso, Palma & Bhatia, 2013;

Levy, 2013). People who are suicidal, however, may be particularly vulnerable to insecure attachment styles and lack an ability to connect with others. A practical implication of this finding, therefore, is that attachment-based therapy may be a particularly appropriate opportunity for people to redevelop their ability to relate to others and feel connected or supported and consequently protected from suicide (Bostik & Everall, 2007).

The current theory also maintains that different relationships are important at different life stages. For example, traumatic experiences and bullying experienced at certain life stages can fragment an individual's perception of their worthiness in relationships. This mechanism is substantiated by ample research that reports bullying and adversity as risk factors for suicide (Corcoran et al., 2006; Cui et al., 2011; Daine et al., 2013; Kim et al., 2014; Stone et al., 2014). A notable case example of the impact of a traumatic loss of a connection that is of crucial importance at a specific life stage is seen with professional footballer, Robert Enke. His death by suicide was partially attributed to difficulties coping with the loss of his 6 year old daughter (Reng, 2011). This finding may offer further beneficial knowledge for mental health professionals in that it is worth exploring the quality of an individual's relationships at a number of stages in their life and investigating the impact of these connections on their current presentation.

The current theory claims that if the quality of an individual's relationships is so poor that they are deemed toxic, there is an added risk of suicide. Toxic relationships include relationships that involve physical, sexual or emotional abuse. Co-dependency and submissiveness are other forms of toxic or dysfunctional relationships. There are numerous studies that have shown how toxic relationships are risk factors for suicide (Kidd, 2004; Untu et al., 2014; WHO, 2014; Yip et al., 2015). Toxic relationships also have a negative effect on one's ability to develop adaptive connections with others. For example, one's ability to trust people is negatively impacted by experiences of toxic relationships. The link between trust,

quality of connections and suicide does not appear to have been previously researched. On the other hand, the trust dynamic in one's experience of relationships is critical from infancy (Erikson, 1980). In addition, Pretzel (1967) posits that it is the experience of mistrust from infancy that can play a critical role in later social isolation and eventual suicide. Participants in the current study revealed how it can be inappropriate to delve into a client's previous experiences of toxic relationships in short-term suicide intervention work. This aspect of one's life, however, may be critical to informing their thoughts of suicide and may need to be addressed when offering therapeutic support. It is, therefore, suggested that abuse-specific intervention services may be a necessary port of call for some people in fully resolving their suicidality.

#### ***5.2.4 Family and Other Close Connections***

Family, or who one perceives to be their family, emerged as a key factor for one's sense of connectedness. Family is seen as where people develop their initial understanding of connection and what it is like to have relationships. It is also where people learn how relationship roles and interpersonal emotions develop. The reason given for family relationships being so important is that family is one of the most common places that a person will experience unconditional love. The literature shows that family support and adaptive family connections can be significant protective buffers against suicide and can be helpful for recovery (Kaminski et al., 2010; Oliffe et al., 2012; Purcell et al., 2012; Stone et al., 2014).

On the other hand, family can play a major role in one's development of suicidal ideation and intent. Because emotions tend to be so intense in the family environment, if the family relationships are not balanced then family can be a barrier to positive connections. Anderson et al. (2012) found that suicidal behaviour can be generated by family dynamics. They reported that such behaviour could stem from generations of family interactions

(Boscolo, 1987; Dallos & Draper, 2010). Furthermore, family discord can be a contributing factor to suicidality (Opperman et al., 2015; Ratnarajah et al., 2014). A salient example of the effect of family discord is noted for the case of Kurt Cobain. His stepmother, Jenny Cobain remarked, “I don’t know how anybody deals with having your whole family reject you.” when trying to explain his suicide (Morgen & Behrens, 2015). This finding offers support to the worth of family support in suicide intervention. Interventions may be particularly helpful if they can educate and develop a family’s support skills for the person who is suicidal and involve them in the recovery.

Other research has shown that positive relationships with parents can have a positive association with suicide for minorities and peer connectedness can be associated with increased suicide behaviours (Kaminski et al., 2010; Russell & Joyner, 2001; Teasdale & Bradley-Engen, 2010). As mentioned previously, the quality of one’s connections appears to play a role in the development of suicide. It is feasible, therefore, that the quality of relationships with peers and family members, rather than their presence alone, is most important for them to be adaptive (Purcell et al., 2012). Higher quality relationships may include social support, openness, trust and empathy whereas connections that have a negative impact on suicidality may include delinquency, peer victimisation, bullying, and non-acceptance (Kaminski et al., 2010; Russell & Joyner, 2001; Teasdale & Bradley-Engen, 2010).

One’s parents, in particular, can provide an individual with their understanding of relationships. Parents have an influence on their children’s relationship development and can model positive connections for their child (Cero & Sifers, 2013; Logan et al., 2011). Parenting styles can also have an effect on one’s propensity to become suicidal (Donath, Graessel, Baier, Bleich & Hillemacher, 2014; Ehnvall, Parker, Hadzi-Pavlovic & Malhi, 2008). An important implication of the current study, therefore, is that parental education on

how to support a child's development of adaptive relationships may be vital in efforts to decrease rates of suicide.

Another mechanism of the current theory is that almost all people can have at least one meaningful connection that will offer them sustainment. Examples of sustaining connections include friends, voluntary work, hobbies, and education. Feeling as though you are a part of something and that you have a necessary role is protective against suicide whereas a lack of connection with anything breeds suicidality. Examples of sustaining connections in the literature include social activity, physical activity, employment, school, religion, and sport (DES, 2013; Di Fulvio, 2011; Joiner, et al., 2006; Surgenor, 2014). Some other connectedness recommendations include joining a local activity centre, regular walks with a pet, making efforts to interact with other members of the community, keeping in touch and meeting face-to-face with acquaintances for a meal, and joining a religious community (Ciro & Sifers, 2013; MacDonald, 2014).

### ***5.2.5 Connectedness and Recovery***

According to the current theory, connectedness is one of the most important facets in recovery from suicide ideation and intent. Therapy is seen as the vehicle by which positive connections develop for someone who is suicidal. To that extent, the therapeutic relationship is vital to recovery and is often the first positive connection an individual can develop when attempting to turn away from suicide. The therapeutic relationship can be nourishing for the client whereby they start to feel a sense of value in themselves that someone is willing to be there for them. This connection then contributes to critical aspects of healing that a person may not have had up until this point such as love, hope, support, and company (Bartimole, 2009; Purcell et al., 2012; Sun & Long, 2013). The therapeutic relationship can give a client a reference point for positive connections and can guide them back into connections in their

daily lives (Bernecker, Constantino, Pazzaglia, Ravitz & McBride, 2014; Cutcliffe & Stevenson, 2004; Haase et al., 2008). Clients can actually find that they build more positive connections in their lives as a result of the therapeutic connection. Furthermore, it can develop new meaning and hope for a client and teach them about the resources they have that they may not have been previously aware of. Numerous studies have substantiated the claim that the therapeutic relationship or alliance is the most critical aspect of therapy (Horvath, Del Re, Fluckiger & Symonds, 2011; Lambert & Barley, 2001). For suicide, in particular, the therapeutic relationship is deemed key to the recovery process. On the basis of this element of the current theory, and previous research, psychotherapy is a desirable intervention for individuals who are suicidal. One of the most salient mechanisms for its effectiveness seems to be the connectedness aspect of the therapeutic relationship. This is an aspect of therapy, therefore, that should be promoted and encouraged for people who are suicidal.

### ***5.2.6 The Therapy***

According to the current theory, there are a number of specific aspects of the therapy that play a role in one's recovery from suicide. The therapist's personal characteristics, for instance, have an important function. Recommended characteristics for a therapist in order to be able to develop a close relationship with someone who is suicidal include interest, motivation, bravery, will, and recognition of mutual value (rather than pitying; Cutcliffe & Stevenson, 2004). Furthermore, in order to help develop a client's sense of connection, a therapist must be grounded and have significant personal development training themselves. Therapists' personal therapy is seen as critical to psychotherapy work and training and can contribute to their grounding with clients, empathy, competence, and reliability (Bike, Norcross & Schatz, 2009; Orlinsky, Schofield, Schroder & Kazantzis, 2011; Phillips, 2011; Rake & Paley, 2009; Wiseman & Shefler, 2001). In addition, personal fear can be a

hindrance to helping someone who is suicidal and personal development work can teach a professional how to be open, understanding, and trusting of the client even in the gravest of situations. If the helper is fearful then the individual can experience an absence of care and subsequently intensified feelings of isolation (Whisenhunt et al., 2014). Further important characteristics include compassion, trust, openness, and the ability to give the client time and space (Cutcliffe & Stevenson, 2004). The current theory maintains that these therapist characteristics are all particularly relevant to the therapeutic relationship with someone who is suicidal. This is an important aspect of the theory as it posits that the specific therapeutic relationship training undergone by psychotherapists puts them in the best position to offer support for people who are suicidal (rather than other professionals who have not had this extensive training in relationship dynamics). It may also be necessary to emphasise the skills listed above in the training of mental health professionals who are working with people who are suicidal in particular.

There are various aspects of the therapy itself that appear to make a difference in developing an adaptive therapeutic relationship with a client who is suicidal and it may be helpful for mental health professionals to be aware of these. Factors are said to come into play from the moment the client enters the room and include the initial contact between therapist and client (such as body language and non-verbal gestures) and the atmosphere of the room. Such factors do not appear to have an extensive research base but seem likely to contribute to a pleasant experience for the client and therefore an increased likelihood of engagement with the therapist and the process. A number of different therapeutic techniques may also be used in therapeutic sessions with someone who is suicidal. The importance of different skills and models tends to ebb and flow throughout sessions and it may be helpful for therapists to be aware of what approach the client may need at any given point. A range of different models have been shown to be effective in decreasing suicidality (Donker et al.,

2013; Ougrin et al., 2015; Winter et al., 2014) but in order to develop a sense of connectedness that can target specific problems related to suicide, a person-centred and solution-focussed approach may be best suited (MacLeod, 2014). One of the reasons why a person-centred approach may be best suited, according to the current theory, is because it means that the therapist can go at a client's pace. Research has supported the importance of understanding a client's suicidality from their frame of reference (Cutcliffe & Stevenson, 2004; Michel et al., 2009).

Some barriers exist that can make adaptive connection difficult in therapy with someone who is suicidal. For instance, when someone is attempting to support an individual who is suicidal but they have not completed appropriate training, are offering inappropriate advice or do not have enough experience to manage the situation, the therapeutic connection may not emerge or can be fragmented. When this is the case, an individual's suicidality may not decrease. Mistakes in therapy can be detrimental for therapeutic connection and therapeutic outcomes for people who are suicidal (Freckelton, 2011; Kearns, 2007). On the other hand, discord is bound to happen in therapy and when it is worked through, both the client and therapist can learn a lot about the individual's methods of connecting (Hill, 2010). Another barrier to connection in therapy is that of antidepressant and antipsychotic medication. When individuals are taking large doses of such medication on a daily basis, a therapeutic connection is difficult to generate. This is because anti-psychotic medication can contribute to feelings of numbness and disconnection for a client and thus interpersonal difficulties (Gibson, Cartwright & Read, 2014; Read, Cartwright & Gibson, 2014). Medication may be necessary for an individual's safety at times of acute suicidality but when attempting to recover from thoughts of suicide, high doses can block therapeutic connection. Furthermore, the client's underlying difficulties may never be adequately addressed if they are not fully experiencing their emotions as part of their recovery. Effective liaison between

medical professionals, mental health professionals, and the client is recommended in order to achieve the most successful outcomes for a client who is taking medication.

### ***5.2.7 The Client***

There are aspects of the client that play a role in the development of the relationship in therapy and subsequent recovery from suicide intent. The current theory notes that each client is uniquely individual and that each therapeutic relationship is distinct as a result. The different client characteristics that may be of importance include age, gender, values, past experiences, capacity to self care, previous relationships, and capacity for pain. Many of these have been cited as playing a role in suicidality (WHO, 2014). The current theory maintains that they may also play a role in a suicidal individual's ability to connect in therapy and must be taken into account for each individual in therapy. The theory also maintains that clients attending therapy have a personal responsibility to engage with the relationship development (Overholser, 2005). It is a two-way process and without the client's input, the connection is not possible. Furthermore, people who are suicidal but who are attempting to recover are regularly faced with the ambiguity of wanting to die but also wanting to live (Joiner, 2005; Shneidman, 1996). If an individual attending therapy for suicide can be more in touch with the part of them that wants to live, the therapeutic connection comes easier. Again, these may be helpful aspects of the individual to be aware of when supporting someone who is suicidal.

In order to form an adaptive therapeutic connection, it may be beneficial to take a client's particular life stage into account (Wilson, 1996). For example, clients under 18 must have parent/guardian consent to take part in therapy and this may have an effect on their trust in the therapeutic relationship (King & Kramer, 2008). Moreover, Dooley and Fitzgerald (2012) found that 20% of young people felt they had no one to talk to about their problems.

Young people, therefore, may require particular forms of intervention and prevention strategies (Illback et al., 2010). The Good Behavior Game (Barrish, Saunders & Wolf, 1969) may be an example of a beneficial prevention programme to implement in schools because its connectedness elements are specific to young children. It focuses on teamwork in developing young children's ability to regulate emotions.

There are a number of individual barriers to connection that people who are suicidal can experience. Having a clinical diagnosis may be associated with difficulties in connecting in therapy. Specific diagnoses where therapeutic connection may be particularly fragile from the point of view of the current thesis include Borderline Personality Disorder (BPD), and Autism Spectrum Disorder (ASD). BPD and ASD are characterised by interpersonal relationship difficulties (American Psychiatric Association, 2013) and these may be what contribute to therapeutic relationship difficulties. Furthermore, clinical diagnoses and psychiatric illnesses are listed as risk factors for suicide in previous research and people with BPD and ASD may be particularly at risk (Arsenault-Lapierre et al., 2004; Baus et al., 2014; Cavanagh, Carson, Sharpe & Lawrie, 2003; Mayes, Gorman, Hillwig-Garcia & Syed, 2013). The fragility of relationships for clients with these diagnoses appears to be relevant to developing a connection in therapy and specific therapeutic models (such as DBT) may be most helpful in such cases (Linehan et al., 2006).

Further client characteristics of suicidal clients that can act as barriers to therapeutic connection include cognitive distortions, pessimism, and a negative worldview. Moreover, ETS posits that people who are suicidal exhibit restricted cognitive focus, concrete thinking, rigidity of thought, confined goals, and rejection of reason (Baumeister, 1990). These negative and maladaptive thinking patterns have been associated with suicide in the literature (Jager-Hyman et al., 2014; Krajniak, Miranda & Wheeler, 2013; Wolff et al., 2013) and their obstructive effect on relationship development may be playing a part. Cognitive distortions

that have been shown to be relevant to suicide include hopelessness, rigidity, and personalising (Öncü & Sakarya, 2013). These elements seem related to interpersonal difficulties, may be areas worth focusing on for intervention, and may require elements of CBT (Rudd, 2000).

A final client characteristic that can be a major impediment to therapeutic connection is the mask that people who are suicidal can put on. There can be a tendency for people who are suicidal to keep their darkest sentiments to themselves (perhaps because they feel no one can really help or they fear hospitalisation; Whisenhunt et al., 2014). This can make connection difficult. Research supports the notion that people who are suicidal may not talk directly about their most significant difficulties to the people closest to them (Barnes, Pazuer & Lester, 2014). On the other hand, Owen et al. (2012) noted that people often give indirect clues about their suicide intent but this can be difficult to pick up on. An example of this paradox may be seen in the example of Gary Speed, a professional football manager, who died by suicide. The suicide was seemingly unexpected by his family although his wife reported that he had sent her a text message pertaining to suicide in the week before his death (Boyle, 2012). There may be a dichotomy for people who are suicidal related to their ambivalence for death. This includes the wish to die and having to cover up intention so that a plan for death is not foiled but also the wish to live and the hope that someone can connect with their pain and offer a different solution. It is important, therefore, to be aware of the potential mask for suicidal individuals and to be responsive to any signs that a person may give.

### ***5.2.8 The Service Required***

The current theory proposes key components of the service required for the most adaptive conditions for developing a positive therapeutic connection. Being able to attend therapy

more than once in the initial stages of recovery can be more conducive to a positive therapeutic connection. Common therapeutic practice involves sessions for one hour per week (Lauer & Tangen-Petratis, 2014) but working with someone who is suicidal may require more contact. Higher frequency of therapy sessions has been associated with quicker positive outcomes for psychotherapy in previous studies (Erekson, 2014; Freedman, Hoffenberg, Vorus & Frosch, 1999) and the current theory posits that the quicker development of therapeutic connection contributes to this. Moreover, a number of studies have shown that accuracy of assessment and quality of care are clearly improved when the health care professional takes the time to build a relationship with a client experiencing difficulty (Baik, Bowers, Oakley & Susman, 2005; Casey, 2010; Scott et al., 2008). The amount of contact time with a client has also been linked to higher efficacy of intervention (Fleischmann et al., 2008) and is one of the critical components of the empirically validated DBT (Linehan, 2008). Given the findings of the current study, key attributes for a suicide-intervention service may include a client-centred psychotherapy model where clients are listened to and given extended contact time (Paulson & Worth, 2002; Whisenhunt et al., 2014).

Research studies have shown that the client-therapist match is important for therapeutic alliance (Jacob, 2005; Wiseman & Tishby, 2014) and the current study claims that this is of particular importance when working with suicide. Being given the option to change therapist at any time makes it easier for someone who is suicidal to find a therapist who will suit them and it gives them a sense of agency as part of their relationship choices in recovery. The current theory has already established the potential importance of family in suicide trajectory. Involvement of family in the recovery process, however, has also been shown to improve outcomes for people who are suicidal (especially for young people; Asarnow, Berk & Baraff, 2009; Sun, Chiang, Lin & Chen, 2014). Education on preventive

and caring skills may hence be necessary for family members of people who are suicidal (Fan-ko, Long, Xuan-Yi & Hui-Man, 2008). Other service attributes deemed helpful for therapeutic connection include the service being free of charge, the service being specifically for suicide intervention, and clients not needing a referral to gain access to treatment. These factors make a service easily accessible and can add to a client's comfort in the environment.

The better the liaison structure of a service, the better it may be for a client's sense of connectedness. Multiple avenues for support following a suicide attempt are recommended for the individual and their close community (Knapp, 2015). When a service can give a client options and variety for developing further adaptive connections then they are more likely to engage with the therapeutic process. This may also include liaison with other mental health services, as there is sometimes more than one service involved to help a client to recover from suicide.

### **5.3 Strengths and Areas for Improvement**

The current study endeavoured to use valid and reliable research methods to develop a project that would give more insight to the phenomenon of suicide and add to existing theory. There were a number of strengths and limitations of the study and they will be detailed here. There has been growing concern in the literature that research in suicide has become stagnant and based predominantly on quantitative data rather than giving insight and understanding to the process (Hjelmeland & Knizek, 2010). The current study is a response to the pleas for greater understanding of suicide in a way that can be more helpful for intervention and prevention. A strength of the study is that it offers greater insight and understanding to the processes of suicide with a theory that is thoroughly supported by empirical evidence.

The current study conducted individual interviews with professional psychotherapists who had been working in a suicide-specific service. This is a novel methodology as most

previous qualitative research on suicide has been with suicide attempt survivors or relatives of people who have died by suicide. There have been studies exploring suicide with mental health professionals (Christianson & Everall, 2009) but not professionals whose work is solely in the field of suicide. People who have survived suicide attempts or relatives of people who have died can only draw on the experience of one person (or maybe a couple of more that they have encountered in their lives). They are also inextricably personally attached to the experience of suicide and may not be in a position to take a step back from the experience and observe what has happened. Therapists may be in a much better position to give substantial and accurate insight into suicide processes. For instance, the 12 therapists in the current study worked in a suicide-specific intervention service, had encounters with over 3,000 people who were suicidal and could therefore draw from a wide range of presentations to give the qualitative data richness unmatched in previous research. Furthermore, the therapists had extensive training in the field of psychotherapy and their own personal therapy. It is predicted that these factors helped them to take a step back from the personalised cases, not be too emotionally-involved, and consequently give more accurate reflections. On the other hand, the theory is based solely on therapists' experiences and the route to recovery, therefore, is outlined in the context of therapy alone. It may be helpful to investigate other routes to recovery in future studies.

The current study is based on elements of a number of theories that are supported by empirical data. There is a solid base of literature and support for the significance of connectedness in the processes of suicide and it is therefore reasonable to assume that the current study fits with previous knowledge on the subject. The current study and subsequent theory incorporates significant elements from well established theories such as Durkheim (1951), Alloy et al. (1990), Baumeister, (1990), Kaplan and Worth (1993), Hagerty et al. (1993), Shneidman (1996), Linehan (2008), and Joiner (2009) as well as emerging theories

such as Gordone et al. (2011) and Sun and Long (2013). It is helpful that there are a number of paradigms by which to understand suicide, as it is a complex and dynamic process. Adding theory to the literature that incorporates previous models helps to further shape our understanding of the phenomenon.

The difference between genders was not explored as part of the current theory. It is clear from prevalence data that females and males have different propensities for suicide (Oquendo et al., 2014) yet the subjects of the interviews in the current study did not make any distinction between genders. Connectedness, in particular, seems like it would be experienced differently for men and women as one of the theories posited for women's protection from suicide is their better ability to seek help and glean social support. Masculinity is often culturally associated with emotional control and not being vulnerable whereby these may be key factors contributing to an inability to connect when support is most needed. Research has shown that men have the ability to talk about their difficulties when they avail of the opportunity (Emslie, Ridge, Ziebland & Hunt, 2006) but this was not investigated in the current study.

The current theory incorporates life span and life stages for different aspects of connectedness and suicide. This was not integrated in the initial conceptualisation of the study, however, and a greater emphasis on the differences in connectedness across the lifespan may have lead to a better informed theory. Past studies have shown unique differences in connectedness factors (such as TB and PB) for different age groups (Jahn & Cukrowicz, 2011). This is an entity that could have been explored in more detail for the current theory.

The current study was completed in a specifically Irish context using qualitative methodology. The findings, therefore, are preliminary and are not generalisable across cultures and contexts. Suicide rates differ in different countries and different cultures and

there is, therefore, a need for cross-cultural research in the area (Stack, 2000). Suicide prevalence rates seem to be different in countries with lower population density, higher oppression, and specific histories. The construct of connectedness may play an important role in such factors and therefore may be perceived differently in a variety of countries. The current study, however, can only account for it in a uniquely Irish sample. Furthermore, given that there are many people presenting to suicide services in Ireland from different cultural contexts (such as the travelling community) and different countries of origin (over 700,000 people in Ireland with a different country of origin including rapidly growing communities of Eastern Europeans and Indians; CSO, 2012), it is desirable to have an understanding of connectedness and suicide from a range of cultural perspectives. In addition, the current study only involved discussions with psychotherapists whereas a more holistic understanding of suicide intervention may be gained by interviewing other professionals working in the area.

#### **5.4 Future Research Suggestions**

Kelleher, Keeley and Corcoran (1997) and Kelleher et al. (2002) described a growing trend of suicide in rural counties (such as Leitrim) and CSO figures have shown that the four least densely populated counties in the Republic of Ireland have experienced suicide rates of almost double the national average, on occasion, in recent years (i.e., Leitrim had a rate of 18.7 in 2012, Mayo had a rate of 19.9 in 2012, Roscommon had a rate of 18.6 in 2013 and Kerry had rates of 18.8 and 19.4 in 2012 and 2013). Contrastingly, the most densely populated counties (Dublin, Kildare and Meath) have had rates close to or lower than the average. An Irish qualitative study that interviewed 26 men from rural areas (who had been admitted to hospital following a suicide attempt) found that suicide vulnerability, however, appeared to be explained more by rural attitudes, economic disadvantages, personal biographical experiences, and an inclination to use alcohol to self-medicate rather than a lack

of connectedness (Cleary, Feeney & Macken-Walsh, 2013). The prevalence research above, therefore, may not offer conclusive evidence that physical proximity to others (which would presumably relate to the increased likelihood of interpersonal contact) plays a role in suicide but it may be worth further investigation. An international example of this possibility is that of Greenland. Greenland is one of the most sparsely populated countries in the world and also has one of the highest rates of suicide (100 per 100,000; Bjerregaard and Larsen, 2015).

Participants described a domino effect of one disconnection leading to several more (and likewise one positive connection leading to others). This may be an important area for further suicide research to focus on, as awareness of the detrimental effects of one significant connection loss could be crucial in suicide prevention and intervention. Furthermore, the clustering effect that occurs with some cases of suicide (Niedzwiedz, Haw, Hawton & Platt, 2014) may be a result of a form of the domino effect that occurs in the area of connectedness. The interpersonal aspect of suicide may be a critical component of its 'contagion' effect. This may be different to the domino effect that looks at the impact of one connection on others but it may be similar on another level whereby a connection in suicide or resilience may have an impact on others; further research is needed.

A characteristic of connectedness detailed in the current theory is that of spiritual connectedness. Additionally, some research supports the claim that perceived connection with a religion, belief system or spirituality can be sustaining and therefore protective against the development of suicide (Cleary et al., 2013; WHO, 2014). Research investigating the intricacies of connection with religion and spirituality that are sustaining for people may be of particular relevance given the ever-changing face of religion in the modern era (Ó'Murchú, 1999).

## Chapter 6 – Conclusion and Personal Reflections

The current study acknowledges people's freedom of choice and it is clear that people often make the decision to die by suicide. The current study also takes the view, however, that suicide is not the desired answer to life's difficulties. The reality that life becomes too intolerable and that human suffering becomes so great that people see suicide as their only option is tragic. Given this stance, it is posited that research illuminating the paths to this decision and giving insight into how people may choose life instead, is worthwhile. The construct under investigation in relation to the suicide pathways in the current study was that of connectedness. It is worth noting here that I, as a psychologist, have a considerable interest in connections and relationships and how they play a role in shaping people's emotional well-being. From that perspective, the current study and the research question were heavily influenced by my interest in relationships and the role they play in suicidality. I have always placed an importance on the impact of adaptive relationships on a person's quality of life and this stance was bound to impact on the data generated in the current study. I maintained a scientific viewpoint throughout the process and attempted in earnest to distance the research from any biases but there is clearly a part of me incorporated in the piece. The impact of my personal stance has been further acknowledged through the use of memos within the CGT analysis and through basing the methodology in a social constructionist philosophy.

Connectedness was found to play an important role in the processes leading towards someone's suicide intent and in helping them to decrease their suicidality. One of the central mechanisms that connectedness acts upon appears to be hope. From completing this research and immersing myself in the area of suicide literature and applied work over the past year, my understanding is that connectedness can give people hope for a meaningful life. A sense of connectedness gives a person meaning and purpose in their life, which then gives them hope for their future. Giving people reasons to live and purpose for life is what keeps them

alive and well. Connectedness seems to be a vehicle through which people can develop meaning and hope and the current study aimed to show the mechanisms behind how this is done.

The medical model is often used for treating people who are suicidal. This may be due to the research that emphasises psychiatric diagnoses in people who have died by suicide (Cavanagh et al., 2003). Pridmore (2015) argues that this is a faulty connection and that previously predominant theories of suicide based on mental disorder or illness have not been found to account for suicide the way interpersonal theories have (Christensen et al., 2013; Linehan, 2008). One of the most important clinical applications unearthed from the current study is the worthiness of connectedness in the treatment and prevention of suicide but training in developing therapeutic relationships is not a core competency for medical professionals the way it is for psychotherapists, counsellors and psychologists. A differential model for suicide treatment, based upon human relationships, therefore, may be preferable and more effective.

Comtois and Linehan (2006) warned that identifying effective scientific research on suicide is only worthwhile if it is effectively applied to service provision. The effective connectedness interventions of Motto and Bostrom (2001) and Fleishman et al. (2008), however, do not seem to be common practice for suicide intervention; certainly not in Ireland. Particularly in relation to Motto and Bostrom's intervention it is surprising that something as low cost as a personal letter to people who have experienced crisis does not seem to be common practice for Irish mental health services. If government and health professionals are serious about decreasing the numbers of suicide in Ireland then, based on the current findings, more contact is required for people who are suicidal with experts who are willing to compassionately provide them with a platform to develop more adaptive relationships and hence more hope and meaning in their lives.

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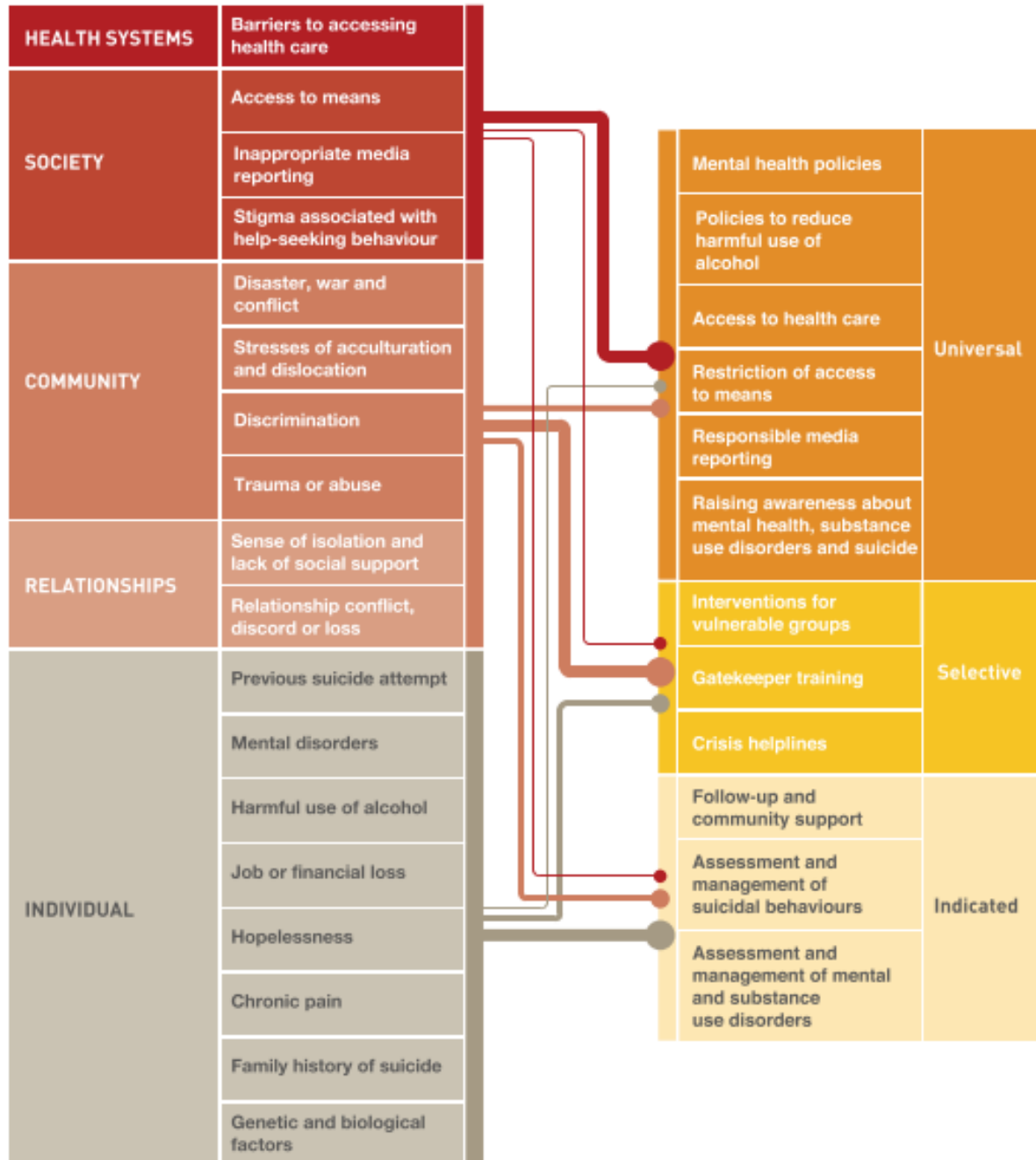
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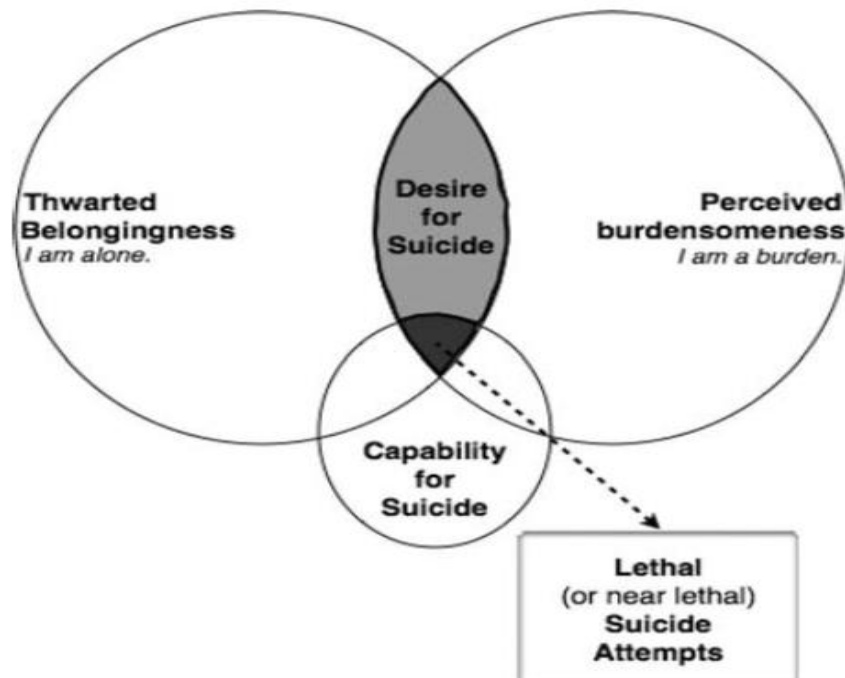
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Appendices

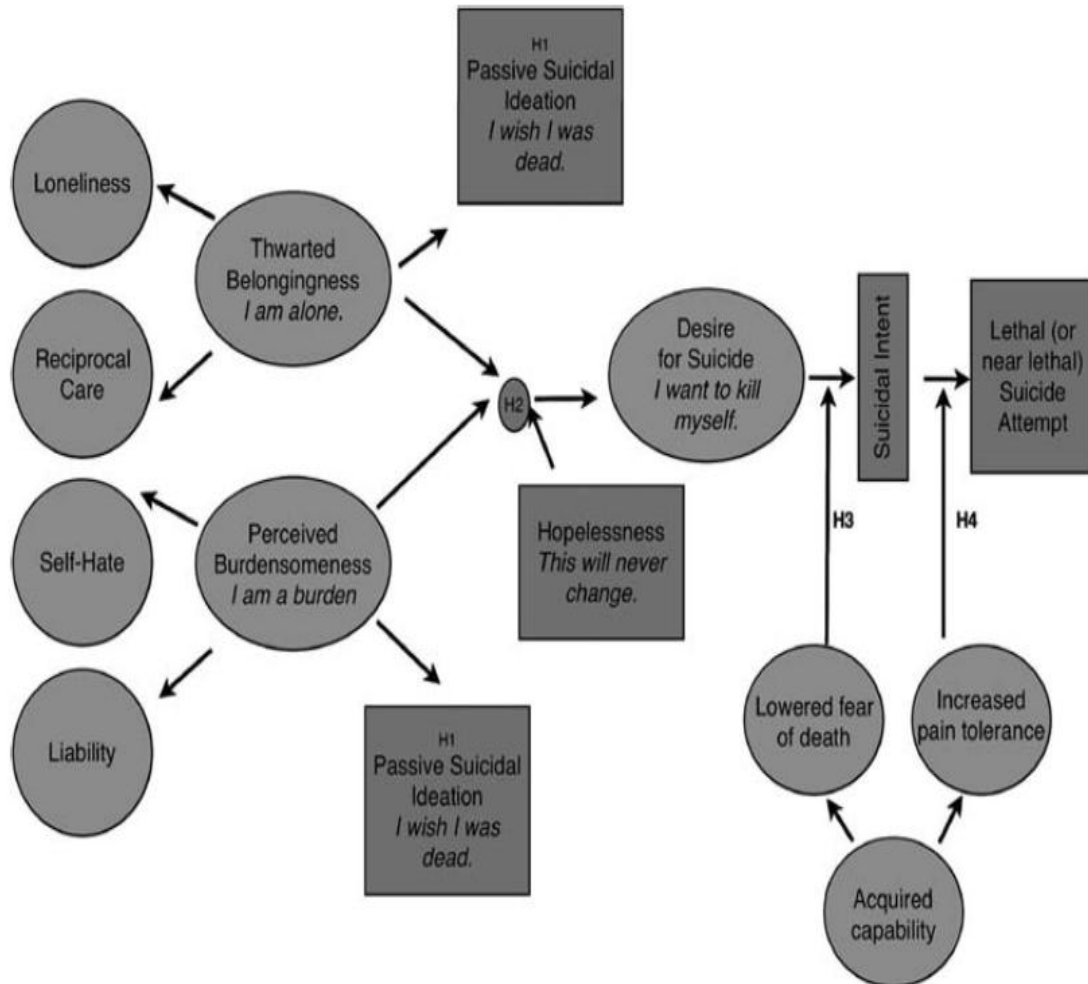
Appendix A: WHO (2014) Risk Factors and Corresponding Interventions



**Appendix B:** The Interpersonal Theory of Suicide adapted from Van Orden et al. (2010)



**Appendix C: The Mechanisms of the Interpersonal Theory of Suicide (Van Orden et al., 2010).**



## Appendix D: Semi-structured Interview Schedule

This is a semi-structured interview whereby I have a list of questions about the topic that I will be asking you. I may also pick up on some of the things you discuss and ask questions about them. Everything you say is useful so please feel free to keep talking if you feel it is relevant.

- How long have you been working in the area of supporting people who are suicidal?
- Approximately how many people have you supported who have been suicidal?
- Tell me a bit about how you work therapeutically with someone who is suicidal?
- Connectedness is defined as a sense of interpersonal closeness with the broader social world. For example, having meaningful relationships with other people helps someone to feel more connected to the world. Other examples may be having close relationships in family, being part of a sports team or having a positive therapeutic relationship in counselling. What are your thoughts on connectedness? Do you have any questions on the topic?
- What role might connectedness have in relation to therapy from someone who is suicidal?
- What role do you think that relationships, in general, can play in suicide? What role do they play in your therapy for someone who is suicidal?
- How difficult is it for someone who is suicidal to establish new connections?
- What kind of relationship, if any, do you think might there be between suicidal ideation and the desire to be connected?
- What, do you think, people who are suicidal believe about connectedness in relation to their suicide ideation?
- What are the important connections/relations to focus on in the recovery from suicide ideation and intent?
- How vital do you think that connectedness is in terms of the will to live?
- What makes it difficult to establish a connection with a client? What makes it easier?
- Could you envisage a scenario where connectedness would be less important or be disadvantageous for the client? Are there other facets that are more important?
- Is there anything that we've spoken about that you feel might be useful for Pieta House in terms of identification, assessment or treatment?
- Is there anything that has come up for you in these discussions, that you have not mentioned yet, that you think might be particularly relevant to the topic?

Difficult experiences may have been discussed in this interview whereby distress may have emerged for you. Is there anything that we have spoken about that may be distressing for you now? Do you feel you may need additional support in relation to what we have discussed? Would it be helpful for me to give you a call in the coming week?

These questions are a guideline but it will be up to the researcher to pursue relevant data within the interview and to pose the necessary questions to do so.

**Appendix E: Consent Form****CONSENT FORM****Consent Section:**

I, the undersigned, declare that I am willing to take part in research for the project entitled:

“The Role of Connectedness on the Paths to and from Suicide: Exploring Mental Health Professionals' Understandings”

- I declare that I have been fully briefed on the nature of this study and my role in it and have been given the opportunity to ask questions before agreeing to participate.
- The nature of my participation has been explained to me and I have full knowledge of how the information collected will be used.
- I am also aware that my participation in this study will be audio-recorded and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am entitled to copies of all recordings made and am fully informed as to what will happen to these recordings once the study is completed.
- I fully understand that there is no obligation on me to participate in this study.
- I fully understand that I am free to withdraw my participation at any time without having to explain or give a reason.
- I am also entitled to full confidentiality in terms of my participation and personal details.

\_\_\_\_\_

\_\_\_\_\_

Signature of participant

Date

Witnessed by \_\_\_\_\_

**Appendix F: Recruitment Letter****RECRUITMENT LETTER**

Dear Potential Participant,

My name is Cian Aherne and I am a Clinical Psychologist in Training in the University of Limerick, working under the supervision of Dr. Barry Coughlan in the Department of Psychology. We are undertaking research which aims to develop an understanding of specific aspects of suicide. This research is specifically interested in the role played by connectedness in the route to and from suicidal intent. Connectedness is defined as a sense of interpersonal closeness with the broader social world. The research will explore how connectedness fits into Irish mental health professionals' therapeutic work.

You are invited to take part in a research interview in relation to your practice and understandings from working with people who have attempted suicide or have been actively suicidal. Interviews will be recorded by the researcher and transcribed verbatim to be analysed for a research thesis. Interviews will last between 60 minutes and 120 minutes and may involve sensitive discussion in relation to suicide and clients you may have worked with. They can be organised to take place in Pieta House or University of Limerick. All identifying information will be anonymised, participants are free to withdraw their information at any stage and participants have the right not to answer questions.

The purpose of the study is to develop further insight into the processes of suicide and to add insight to the area that may not have previously been researched. We are inviting you to take part in this study. If you are happy to take part, we would appreciate if you could please sign the enclosed consent form and return it to the researcher as soon as possible to enable us to organise a time and location suitable to you for the interview.

Please read the information leaflet before signing the consent form. If you have any further queries about this study please do not hesitate to contact Mr. Cian Aherne by phone at 061234345 or by email at [barry.coughlan@ul.ie](mailto:barry.coughlan@ul.ie). We hope that you will be happy to take part in this study and to contribute your valuable insight to the ongoing understanding of suicide in Ireland. Thank you for your time.

Yours sincerely,

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Cian Aherne  
Psychologist in Clinical Training

Dr. Barry Coughlan  
Assistant Director U.L. Clinical Psychology Doctorate

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee. If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee  
EHS Faculty Office  
University of Limerick  
Tel (061) 234101  
[anne.obrien@ul.ie](mailto:anne.obrien@ul.ie)

**Appendix G: Information Sheet****INFORMATION SHEET****The Role of Connectedness on the Paths to and from Suicide: Exploring Mental Health Professionals' Understandings****Introduction**

This research study will be investigating the insights and understandings of suicide from mental health professionals in Ireland. Before you decide to give consent to participate in the project, there is more information below that will explain to you why the study is being done and what it will involve. If you agree to give consent, we will ask you to sign a Consent Form. If there is anything that you are not clear about, we will be happy to explain it to you. Please take as much time as you need to read it. You should only give consent to participate in this study when you feel that you understand what is being asked of you and you have had enough time to think about the decision.

Thank you for reading this.

**Who is carrying out the study?**

The study is being carried out by Cian Aherne (Psychologist in Clinical Training) and Dr. Barry Coughlan, Department of Psychology at the University of Limerick.

**What is the study about?**

The study seeks to explore the understandings of mental health professionals in relation to suicide in Ireland. In particular, the role of connectedness in suicide will be explored. Connectedness is defined as a sense of interpersonal closeness with the broader social world. Research has shown that connectedness and healthy relationships play an important role in people's suicidality and recovery from suicidal intent. The study specifically aims to develop understanding and theory in relation to connectedness and the path to and from suicide from mental health professionals' perspectives. Full ethical approval has been obtained for this research through the University of Limerick.

**What will I have to do?**

Following giving consent, a time and location for a research interview will be arranged between you and the researcher. The interview will take between 60 and 120 minutes and will be electronically recorded. The interview will be exploring aspects of your work with people who have been suicidal and your understanding of the suicidal process. In particular the role of connectedness and relationships with such clients will be explored as well as the aspects of work that you feel underpin a suicidal client's path to recovery.

**All information will be kept confidential and at no stage will the participant or their clients be identified in the findings that are reported.**

**What are the benefits in taking part?**

You are an expert in the field of applied suicide intervention and your insights and views are therefore highly coveted in the field of suicide research. By taking part in this study, you are adding to the literature base on suicide and helping mental health professionals to gain further

understanding of suicidal processes. The research will be used to inform future interventions and prevention techniques and may help in the ongoing efforts to reduce the number of suicides in Ireland. The interview may also give you the opportunity to think about suicide in a way that you have not had the opportunity to do so previously and could be an interesting opportunity to personally assess where you and your practice stand in relation to suicide.

### **What are the potential risks of taking part?**

Suicide is a sensitive subject and talking about your clients who have had a history of suicidal behaviours and intent may be difficult. Disturbing images and experiences may arise in discussing this topic and it is advised that you have appropriate supports in place in the knowledge that you will be discussing this topic.

### **What happens to the information?**

All information that is collected during the course of the research will be kept strictly confidential. All participants' identities and the identities of their clients will be made anonymous. All information collected in this research study will be stored in the principal investigator's office and will be in accordance with ethical guidelines. The study will be submitted as part of the researcher's Clinical Psychology Doctoral Thesis. It is the intent of the researcher to apply for the research to be published in an international peer-reviewed journal when complete – the participants will not be identified in any way. An executive summary of the research can be provided for participants on request. In addition, the researcher will offer a presentation of these results to the services of the participants involved.

### **Who else is taking part?**

The research team will be asking professionals from suicide intervention services in Ireland to participate in interviews. It is estimated that 12-15 professionals will complete these interviews.

### **What happens if I change my mind during the study?**

If you decide to give consent to take part, you will be asked to sign a consent form and will be given this information sheet to keep. You can withdraw consent from this study, without penalty or consequence of any kind, at any time. If this situation should arise, any of your data will be removed.

### **What if I have more questions or do not understand something?**

The research team will be available for you to contact if you have any questions during the study. This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee. If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee

EHS Faculty Office

University of Limerick

Tel (061) 234101

[anne.obrien@ul.ie](mailto:anne.obrien@ul.ie)