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MISSING THE MARK: THE PERCEIVED ROLE OF FAMILY MEMBERS IN THE
STIGMA, SILENCE, AND MISUNDERSTANDINGS AROUND SUICIDALITY

by

Taylor M. Binnix

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

Major: Sociology

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DEDICATION

This thesis is dedicated in memory of “Sadie.”

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ABSTRACT

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Durkheim's work on how integration and regulation shape suicide rates still guides research on suicide, yet one of Durkheim's enduring weaknesses was not exploring the essence of suicide at the interactional level. Modern suicidologists have noted a dearth of qualitative research on suicide, and *The Way Forward* (2014) called for more research that includes voices of those who have lived through being suicidal. To this end, I conducted 20 in-depth interviews with adults who were formerly suicidal. I aimed to understand how formerly suicidal individuals account for their experiences contemplating or attempting suicide and their relations with family members around their suicidal period(s). I use Goffman's *Stigma* to frame how my respondents made sense of themselves and their family's conduct after suicidality. My findings suggest that the stigma, silence, and misunderstandings around suicidality are perceived as some of the most formidable barriers that preclude a suicidal individual from receiving help.

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INTRODUCTION

Some people see it as, “oh, well, you’re weak,” you know? “You failed.” Or, “you’re weak, not only for believing that you should commit suicide, but you’re weak for trying to commit suicide, and you failed at it, so you can’t even kill yourself.” –Paige

I knew that [my brother] was dead. And, when [his wife] called and said that he had taken his own life, my immediate reaction was, “that bastard! He succeeded, and I failed!” –Nathan

Emile Durkheim’s seminal work *Suicide* (1951) remains the cornerstone for sociological inquiry into suicide. Durkheim conceptualized integration and regulation as the primary social forces that influence societal suicide rates (Durkheim 1951). He posited that social integration was achieved through individual bonds that forged an attachment to a social group. According to Durkheim, a result of social integration was moral regulation, whereby an individual internalized the normative demands imposed by the group such that he/she accepted, believed in, and maintained the group’s social order. In other words, integration referred to the sense of connection that generated within a social group, such that an individual became subject to the moral demands of the group through regulation (Bearman 1991). For Durkheim, suicide could result from extreme levels of integration or regulation on both ends of these conceptual continuums.

While much of the sociological inquiry into suicide has been concerned with testing and retesting Durkheim’s hypotheses (Breault 1986; Stack 1990; Thorlindsson and Bjarnason 1998), scholars have also questioned the limitations of Durkheim’s work (Abrutyn and Mueller 2014a; Johnson 1965) as well as Durkheim’s theoretical ambiguity (Bearman 1991; Beautrais 2000). Because of this, many social scientists have worked to clarify Durkheimian concepts (Bjarnason 1994; Johnson 1965; Pescosolido 1990), better measure the effects of integration and regulation

on individuals (Thorlindsson and Bjarnason 1998), and expand upon Durkheim's original thesis (Abrutyn and Mueller 2014b; Turner 2003). Although the Durkheimian perspective is in need of updating and elaboration, scholars agree that Durkheim's contribution was foundational for the sociological study of suicide (Wray, Colen, and Pescosolido 2011).

One of Durkheim's enduring weaknesses is that he does not explore the essence of suicide at the interactional level. Other scholars have endeavored to do this from a quantitative perspective. For instance, families are considered essential to mental, emotional, and social well-being (Campbell, Connidis, and Davies 1999; Grzywacz and Marks 1999; McLanahan, Tach, and Schneider 2013; Thoits 2011a; Umberson and Karas Montez 2010), yet the sparse research that has been done on the role of familial social ties in an individual's experience of suicidality has focused on the familial risk factors that contribute to the likelihood of developing suicidality (Beautrais 2000; Denney 2010; Fergusson, Woodward, and Horwood 2000). Previous quantitative research has also sought to operationalize the construct of integration (Baller and Richardson 2009; Bearman and Moody 2004; Pescosolido 1990; Thorlindsson and Bjarnason 1998) and apply measures of integration to family units (Gulbas et al. 2011; Peña et al. 2011; Thornton and Young-DeMarco 2001). None of the existing research has sought to explore how an individual might perceive his/her family's involvement during or after being suicidal.

The concepts of integration and regulation suggest that stigma should have a role in our understandings of suicidality, yet stigma as a topic has been neglected in the suicidology literature. There is no literature on the role of stigma in the lives of former suicide ideators or suicide attempt survivors. Although there is substantial research regarding stigma and mental illness (Corrigan and Miller 2004; Corrigan and Penn 1999; Link et al. 2004; Rusch et al. 2014; Scheff 1974; Schulze and Angermeyer 2003; Thoits 2011b), and some research regarding

stigma for those surviving family members who are bereaved by suicide (Cvinar 2005; Lester and Walker 2006; Sudak, Maxim, and Carpenter 2008), this gap is surprising given that symptoms of suicidality are closely related to mental illness.

In this study, I conducted 20 in-depth interviews with adults who were formerly suicidal, including 13 who had lived through a suicide attempt and seven who had lived through periods of suicidal ideation. I aimed to understand how formerly suicidal individuals account for their experiences with suicide and their subsequent relations with family members and significant others in the aftermath of contemplating or attempting suicide. Instead of trying to measure the levels of integration and regulation that former suicide ideators and suicide attempt survivors had with family and loved ones, I listened to them tell stories of survivorship to see if they appealed to themes regarding integration and regulation while explaining their experiences with family before, during, and after being suicidal. I used Goffman's concept of stigma to frame how my respondents made sense of themselves and their family's conduct after suicidality.

Stigma around suicidality, silence around suicidality, and misunderstandings around suicidality were the most notable themes that emerged from the data. In the sections that follow, I discuss the importance of families to mental health, the existing family literature on suicidality, Goffman's concept of stigma, my methods for this study, my findings, and a discussion of how Goffman's stigma can be used to interpret lived experiences with suicidality. In the conclusion, I discuss the implications of my findings for researchers, clinicians and loved ones, as well as the limitations of my study and directions for future research regarding suicide survivorship.

LITERATURE REVIEW

The Importance of Families to Mental Health

That families are important to individual member's health and well-being has long been assumed by social scientists (Coser 1971: 308), and one of Durkheim's famous hypotheses in *Suicide* (Durkheim 1951: 173) argues that egoistic suicide was inversely associated with "domestic," or familial integration. Authors have found support for Durkheim's theory of integration when testing its effects on suicide rates within family units. To be specific, studies have upheld Durkheim's theory that supportive marital relations exert a strong protective influence over the risk of suicide while divorce confers a higher risk for suicide (Breault 1986; Gibbs 1969; Stack 1990; Stafford and Gibbs 1988). The mental, physical, and emotional advantages of socially supportive relationships cannot be overstated (Berkman et al. 2000; Thoits 2011a; Umberson and Karas Montez 2010). Psychological distress is inversely related to satisfaction with social support in marriages or families (Denney 2010; Eshleman 1965; Kurdek 1989), such that as perceived social support and levels of integration decrease, psychological distress and thus, the risk for suicide increase. While the impact of supportive families on well-being and psychological stability is clear, having been tested and supported across demographic contexts (Kurdek 1989; Vandeleur et al. 2009), families vary in terms of the closeness of relationships, unity, social support, interdependence, and proximity. Each of these factors can influence suicidality (Peña et al. 2011; Romero and Ruiz 2007), so it is reasonable to expect that specific familial dynamics will support a person's mental health more than others.

The majority of suicide scholarship has looked to verify the protective benefits of family ties (Bridge, Goldstein, and Brent 2006; Compton, Thompson, and Kaslow 2005; D'Attilio et al. 1992), while often ignoring the potential problems associated with family relationships (Abrutyn

and Mueller 2015; Formoso, Gonzales, and Aiken 2000). For instance, the perceived social support from the family and the degree to which an individual feels like they matter, i.e. have meaning or worth, are crucial social factors in the onset and recovery from suicidality (D'Attilio et al. 1992; Elliott, Colangelo, and Gelles 2005; Thoits 2011a; Zhu et al. 2013). Familial dysfunction, such as marital discord or parental absence, increases the risk of suicidality because of the lack of social support to the distressed individual (Beautrais 2000; Bolger et al. 1989; Bridge et al. 2006; Fergusson et al. 2000; Liu 2004). Perceived social support involves the sense that others will be able to provide specific resources that address particular needs of the individual, such as emotional support or financial assistance, while mattering is more generally conceptualized as the belief that others are truly invested in one's welfare (Elliott et al. 2005). This sense of social support is largely absent to those facing a suicidal crisis; many suicidal young people neglect to seek help because of embarrassment, failing to recognize the severity of the problem, believing that nobody could help, and desiring to rely solely on one's self (Freedenthal and Stiffman 2007). Apart from formal help-seeking, studies show that higher levels of helpful, i.e. socially supportive, behaviors from family members that reflect familial cohesion, collective efficacy, family attachment, and group solidarity or connectedness have a tendency to reduce the likelihood of individual suicides (Au, Lau, and Lee 2009; Denney 2010; Maimon, Browning, and Brooks-Gunn 2010; Matlin, Molock, and Tebes 2011). These are important factors for consideration when assessing how the responses from family members during or after a suicidal crisis might influence the direction of the suicidal individual's resiliency.

Analyzing stigma

Suicidology researchers have neglected the concept of stigma when studying how suicidal individuals and their family members live through and cope with the aftermath of feeling suicidal, or knowing someone who has been suicidal. Members of stigmatized groups are often discriminated against in employment, housing, healthcare, education, and even by their families (Lucas and Phelan 2012; Major and O'Brien 2005). Family members may intentionally or unknowingly perpetuate stigma, shameful attitudes, negativity, and fear around suicidality and mental health concerns. The perpetuation of stigma around suicidality can act as a formidable barrier for help-seeking (Batterham, Calear, and Christensen 2013; Canetto and Sakinofsky 1998; Rusch et al. 2014; Simon and Nath 2004; US Department of Health and Human Services (HHS) 2012). In this section, I discuss Goffman's theory of stigma including dramaturgy, the definition of stigma, types of stigma, impression management, identity dilemmas, and other relevant research in the Goffmanian tradition. Then, I address what the existing literature says about attitudes towards suicide and the shame about suicide, both of which are connected to suicide stigma.

Goffman's Stigma

In *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman argues that stigma is a powerful negative social label that radically changes a person's social identity and self-concept. While much of the inquiry into how stigma is conceptualized in terms of identity construction has been concerned with testing Goffman's claims (Grier, Rambo, and Taylor 2014; Link et al. 2004; Thoits 2011b), some scholars have questioned the limitations (Ellis 1998; Green et al. 2005), or sought to extend the definition (Jones et al. 1984; Link and Phelan 2001) and

implications (Lucas and Phelan 2012) of Goffman's *Stigma*. Here, I review key concepts from Goffman's theory of stigma which will later inform the analysis of my interview materials.

Dramaturgy. Much of Goffman's work is rooted in the idea that identity is socially constructed. For Goffman, there is no core "self," but rather, the pressure to maintain one's selfhood is external, rooted in the social roles that impose sets of expectations and obligations on actors. Goffman terms the performance of "self" as *dramaturgy* (Goffman 1959), which views society through the metaphor of theater, where individuals are social "actors" and the site of social interaction is a "stage."

Because the site of social interaction is contingent on situational contexts, so is the construction of the self. In other words, the definition of the "self" in one situational context may be different than the self in another situational context. Thus, Goffman analyzed the nature of the shifting "self" as if it were a role "performance" (Goffman 1959). Goffman referred to the performance of identity as reflective of the situational context at hand, where an actor uses "masks" to constantly negotiate and redefine the "self" with reference to other social actors and the world.

Definition of stigma. One of the most commonly cited definitions of stigma in sociological literature is taken from the first pages of Goffman's *Stigma* (1963). "Stigma" refers to an attribute that is "deeply discrediting" that "reduces [the stigma-holder] from a whole and usual person to a tainted and discounted one" (Goffman 1963: 3). Moreover, Goffman stressed that "by definition, of course, we believe the person with the stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkably, reduce their life chances" (Goffman 1963: 5). Importantly, Goffman observed that

the language of stigma must tend towards a language of relationships, not attributes, and especially the relationship between an “attribute and a stereotype” (Goffman 1963: 4).

This definition of stigma makes sense when interpreted in alignment with dramaturgy. The perception of a stigma hinges on its situational relevance. The assignment of a stigma to an identity hinges on whether a social other imposes an undesirable social identity on an individual. Therefore, even if a stigmatized person does not personally identify with the social label of their stigma, they must still deal with the interpersonal difficulties that arise from a discredited identity conferred by other people (Thoits 2011b). This means that being stigmatized is not a result of an individual’s particular features, but rather is a result of the interaction between an individual and the social other who negatively evaluates the differences between them (Green et al. 2005).

According to Goffman, bearing a stigma results in a spoiled identity, which could take one of three forms: a blemish of character, a tribal stigma, or a physical deformity. A character blemish is like a moral failing, when one has failed at a prescribed social role. This may cause embarrassment (Gross and Stone 1964) or shame (Scheff 2014). Race, religion, and ethnicity are examples of tribal stigmas. Physical deformities are bodily abnormalities that are apparent on one’s body and easily perceived others, such as blindness or the absence of a limb.

Types of stigma. Goffman discusses two types of stigma: discredited and discreditable (Goffman 1963: 41). The control of personal and social information through discredited stigmas or discreditable stigmas is important for gauging the knowledge that a social other has of an individual’s stigma. A discredited stigma is one that is publically recognized and known. A discreditable stigma is not necessarily known from the outside, but could be found out by a social other through contact or disclosure. For instance, persons with mental illness more

frequently experience discreditable stigma before disclosing their mental illness to others. At that point, mental illness stigma transitions to discredited stigma, upon being found out by social others (Corrigan and Penn 1999; Thoits 2011b). On the other hand, persons who are subject to racial stereotypes better exemplify a discredited stigma because their outward characteristics, which are readily apparent to others, associate them with a racial minority group (Corrigan and Penn 1999).

Impression management. Discredited stigmas and discreditable stigmas require different strategies for impression management. The maintenance of one's social identity is important for facilitating social interaction, so that an individual is able to "pass" without disrupting social interaction (Goffman 1963). Impression management can be difficult if one is unsure of what the social other thinks or perceives about a stigmatized attribute. To manage a discredited stigma, an individual might deny their stigmatized status, pretend that the stigmatized status does not exist, or surround themselves with like-others in an enclave of those who either share the stigma or can assist with concealing the stigma. To manage a discreditable stigma, an individual might voluntarily disclose their stigma, avoid intimacy with others so as to not necessitate disclosing the stigma, or spend time in a large group of social others who are ignorant about the stigma. The reason an individual usually invests so much time and care into managing his/her impression, Goffman argued, is to avoid embarrassment to the best of his/her ability (Scheff 2014).

Identity dilemmas and interactional disruptions at the micro-level. Because stigma arises through interactional processes at the micro-level, the risk always exists that an interaction might be interrupted by the revelation or presence of a stigma. When a stigma yields the need to negotiate status during an interaction, the result could be problematic (Goffman 1963; Thoits 1985). Goffman emphasized that the revealing of, or presence of, a stigmatized characteristic

may disrupt social interaction by causing discomfort and awkwardness, particularly when the social other is ignorant about how to conduct themselves in response to the stigmatized attribute, or is unaware of their own status in relation to the stigma-holder (Goffman 1963; Grier et al. 2014; Lucas and Phelan 2012). Indeed, the obtrusiveness of the stigma (i.e. degree to which the stigmatized condition disrupts social interaction), the perceptibility of the stigma (i.e. visibility), and the controllability of the stigma, are critical factors in determining the reaction of a social other to a stigmatized individual (Link and Phelan 2001; Link et al. 2004).

Other relevant research in the Goffmanian tradition. By describing the forms and effects of stigma, Goffman articulates his theoretical contribution about “normal” societal functioning by showing the effects of extreme discrepancies to what is routinized and typical. Former authors have sought to clarify or expand upon Goffman’s conceptualization of stigma by either narrowing or broadening its definition (Dunn and Creek 2015; Link and Phelan 2001; Major and O’Brien 2005), yet there is still a gap in the literature about the effects of perceived stigma on the family members or significant others of the stigmatized individual (Green et al. 2005). Goffman calls this “courtesy stigma,” suggesting that stigma not only affects the experiences of the stigma-holder, but also has social consequences for those with whom the stigma-holder most closely associates (Corrigan and Miller 2004; Goffman 1963).

Attitudes about suicide among families

In addition to being an important source of social support, family members socialize each other. In particular, they transmit attitudes about our emotions and our behaviors, and even stigmatizing attitudes. Whether they see suicide as morally reprehensible, as a product of mental illness, etc., the meanings family members attribute to suicidal behavior matters. Commonly held attitudes about suicide, combined with the shame and silence surrounding mental illness (Scheff

2014), may preclude suicidal individuals from receiving care or may intensify suicidality. The stigma around mental health elicits status loss (Corrigan and Penn 1999; Green et al. 2005; Lucas and Phelan 2012), stereotyping, rejections, lessened power, and discrimination for the mentally ill (Thoits 2011b), all of which may reinforce one's suicidal feelings. Suicidal individuals may be reluctant to share honestly about their suicidal struggles or hesitate to seek help from others because of the fear of shaming by family members or significant others, and the associated stigma that it encompasses (Thoits 2011b).

Shame about suicide

Strong emotions can result from people's experiences with social support or stigmatizing attitudes in their families. Families are small groups in which our identities are emotionally anchored (Lawler 1992) and from which we are likely to derive positive emotional rewards (Collins 1981) or painful emotional consequences. Because many people are strongly motivated to maintain good relationships with their family members, the emotional consequences of family life can be intense.

Certain emotions, that are sociocultural, like shame, serve as self-regulating emotions (Shott 1979; Summers-Effler 2004) that can change our behaviors or actions. For example, shame is a signal that something associated with the self is threatening cherished social relationships (Scheff 2000), and thus we are motivated to act in a way that counteracts the negative feeling. Shame results from the perception that one has failed in the eyes of others at fulfilling an assigned social role, letting others down and highlighting one's social or moral faults (Baumeister 1990; Lester 1997; Mokros 1995; Scheff 2000; Turner 2010: 243). In response to suicidal crises, family members might contribute to inducing shame by ascribing blame or misdirecting their own painful emotions outwardly towards their suicidal loved one.

Shame itself is a stigmatizing social emotion (Abrutyn and Mueller 2014b; Corrigan and Miller 2004; Force 2014; Thoits 2011b). Shame threatens the self, saturating the owner in feelings of disappointment, inadequacy, incompetency, unattraction, blameworthiness, or guilt (Baumeister 1990). Shame is further intensified by the subsequent feelings of anger, sadness, and/or fear (Turner 2007). In addition, shame begets shame, seeking secrecy, or the desire to hide from others (Scheff 2000). Hence, shame appears to motivate and maintain suicidal thoughts and sometimes even drive suicidal actions (Abrutyn and Mueller 2014b; Kalafat and Lester 2000; Lester 1997; Mokros 1995). To the extent that experiences with families trigger feelings of shame, families hold the potential to perpetuate and reinforce feelings of social isolation, shame, and emotional distress, thereby making it harder for an individual to recover from suicidality.

METHOD

Aiming to understand the perceived role of family members in supporting an individual through being suicidal, I used a convenience sample of 20 in-depth semi-structured interviews with adults who identified themselves as formerly suicidal, because of having contemplated or attempted suicide in their past. I conducted one-on-one interviews in person or over the phone. I scheduled in-person interviews at a location of the respondent's choosing. I scheduled phone interviews with respondents at a time that was mutually convenient for the respondent and myself. This study received approval for research with human subjects from the Institutional Review Board at the University of Memphis.

Recruiting

I recruited respondents through a variety of convenience methods and snowball sampling techniques. I relied on word of mouth, and flyers (Appendix A) posted in public forums that

served as advertisements for this study. Respondents who volunteered were selected if they (a) were 18 years of age or older, (b) claimed to have to formerly contemplated or attempted suicide in their lifetime, and (c) were willing to participate in the research which involved discussing their experiences with suicidality.

Interviewing

I interviewed respondents over a six-month period in 2015. Interviews usually lasted between 60-90 minutes. I conducted in-person interviews at a location where the respondent felt comfortable, such as in their home or in a private office. I conducted phone interviews from within a private office to ensure respondents' privacy during their interview. Upon granting his/her consent (Appendix B), I digitally recorded the interview for each respondent, and then I subsequently transcribed all recorded material.

Topics of discussion during interviews included: the life circumstances that led up to the respondent's suicidal periods; the nature of the respondent's relationship with family members before, during, and after being suicidal; the types of general reactions and support that the suicidal individual received from relatives, friends, colleagues, or mental health professionals; and how the respondent's life perspective changed since being suicidal. In this study, I primarily focused on responses to the following open-ended questions, and other related questions:

- What was your family like, growing up?
- How did your family respond to you while you were suicidal, and in the aftermath of being suicidal?
- How did your family's views on suicide change after you were suicidal?
- How have your views about suicide changed after being suicidal?

Appendix C is the complete interview guide that I used while conducting interviews. I also offered a list of professional resources to respondents in the event that they became distraught or requested to discontinue their interview (Appendix D). None of the respondents in my sample requested to end their interview before the organic conclusion of our conversation.

Sample demographics

I requested that respondents complete a brief questionnaire to capture the demographics of my sample (Appendix E). The median age of the respondents in my sample was 35.5 years (range = 22-65 years). The sample included three male respondents (15%), 16 female respondents (80%), and one respondent who identified as gender-fluid (5%). The sample included primarily respondents who were white (90%). The median annual household income for respondents was \$60,000. The income distribution of respondents in the sample included one respondent (5%) with an annual household income of \$19,999 or less, 14 respondents (70%) with an income of \$20,000-\$59,999, and five respondents (25%) with an income of \$100,000 or greater.

Analytic strategy

I coded the interviews using QSR Nvivo 10 software for qualitative data. I de-identified the data to protect respondents' privacy and anonymity by assigning pseudonyms and changing or redacting identifying details, including the names of specific people and places. In my study, all respondents were referred to by their anonymous pseudonym. All of the transcripts were first coded using a grounded open-coding process that was issue-focused, concentrating on notable, recurring themes (Weiss 1994). Next, I further coded to narrow the focus of my analysis, integrating similar excerpts from respondent cases to draw attention to the themes most relevant for this study (Weiss 1994). With this, I captured more specifically the nature of respondents'

relationships with their families, the circumstances surrounding the respondents' suicidality and recovery, and the reactions of family members to the respondents' suicidality. From these accounts of lived experiences with suicidality, in the following section, I analyze my respondents' suicidality both numerically and through their descriptions. While the numbers were helpful, the qualitative analysis revealed a great deal more.

RESULTS

In this section, I detailed the responses of formerly suicidal individuals as they spoke to me about what their experience was like feeling suicidal. By conducting in-depth, semi-structured interviews, I aimed to understand the suicidal experience more fully by considering the perspective of those who have lived through periods of contemplating or attempting suicide. I was also interested in what the respondents perceived as the role of their family members in influencing their resiliency following being suicidal, as well as some of the most significant barriers that respondents perceived precluded them from seeking help or getting support for their suicidality. I begin this discussion by summarizing how I classified the cases of each respondent. Following that, I identify the most notable factors that respondents described as affecting their experience living through a suicidal crisis. I focus on the stigma around suicidality, the silence around suicidality, and the misunderstandings around suicidality that respondents discussed facing from within their families as well as from society in general.

Suicidality, resiliency, and family dynamics, by the numbers

I created two categories to classify the degree of the respondent's suicidality. I classified those respondents who claimed to have contemplated suicide without acting on their suicidal impulses in a way that caused physical, bodily harm as "ideators". In some cases, ideators had a near attempt that did not result in physical, bodily harm. I classified those respondents who

claimed to have made one or more suicide attempts that resulted in physical, bodily harm, such as vomiting or bleeding, and/or required medical attention as “attempters.” I also created two categories to classify the degree of the respondent’s resiliency. Referring to the aftermath of the respondents’ suicidal period(s), I classified the respondents as experiencing either “recovery,” having recovered from their suicidal period(s) such that suicidality was no longer a pervasive train of thought for him/her at the time of the interview, or as “ongoing,” trapped in a negative feedback loop of recurrent suicidality. I classified a respondent as experiencing ongoing suicidality when he/she claimed that the negative consequences of being suicidal reinforced suicidal feelings or caused suicidal feelings to cyclically reoccur at various points throughout his/her life. Additionally, I categorized the family dynamic of the respondent as either “supportive” or “discordant.” I categorized the respondent’s family dynamic as supportive when respondents claimed that family members were open to assisting them with finding treatment options, willing to talk openly about mental health concerns, and/or provided financial assistance to the respondent, among other things. In contrast, I categorized the family dynamic of the respondent as discordant when the respondent reported abuse, divorce, financial struggle, multiple childhood residences, familial instability, or other difficult circumstances that occurred before he/she was suicidal. Table 1 displays the frequency of respondents’ degree of suicidality, resiliency, and family dynamic. Table 2 presents a cross-tabulation of suicidality, family dynamics, and resiliency.

Table 1: Frequency Chart of Respondent Cases

		Frequency	Percent
Degree of suicidality	Ideators	7	35
	Attempters	13	65
	Total	20	100
Resiliency	Recovery	10	50
	Ongoing	10	50
	Total	20	100
Family dynamic	Supportive	9	45
	Discordant	11	55
	Total	20	100

**Table 2: Respondent's Resiliency
*Family Dynamic *Respondent's Suicidality Cross-tabulation**

		Family Dynamic		
		Supportive (N/%)	Discordant (N/%)	Total (N/%)
Suicide Ideators	Freq. Recovery % within family dynamic	2 66.7	3 75	5 71.5
	Freq. Ongoing % within family dynamic	1 33.3	1 25	2 28.5
	Total	3 100	4 100	7 100
Suicide Attempters	Freq. Recovery % within family dynamic	2 33.3	3 42.9	5 38.5
	Freq. Ongoing % within family dynamic	4 66.7	4 57.1	8 61.5
	Total	6 100	7 100	13 100

While the numbers of respondents in each cell are small, there appears to be no discernable difference in the severity of contemplating or attempting suicide for the suicidal sufferer as an ideator or attempter. Indeed, the above cross-tabulation reflects that there is not a

significant difference in the recovery for suicide ideators versus suicide attempters. Analyzing both suicide ideators and attempters as representatives of suicidal people is in congruence with Linehan's work (1986) where it was suggested that there is substantial overlap between suicide ideators and suicide attempters in their intent to die (Linehan 1986).

Descriptions of suicidality

Many of the respondents' answers to my questions about their suicidal experiences resonated with the tabular results discussed in the prior section. They talked with me about why they believed that *all suicidal people need to be taken seriously by friends, family members, and clinicians upon disclosing their suicidal feelings or engaging in a suicidal act*. Gina, who attempted suicide using a gun when she was in her 20s, expressed a sense of kinship with all suicide attempters, regardless of the lethality of their method:

There's no such thing as a gesture. If somebody does something to themselves, I don't care what it is, with the intention of ending their life, their story is my story... There's not a degree. There's not, "oh, she wasn't serious because she just took pills." That's just bullshit. –Gina

Carly, a suicide ideator, likewise expressed that she can empathize with the gravity of seriously contemplating suicide, despite having made only a near-attempt which did not cause her physical, bodily harm:

There are ones that are like, "oh, yea, I thought about suicide once," versus the ones that are like, "no, I've actually contemplated suicide." Because, to somebody that maybe hasn't been through it [contemplating suicide], or knows somebody that's been through it, it's like, just an idea. You know? Like, when I was [ready to jump], I was serious. I was as far away from the edge as from here to right there. What is that, maybe one foot? Or a foot and a half? Maybe? Not even two feet? Like, I was seriously about to go. –Carly

Carly was also someone who claimed to experience ongoing suicidality throughout various periods in her life, while Gina claimed to have mentally and emotionally recovered from her suicidal period. Carly was one of ten respondents (50%) who, while not feeling suicidal at

the time of the interview, claimed that they experienced suicidal ideation as an ongoing, persistent factor in their lives. Although all respondents spoke with me during a time when they were not currently a threat to themselves or others, ongoing suicidal sufferers claimed that feeling suicidal was a perpetual state that they had learned to live with on a regular basis. These respondents talked about their suicidality as if to express a seeming level of comfort with their own thoughts, saying things like:

It's obviously something I've dealt with for enough of my life that I am pretty open about it. Like, to me, it's not anything special, it's just part of my life. I think it's something I'm going to struggle with for my entire life. It's also really scary, though, when I start to feel those thoughts come back, because it is something that is really uniquely difficult; it's hard to get away from your own head. –Kelsey

I still have suicidal thoughts. You know, it's something that I live with. When life gets a bit rough, my initial thoughts turn to suicide. And then, you know, I sort of slap myself around and say, "where the hell did that come from?" There are some of us that just don't necessarily feel as if we belong, and so, it's hard, not necessarily enjoying life. –Nathan

I still, every day, I have thoughts of wanting to die, just because I have so many problems inside of me that no one can help me. And, I just feel like it would be better for everyone if I were to leave. It's just become a part of me. It's like, you know, I have a pinky on my right hand, and I have suicidal thoughts in my brain. –Hillary

In the remainder of this analysis, I highlight what respondents reported as the biggest barriers for help-seeking and receiving support from loved ones during a suicidal crisis. First, respondents identified a continuing stigma surrounding suicidality, which they feel elicits fear, disdain, judgement, or shame on the part of family members and others. Second, they perceived that the stigma surrounding suicidality rendered them silent about their experiences with contemplating or attempting suicide, reticent to share with loved ones honestly about their thoughts or hesitant to seek help. Third, respondents felt that family members misunderstood the depth and pain of their suicidal thoughts. Specifically, respondents felt as though family

members didn't take them seriously or didn't know how to handle their loved one's suicidal crisis.

Stigma around suicidality

Respondents expressed feeling discriminated against, judged, excluded, or devalued by others, including family members, rental/leasing agencies, hospital staff, school or university personnel, and professional organizations. Elise described feeling excluded or rejected by her family:

[If they] find out about a suicide attempt... they will judge you for that, because it's, you know... a loss of control, something scary, something fearful, to discriminate against.... [And] I think some of the things that led me to make attempts were feeling very isolated, and lonely, and misunderstood. Like, I had been really rejected by people; I had some family estrangement, like from some of my extended family members, and also some friends rejected me, and that was all very difficult. –Elise

As Elise recounted her multiple suicide attempts, she claimed that the immediate treatment she received from her family following an attempt was so discouraging that she felt the need to isolate herself further so that her subsequent suicide attempts would be even more private. I interpreted that Elise's choice to not disclose about her subsequent suicidality was rooted in the perceived need she had to hide her stigmatizing attribute from her family so that she would not be further discredited (Goffman 1963).

Elise also shared about an instance of discrimination that she perceived from a leasing agent when she was trying to rent a space to live:

*One time, I was looking for a room to rent in a house, and this older lady had a spare room in her basement, a single-family home. She was interviewing me, and I had a disability pension [for my mental illness.] I said, "that is why my income is disability." And she said, "oh, no, I can't. There used to be a girl here who had depression and she made a suicide attempt and there was too much drama with the ambulance here," and she was so upset, and she said she didn't want that kind of goings on in her home, so, she **refused to rent to me.** –Elise [Emphasis added]*

A few respondents claimed that they also felt stigmatized by hospital staff, and/or upset by the treatment they received at the hospital. Respondents described their hospital treatment for suicidality by saying things like: "...in the emergency room, being chained or handcuffed, or having your feet handcuffed to a gurney, or whatever... it's really quite dehumanizing." Another respondent suggested that being at the hospital for contemplating or attempting suicide "feels like jail."

Morgan shared about what it was like to return to her university following a hospital stay for feeling suicidal. She threatened to jump off a building but did not make an attempt.

*And the next week [after I was hospitalized], it was really weird. Like, I got back to school, and the school had told my roommates what happened, and like, I don't know. It was really weird because the school was even like **wanting to kick me out** of the dorms. And the whole experience was weird, it was like me trying to reassure everyone else that it was okay, instead of the other way around. It was me having to explain to everybody, like, "oh, it's fine. Everything's fine." ... I felt like they were **afraid of me** a little bit, like everyone felt like they had to **walk on eggshells**. And it was really weird because I was like, "I've felt like this my whole life. Nothing is really changed. It's always been like this." But for some reason, if you go to the hospital for depression or something, all of a sudden, people are like **scared of you**. –Morgan [Emphasis added]*

Andrew likewise detailed his perception of facing stigma from university personnel after disclosing his history with attempting suicide:

There was actually one [college] I applied to that later wrote me, because I asked them, when I had gotten in to all of the schools that I applied to but not that one school, I asked them why I didn't get in, and their response essentially was that they didn't know how stable I could possibly be with my mental health and they didn't want to take a gamble with the students that were on that campus. –Andrew

Andre's experience and Elise's experience highlighted the perceived acceptability of institutions and individuals to openly discriminate against individuals with mental illness or a history of suicide, which illustrates how deeply stigmatizing and discrediting it can be to survive through period(s) of suicidality. The fear reported by former suicide ideators and suicide attempt

survivors of others' stigmatizing responses towards them was often rooted in their interpersonal experiences with rejection.

Professional organizations whose goals were directed towards mental illness or suicide prevention were yet another source of the perceived stigma surrounding suicidality for respondents. Several respondents talked about instances when they felt discriminated against by such institutions. Erica, a suicide attempter who was left with a physical disability as a result of her attempt, offers an example:

I went to a disability advocacy network conference, and there was a [professional representative] there. I was walking around the conference center with my dog, my service dog. I walked up to this booth and said, "so, what is this booth about?" and she said, "[our organization] only deals with people who have mental health issues. We don't deal with people with physical disabilities." And I think, well, first, my jaw hit the floor, because I was shocked. And then it made me really mad! So then I said, "well, lady, my [physical disability] is a piece of cake. It's my depression that keeps me from being able to work a full-time job. And you shouldn't put people in boxes like that." –Erica

All 20 respondents referred to the perceived stigma around suicidality at least two or more times during their interviews. 14 respondents (70%) expressed their perceptions of facing suicide stigma more than 10 times during our 60-90 minute conversations. Accounts of the lived experiences of people who were formerly suicidal help to shed light on how these individuals reported that they were able to navigate their social matrix, laden with stigma and judgement.

Silence around suicidality

Many respondents talked about how the pervasive stigma around suicidality often rendered them silent about their suicidal experiences. Respondents suggested that they frequently didn't want to share about their suicidality with loved ones because they feared what their family members might say or do in response. This silence, according to respondents, tended to reinforce suicidal feelings. In addition, respondents generally agreed that the stigma surrounding

suicidality, and the accompanying fear and shame that arose from the stigma, were great. Many people have a fear of death and the unknown. Fear often arose from the anticipation of unexpected behaviors from mentally ill and suicidal people (Corrigan and Miller 2004; Link et al. 2004). Several respondents, including Elise and Nancy (both in their 40s) described feeling as if their families were extra-cautious around them following their suicide attempts, for months and even years after the fact:

I think that they are afraid of it. I think that's always been the case. Like, maybe it is immediately after the attempt when I'm still depressed, and maybe still feeling suicidal, but I mean, years down the road, after I've recovered? I've stopped. And I'm able to talk about it. And I want to talk about it. –Elise

There is always that question of “well, why did you do that?” There is also a level of fear that isn't really with [a completed suicide] because it's like, “what if you do it again?” or “are you going to do that again?” or, you know, “what was that about?” ... There's fear of, “are you going to do this again?” –Nancy

Veronica shared this during her interview:

*[My friend] saw me, and he said, “is everything okay?” And I just looked at him, and just holding back tears, I said, “I just had a bad day.” You know? And, I just couldn't just go, “you know what? Last night I almost killed myself.” ... I'll just not tell you about it, so you don't have to worry about it. And I think a lot of people do that. Like, “let's just not talk about it so Mom doesn't have to worry. Or Dad, or my brother, they don't have to worry. Just keep it to myself. And I'll take care of it myself.” I think that has to be one of the major features of people who attempt suicide, or think about suicide, or become suicidal, is it is essentially a **lonely business** If you're serious about it, and it does scare you, then **you don't go tell people** about it. And then, that **isolates you further**. And that contributes to the fear, and you wanting to isolate yourself. You don't want other people to feel the fear, so you kind of just take it on yourself, and you're like, “well, I don't want to freak everybody else out, because I'm freaked out.”
–Veronica [Emphasis added]*

Here, Veronica seemed to express concern for how her loved ones would react if they knew about the gravity of her suicidal feelings. It was as if Veronica felt that she was protecting her loved ones by not sharing honestly about her suicidal thoughts. Veronica also felt as though disclosing her suicidality would change the perception that other people had of her. She reported

fearing that talking about feeling suicidal would make her appear vulnerable or weak and diminish the severity of her suicidality, which was another reason she gave that she felt justified her silence:

I don't know, it's scary to actually say it [when I'm suicidal]. To me, it's scary to actually say it because it is so, well, when it's real, it's so real that it would almost seem like you're making light of it, or you're not giving it the seriousness that it warrants if you just talk about it. And so, I keep it in. And, I don't know, I think also there's something about it that might make me feel like it's expressing a vulnerability and a weakness. I don't usually show that in my outward personality. –Veronica

Other respondents also expressed fear regarding how their loved ones might react if they knew the respondent was experiencing suicidality. According to respondents, fear also engendered scorn, lack of empathy, or distrust. In families that hold negative or stigmatizing attitudes towards mental illness, suicidal individuals were reluctant to share honestly about their suicidal struggles or hesitated to seek help from others because of the fear of shaming by family members or significant others (Thoits 2011b). Such paralyzing fear and silence intensified the perceived stigma around suicidality.

According to respondents, his/her suicidal thoughts were not intended to cause emotional hurt to anyone else. Sometimes, suicidal people wished that someone would understand and share in their pain. Interestingly, respondents suggested that the suicidal person might choose not to share his/her suicidal thoughts out of compassion for his/her significant others, not wanting to burden them or scare them further. A suicidal person may choose to suffer in isolation, respondents claimed, as a means of protecting their loved ones.

Tessa summed up her thoughts on how the perceived stigma was likely why suicidal people might choose not to share with family members or others about their suicidality, reinforcing the previously stated sentiments of other respondents. Tessa said:

Well, people who are contemplating or going through suicide, they don't wear their emotions on their faces. They're very scared. They're very, well, they make themselves isolated for a reason, to make sure no one knows about why they're doing this. Because they will be judged. They will be critiqued. They will be self-conscious again. –Tessa

Misunderstandings around suicidality

Respondents frequently claimed that their family members would not be able to acknowledge or comprehend the depth of the suicidal feelings. According to respondents, family members were likely unaware of their own role in contributing to one's suicidality, or ignorant of how to act towards their suicidal loved one. According to respondents, family members often misunderstood the reasoning that leads to one's suicide, referring to suicidal people as appearing selfish or weak. Importantly, formerly suicidal individuals often reported that feeling suicidal arose from a need to end intense emotional pain. This explanation for suicidality was also described as a last resort to escape from their own desperation when no other coping mechanisms had worked.

In this example, one respondent shared how she felt that her parents seemed clueless about her suicidal distress. Hillary described feeling that her parents were largely unsupportive of her, and stated:

I wanted to die! I wanted to end my existence! I wanted to be no more! It was like, "do you not understand what I'm saying?" And I think, with my parents mainly, that was the biggest thing: they looked at it like, "but what did I do? We've done this, and we've done that..." and I'm there like, "well, what did you not do?!"
–Hillary

Respondents often stated that their family members should have sought help for themselves during the respondent's suicidal period(s). Respondents felt that this might have helped to alleviate the ignorance or shame that family members were faced with upon learning of a loved one's suicidal crisis. Many respondents reported that their family members didn't know

what to do or how to handle their loved one's suicidal crisis. Regarding her family's coping following her suicidality, Danielle described:

I continued going to counseling and trying out different medications and stuff. But, you know, we never sat down and talked about it. And they never went to counseling. And maybe my dad and my step-mom talked about it, but I don't know. There were a few relatives that knew, but pretty much it was just like forgetting that it happened I guess. It was sort of like I brought shame upon my family and stuff like that. –Danielle

Based on this reflection on how her family viewed her suicidal actions, Danielle felt the weight of her suicidal past as something to be ashamed of, because her suicidal past was not readily acknowledged by her family. Such repression elicited feelings of sadness, fear, or anxiety, and, as in Danielle's case, intensified social estrangement, sanctioning, or isolation (Turner 2010). Indeed, the family members and friends supporting a suicidal loved one needed additional support, in the forms of networks, education, assistance, and resources for themselves (Force 2014). Paige, a suicide ideator, provided another example of someone who felt as though her mother was unprepared to deal with her suicidal crisis. She felt that her mother minimized, or perhaps even dismissed, the severity of her suicidality when Paige threatened suicide as a teenager:

I went into the kitchen, and grabbed a knife, and as soon as the blade touched my skin, I think I realized that, oh my God, this is (a) final, and (b) will probably hurt, and (c) what happens if it doesn't work out? And [I guess] I noticed my mom when she started talking, but it was really dramatic. I put the knife on my wrist and I was like, "ugh, I can't do it!" And my mom was like, "God, you're so dramatic! Go to your room!" And so I went back to my room and laid down in the fetal position and fell asleep on the floor... I think she just had so much to deal with, she was under so much stress that one more thing would have, well, she just couldn't take it. –Paige

Those who have lived experiences with suicidality were often dismissed as "merely attention-seekers" (Sudak et al. 2008) or as acting selfishly. Selfishness was a commonly mislabeled justification of suicidal feelings in so far as many people viewed suicide as a selfish

act (Batterham et al. 2013). Yet, one respondent commented on how the perception of suicide as selfish was contradictory to what is normally an otherwise individualistic mindset in the United States:

A lot of the rhetoric about suicide is that people tend to look at it as this horribly selfish act. But I think that minimizes a lot of the pain that people who are suicidal are feeling; basically you're telling them that their thoughts and their feelings are not valid, and that they should be more concerned with the feelings of other people, which is generally the opposite of what we tell people. Normally, it's like, you know, "you do you! Follow your own heart, your own desires, and don't worry about what people think of you!" Except when it's suicide, and when someone is in so much pain that it's unbearable, and you can't understand that weight and what that pain is like unless you've actually experienced it. –Kelsey

Some other respondents also described feeling as though “selfish” is an inaccurate representation of feeling suicidal. Danielle offered a description of the immense pain that she perceived as a more accurate representation of suicidality for family members and others to consider:

Having gone through that, I now do not work with the idea that suicide is a selfish task. I mean, I can now view it as being an immense pain, you know? A type of pain that won't go away. A type of anguish. And I can identify with people who feel that way because I know what they're going through. And I know that it's hard. They don't want to feel like that. They don't want to have those feelings. But a lot of times it's the brain make-up, or situations that they're in, I can sympathize with those people. –Danielle

Respondents felt that the perception of suicidal people as “weak” in the minds of family members or people in society was antithetic to the strength that they said was really necessary to contemplate suicide in such moments of extreme desperation. Respondents described contemplating suicide as very effortful, thought-provoking, difficult, and painful. One respondent stated *three consecutive times* that attempting suicide was something that he *needed* to do, as if *he had to* attempt suicide out of desperation, not because he was being selfish, despite what he thinks his family felt:

You know, through my attempts, I kept thinking, you know, “I love my family, and I hate the fact that I have to do this to my family. But, it’s something I need to do.” It was something I needed to do. I felt like I needed to do it. You know, what if people say, “yea, well, you needed to do it to your family, so it was a selfish move.” And I’m like, “no, it was a very difficult move!” You know, I’m not going to, well, yea, part of it is [that they’re] trying to help me, but that’s the least of my concerns in that moment. –Tim

It was clear that the pain and desperation of feeling suicidal was not a choice that a suicidal person elected to endure (Covington 2016). Yet, as a result of withstanding such intense mental and emotional anguish, a suicidal person might feel compelled to act towards ending their life as a means of escaping from their pain. Respondents expressed empathy with other suicidal people, as if recognizing why one might look to suicide as a logical option, a desperate plea to end their pain when no other coping mechanisms have worked. Gina said:

There’s no way to control what society thinks, or does, or talks about. But, somebody who [thinks that way, or acts that way], with the intention of ending their life, I don’t care what it is, their story is my story. –Gina

All 20 respondents detailed instances of feeling misunderstood during their suicidal period(s). The majority of respondents felt as though family members or loved ones were uninformed about where to turn to seek help for their suicidal loved one, not knowing what to do, how to act, or what to say, during or after a suicidal crisis.

DISCUSSION

According to my respondents, all suicidal people need to be taken seriously by friends, family members, and clinicians upon disclosing their suicidal feelings or engaging in a suicidal act. Some respondents perceived that their status as a suicide ideator or attempter, or the lethality of their chosen method, might make someone take them less seriously. Respondents claimed that ongoing stigma, the consequent pervasive silence, and the ways that significant others

misunderstood their rationale for considering suicide, served as barriers for help-seeking and receiving support.

If I take my respondents' impressions as accurate accounts of the events surrounding suicidal ideation and attempts, Goffman's theory on stigma offers insight into the lives of people who were formerly suicidal. It is appropriate because mental illness, and furthermore, suicidality, are discreditable stigmatizing attributes (Goffman 1963). Although mental illness has become increasingly less stigmatized over the years (Rusch et al. 2014; Sudak et al. 2008), the stigma around suicidality is still overwhelmingly present (Sudak et al. 2008), and paralyzing to the stigma-holders and the curtesy stigma-holders.

The identity of a suicide attempt survivor or former suicide ideator is socially constructed, reflecting to the public a successful performance or a failed performance of the self. The ideator or attempter identity is negotiated between the suicidal person, their family members, others around them, and the world. Those who have lived through suicidality want to control the definitions being applied to their selves so that they can control the resources that flow to them. Thinking about suicide, or attempting suicide and surviving, is perceived by others as a failed performance, especially in the event of failing at death by suicide. According to Maureen, who shared with her teenage son about her suicide attempt, he was able to perceive how surviving an attempt might have exacerbated the desperation that she was feeling at that time:

And so one of [my son's] questions to me was, "well, how come you didn't die?" And I was like, "well, I just never was successful at it." And he said, "well, I'm really glad about that, but did that make you feel worse?" And I was like, "well, yea," I mean, right? "When you already feel like you can't accomplish things, because you're not good at things and then you can't even accomplish this?!" But, you know, in this conversation, I didn't expect him to ask me that. He was like, "well, you're already feeling bad, and then you're not, I mean, and then

you're alive, so do you feel worse about being alive?" I guess I didn't expect him to be able to think that through. –Maureen

Bearing stigmatizing attributes can lead to potentially harmful consequences that differentiate the stigma-holder's life circumstances from others (Goffman 1963; Link and Phelan 2001; Link et al. 2004). Members of stigmatized groups have decreased life chances (Goffman 1963) and poorer health outcomes (Major and O'Brien 2005). Especially for those respondents who experienced ongoing suicidality throughout their lives (50%), being a member of this stigmatized group might imply that they are fighting for their mental health and emotional well-being in a way that is very taxing and potentially damaging over time.

The idea of mental illness as a deeply discrediting stigma is widely known, accepted, and researched (Corrigan and Penn 1999; Dunn and Creek 2015; Goffman 1963; Green et al. 2005; Thoits 2011b). For former suicide ideators and suicide attempt survivors to try and conform to their expected social role, their stigma would stay discreditable. Those who have lived experiences with suicidality must choose how they will handle the management of their identity with others throughout various social contexts. Once a former suicide ideator or suicide attempt survivor becomes discredited, that is, once other social actors are aware of the person's suicidal past, others became, fearful, distrusting, worried, or judgmental, according to most respondents. Respondents used phrases such as "like I was fragile," "treating me with kid gloves," and "walking on eggshells" to describe how they perceived that their family members and others acted towards them after learning about their suicidal history.

Even respondents who worked in the mental health field expressed feeling that suicide stigma was especially prevalent at their jobs, among co-workers, and among trained professionals who work with suicidal people on a regular basis. A few respondents discussed their perceived need to manage their identity as a former suicide ideator or suicide attempt

survivor around other mental health workers, in order to avoid this stigma. A few of the mental health care workers in my sample claimed they chose not to share about their suicidal past with the people in their lives, or that they chose not to seek help for themselves, because of the stigma associated with it. Heather and Stacie, who both worked in clinical settings, told me about what it was like for them to choose not to disclose their suicidal past to co-workers:

***I hid it** very well. There is no one who knew I was even depressed. I am not exaggerating; **no one knew**. Even though I was working in the mental health field at that time, I had mental health professionals working all around me, in their cubicles, and talking on the phone, and doing brief strategic counseling for people, and of course handling the occasional suicidal call. And I wasn't about to, well, I knew that if I went to someone in my field and said, "I'm suicidal," they're going to pick up the phone and call, and I'm going to be committed. So, **I never went to see a mental health professional**. –Heather [Emphasis added]*

*I mean, I feel like since there is still **such a stigma attached**, that **nobody that I work with** [in the mental health field] knows that I've attempted suicide, or the depth of my depression. It's quite a shame really, but it's really also very fascinating. I think there are still **a lot of people that don't get it**. –Stacie [Emphasis added]*

Even Nancy, whose experience with attempting suicide inspired her work in the mental health field, talked about managing her identity impressions in her professional role as a supervisor to other clinicians:

I used to get asked all the time to find a patient a new therapist because their current therapist couldn't work with their suicidality... And If you're an employee there, clearly you don't say that [you're suicidal], because if you do, you're going to get fired, or something that like. I still feel like it's still challenging to be able to talk about. I feel like professionals are not well-prepared, and I feel like they don't know how to respond properly. –Nancy

Indeed, the stigma around suicide elicited negative responses from others who were worried about threats, dangers, and the unknown (Yang et al. 2007). According to previous literature, mental illness stigma generally yields perceptions of danger, unpredictability, dirtiness, worthlessness, weakness, or ignorance (Lucas and Phelan 2012). One study found that the most

common stigmatizing attitudes that people held towards completed suicides were that the deceased was “punishing others,” “selfish,” “hurtful,” “reckless,” or “weak” (Batterham et al. 2013). Because of the ubiquitous negative stereotypes that accompany suicide, perceptions abound of suicidal people as dangerous, daunting, hazardous, and someone to be feared, presenting a real obstacle to getting help for the suicidal person and compounding suffering for the stigma-holder (Sudak et al. 2008; Yang et al. 2007).

Stigmatizing attributes disrupt social interactions by causing discomfort, eliciting awkwardness, and creating a disparate chasm between the social status of the stigma-holder and his/her social others (Goffman 1963; Lucas and Phelan 2012). Social interaction with a former suicide ideator or suicide attempt survivor has no culturally prescribed script to go with it, social exchange becomes problematic, and few know what to do or say. Goffman reminds us that “curtesy stigma” is extended to the families and close significant others of stigma-holders, who are stigmatized by association (Goffman 1963). Social interaction with the family members of a suicidal person also has no culturally prescribed script to go with it. Social exchange with the family members of a suicidal person becomes problematic because social others in the general public do not know what to do, what to say, or how to respond. The perception of dangerousness as a result of mental illness stigma and suicide stigma is closely linked with fear, anger, and decreased pity for the stigma-holder (Angermeyer and Matschinger 2003; Phelan et al. 2000). The family members assign these stigmatizing impressions to their suicidal loved one, and then the friends, neighbors, and acquaintances who come into contact with the family are likewise afraid. People in society such as family members, friends, loved ones, clinicians, mental health professionals, educators, and additional social actors are afraid of suicidal people because they are afraid of what is unknown and unexpected about feeling suicidal. If I take what my

respondents said about suicide survivorship to be true, then not only is it the enactment of a failed performance, but the aftermath, for the discredited person who was formerly suicidal, can also be perceived as a series of ongoing failed performances. The discreditable formerly suicidal person can be perceived as trapped inside the norm of silence around discussions about suicide, unable to interact about suicide at all. The discredited formerly suicidal person can be viewed as someone who is isolated from the connection they so desperately seek because everyone is afraid of them and no one knows how to think about them or interact with them.

CONCLUSION

With this study, I conceptualized suicidality as a stigmatizing attribute. I also described how formerly suicidal individuals perceived their family's conduct in the aftermath of being suicidal or during their ongoing suicidal distress. I showed how accounts of integration and regulation within families affected perceptions of suicide stigma. I also used qualitative methodology to elucidate and more fully understand the subjective lived experience of suicidality, with both suicide attempters and ideators.

Contribution to the literature on suicide stigma

In my study, I gauged how formerly suicidal individuals perceived that their families were affected by the stigma surrounding their suicidality, how suicide stigma had the propensity to magnify disruptions to social interaction faced by the formerly suicidal person, and how the suicide stigma within families affected the suicidal person during and after being suicidal, according to respondents. My study was in response to the lack of previous literature on the lived experiences of suicidality as told from the perspectives of former suicide ideators and suicide attempt survivors. Stigma research was largely uninformed by stigma-holders themselves (Link and Phelan 2001; Schulze and Angermeyer 2003), which was why it was valuable for me to hear

directly from former suicide ideators or suicide attempt survivors. By including the accounts of people who have lived experiences with suicidality in my study, as encouraged by the recommendations put forth by the Suicide Attempt Survivors Task Force of the Action Alliance (Force 2014), my research helped to shed light on how formerly suicidal individuals perceived that they were able or unable to navigate their social matrix, potentially laden with burden, stigma, and judgement.

Moreover, my work advanced suicidology as a field of study by dialoguing with the stigma literature, and therefore conceptualizing suicidality in a novel way. In fact, some of my respondents talked about this neglect of the perspective of those who have lived experiences with suicidality in their interviews, suggesting that incorporating their voices offers a worthwhile approach for informing directions of future research and suicide prevention interventions. Here are some examples:

*And you know, part of what [these professional organizations] are struggling with is they didn't, well, until recently, they weren't including those who had lived experiences. It's been widely known that they **don't think that they should include people** who have attempted suicide, or have lived experience, because we have nothing to bring to the table. Like, we wouldn't be helpful in how to prevent it. But, they're finally starting to realize, "oh, maybe we should be talking to these attempt survivors so that we can actually prevent suicide. Like, maybe they actually have something to contribute." –Danielle [Emphasis added]*

*For attempt survivors and researchers, in general, [it's about how] we've been neglected. And, in fact, there are still some researchers, some really high-up suicidologists, who don't think that they should be engaging with attempt survivors.... The World Health Organization's definition of suicide is "someone who deliberately takes their own life." Okay? That's absolute bullshit. I mean, there is absolutely **no acknowledgement of the pain**, or the trauma, that somebody actually goes through during a suicidal crisis.... I'm like, "have you even tried to go into the mind of somebody, engage with somebody who has been suicidal, to try and **understand it from their perspective?**" To me, it just shows a **lack of empathy**. –Nathan [Emphasis added]*

Contribution to the literature on families and stigma

In addition to advancements in understanding suicide stigma, my study also contributed to what was previously known about families and mental illness, particularly, the role of mental illness stigma as it influences family dynamics. Goffman addressed the possibility of stigma affecting more social others than just the stigma-holder when he talked about “curtesy stigma” (Goffman 1963), yet no other researchers that focus on suicide or mental illness have explored “curtesy stigma” in their analyses of families dealing with stigma.

Given the importance of families to mental health and well-being, my study examined how people who have lived experiences with suicidality perceived that their families supported or constrained their ability to cope with and recover from feeling suicidal. In my study, I considered how respondents perceived family members’ supportive or unsupportive actions towards them while they were suicidal and after being suicidal. I described how formerly suicidal individuals felt that their families contributed to their recovery from being suicidal or contributed to their experience of ongoing periods of suicidality. Through Goffman’s perspective, I surmised that negative experiences with survivorship can be viewed as a series of ongoing failed performances with self and others.

Contribution to the literature on suicide and integration

Using qualitative data, my study contributed to the literature on how Durkheim’s construct of integration affects the propensity for suicide. My approach studying families as small, integrative social groups translates Durkheim’s theory from a macro-level perspective into a micro-level analysis of the important relational dynamics between suicidal individuals and their close significant others. I conclude that the power of familial support is incredibly meaningful to a person undergoing a suicidal crisis. Respondents who perceived their families as open and

willing to talk about mental health and support them emotionally, can be classified as well-integrated within their family units, and they appeared to be better able to cope in the aftermath of their suicidality.

The impact of supportive, well-integrated families on well-being and psychological stability is clear. This has been tested and upheld in myriad demographic contexts (Kurdek 1989; Vandeleur et al. 2009). Although, families vary in terms of the closeness of relationships, unity, social support, interdependence, and proximity. Each of these integrative factors are subject to influence suicidality (Peña et al. 2011; Romero and Ruiz 2007). Therefore, it is reasonable to expect that some families will be better for a person's mental health than others. In addition, the intensity of the stigma around suicide and the threat that suicide stigma poses to the stigma-holder's identity is contingent on situational cues. The salience of suicide stigma might be connected to levels of integration within small groups or related to the cultural attitudes that small groups hold towards suicide. The situational cues and stereotypes about suicide are widely known and easily recognized (Major and O'Brien 2005), yet different actors and settings elicit different scenes regarding suicidal ideation and attempts. Some scenes, for my respondents, appeared toxic, and some were described as helpful.

In my opinion, Andrew's story epitomized the positive effects of familial integration. Andrew felt that he was able to be open and honest with his parents about his reoccurring suicidal feelings. Because he perceived that his family was receptive to his concerns and took him seriously, he claimed he was better able to manage fairly intense depression later in life, knowing what steps he needed to take to help himself, and knowing how to activate his support network in his times of need. Andrew said:

My parents were always super protective and supportive of me, even when I had to seek treatment. My dad immediately did all the things. He came to pick me up. And my grandmother came and made me food. I mean, my family is really close. My parents are there for me. That's not ever going to change. I can definitely say that, for my dad, the thing that he holds most dearly is his children. That's always been a big thing, we're like a masterpiece, or whatever. Like, we are always going to be on this pedestal, and he is always going to help us out. So, for the longest amount of time, I was never willing to seek help. I always wanted to do everything by myself. I was also really embarrassed about everything that I was going through. I didn't think people would understand. But in college I figured out that you can't really do it by yourself. If you need help, then you need to let your guard down essentially and be like, "I need help." Otherwise, or at least from what I've learned, you're never going to like truly grow, and figure out what it all means, all the things that you need to tackle I guess. So, that's how my family dynamic is. —Andrew

Contribution to the literature on qualitative research on suicide

Several authors previously identified the dearth of qualitative data that provides rich insight into the suicidal experience (Douglas 1967; Hjelmeland and Knizek 2010; Kral, Links, and Bergmans 2012). Qualitative methods further supplement what is already known about families and suicide (Gulbas and Zayas 2015; Gulbas et al. 2011; Peña et al. 2011) as well as what is already known about suicide stigma (Batterham et al. 2013; Lester and Walker 2006; Sudak et al. 2008). Though the benefits of qualitative research are numerous, as of 2008, there were a total of 12 publications spanning the previous decade that involved qualitative investigations of how people live with or get over being suicidal (Lakeman and Fitzgerald 2008). My rationale for interviewing individuals who have lived experiences with suicidality partially stemmed from this paucity of qualitative studies. I used qualitative methods to gain an understanding of the intricacies that defined the suicidal experience in a way combined objective observations and subjective accounts, as qualitative inquiry into lived experiences with suicidality are helpful for capturing and presenting a substantive *understanding* of the suicidal experience rather than an *explanation* (Hjelmeland and Knizek 2010). My purpose with semi-

structured interviews was to explore the subjectivity around suicide by asking former suicide ideators and suicide attempt survivors to talk about their lives, their suicidal periods, their process of resiliency, and the reactions of others to them at each of those times (Kral et al. 2012). By considering the suicidology literature in tandem with the literature on stigma, I also addressed the recommendation made by Link et al. (2004) to use qualitative methods of investigation to more fully grasp the concept of stigma. Through qualitative methods, I was able to suggest how stigma is constructed in social interaction and how people interpret their suicidal thoughts and behaviors (Link et al. 2004).

Limitations to my study

Despite these contributions, my study is not without limitations. In particular, respondents for this study were self-identified volunteers who had formerly contemplated or attempted suicide. Because my recruitment efforts involved snowball sampling techniques to spread information via word of mouth, a large population of suicidal individuals is not represented in my study. Many of my respondents found out about the study through support groups or media projects, in which case, the voices of suicidal individuals who do not have access to those resources or who are consistently isolated due to a lack of knowledge about where to turn for help are not represented in my sample. Also, I relied on information gleaned from interviews to conduct my analyses. Given the overbearing stigma around suicide, it is possible that individuals presented their best face or hid information that they felt would be too embarrassing or shameful. In response to this possibility, I paid close attention to the content and emotional tone of the interviews, taking care to make the respondent feel comfortable to the best of my ability.

The nature of my sample is not demographically representative of the suicidal population at large. My sample is significantly limited in gender and racial diversity. Previous literature documents that men and racial or ethnic minorities face different obstacles than other groups in regards to handling suicidality and mental health concerns (Canetto and Cleary 2012; Canetto and Sakinofsky 1998; Freedenthal and Stiffman 2007; Zayas et al. 2010), which may help explain why fewer men and racial or ethnic minorities elected to be in my sample. This, coupled with a lack of knowledge about, and/or access to, mental health care, makes it even more difficult to recruit these populations. Furthermore, the literature suggests that suicidal ideation may begin as early as childhood or early adolescence (Bearman and Moody 2004; Bolger et al. 1989; US Department of Health and Human Services (HHS) 2012), yet my sample includes only legal adults who were age 18 or older at the time of their interview. Therefore, the voices of young people who are suicidal and who might be the most uninformed about their options for seeking help or support are not represented in my sample. Also, my sample only includes non-institutionalized individuals who are not currently suicidal; thus, the experiences of individuals who are suffering the most with suicide ideation are missing from my analysis.

Implications of my study and directions for future research

Based on my study, I recommend that other avenues of research explore how lived experiences with suicidality can inform anti-stigma intervention efforts, improve knowledge and education about suicide stigma, and offer suggestions or resources to the general public for handling suicidality. Based on what I understood from my respondents about the needs of suicidal people, I recommend that we work intentionally to create safe spaces that will allow suicidal people and their families to feel comfortable talking about how to support those who are currently struggling with thoughts of suicide.

One essential step towards alleviating the stigma around suicidality will be to identify and study the mechanisms through which suicide stigma is generated and perpetuated within families and within society (Corrigan and Miller 2004; Link et al. 2004), and then strategize intervention efforts around the cessation of those mechanisms. For example, conceptualizing and teaching about stigma as inherently social, and having a moral dimension, may inform efforts that more fully target the interpersonal core of stigma. Anti-stigma intervention efforts will be helpful because it is likely that decreasing the stigmatizing attitudes towards suicidality will, over time, facilitate increased help-seeking from those at risk. (Batterham et al. 2013).

It is important that research and community-based interventions work to improve knowledge about mental illness so as to educate people about reducing suicide stigma and appropriately handling suicidality (Simon et al. 2001). Additionally, knowledge of and access to mental health care should be more widely known, so that individuals facing a suicidal crisis, or their family members, will know where to turn or who to call in their time of need.

Encouraging the family members of a suicidal loved one to seek support for themselves is another way to foster support for those in crisis, by finding others who can empathize with their experience and normalize the mourning process (Force 2014; Sudak et al. 2008). Creating a safe space to talk about suicidal feelings or share resources about supporting a suicidal loved one would be invaluable. Based on the stigma around suicidality, the silence around suicidality, and the misunderstandings around suicidality, it is important that professionals and loved ones learn to be open and nonjudgmental in their conversations about suicide. Former suicide ideators and suicide attempt survivors want to be able to talk about their suicidality. A few respondents said that they shared things with me that they could never say to their families, friends, co-workers, or

even their therapists, because they didn't know how others would respond. Here are some examples:

Interviewer: Did you share that [about being suicidal] with anybody while you were going through it?

Respondent: No. To me, there was a lot of shame involved in it. I was afraid that if I told anybody, they would be like my friends in college, and wouldn't come back.

Interviewer: Are there folks in your life now that know this part of you, or that [being suicidal] is part of your history?

Respondent: No, not to this extent. –Stacie

People don't take risks [when they talk about suicide] because we're too busy being sanitized, and talking about quantitative research instead of qualitative research. I mean, people are convinced that everything has to be nice and tidy and "we can't talk about anything bad." I mean, I want to talk about the taste of the gun barrel between my teeth. We've got to! But, yea, this has been great, I mean, I just said things that I have wanted to say for years! –Gina

I implore anyone who knows somebody struggling through a suicidal crisis to inform themselves about the best ways of supporting their suicidal loved one, which may involve asking the suicidal person directly about what might be helpful during their otherwise painful and lonely experience.

Most importantly, until now, relatively little emphasis has been given to the subjective experiences of suicidal people but this is necessary to inform the care and help provided to individuals (Lakeman and Fitzgerald 2008). Individuals who have lived experiences with suicidality are often unable to find survivor-support groups akin to those that friends and family members who are bereaved by suicide have access to (Lester and Walker 2006; Sudak et al. 2008). Knowing somebody else who can share about their suicidal experiences might help someone else in the healing process. Detailed accounts of the pain and suffering as well as useful tools and coping strategies would aid in providing compassionate and empathetic assistance in efforts to engage with helping a suicidal person (Lakeman and Fitzgerald 2008). In society, we need to allow former suicide ideators and suicide attempt survivors room to help others

overcome their own suicidality. In this way, we can learn from others' past experiences feeling suicidal and strive to apply this information in a way that steers the future of suicide prevention.

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Appendix A: Recruitment Flyer



Volunteers Wanted for a Research Study: **Lived Suicide Experiences Study**

Purpose of Study: This study investigates how individuals become suicidal, and the recovery from being suicidal. Volunteers must be willing to participate in a one-on-one interview that will last between 1-2 hours.

Eligibility: All participants:

- (1) must be 18 years or older,
- (2) must have lived through a suicidal experience, including (but not limited to):
 - a. suicidal ideation (aka having suicidal thoughts or contemplating suicide)
 - b. developing a suicide plan
 - c. making a suicide attempt
 - d. or recovering from being suicidal
- (3) must be willing to share confidentially about their experiences

Contact: To volunteer, or to seek more information, please contact Taylor M. Binnix, B.A., Master’s of Arts Candidate at the University of Memphis. This research is being conducted under the guidance of Dr. Seth Abrutyn, Department of Sociology.

To contact by phone: (410)693-0899
 To contact by email: tmbinnix@memphis.edu

<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>	<p>Suicide Experiences Study Contact Taylor M. Binnix: (410)693-0899 or tmbinnix@memphis.edu</p>
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Appendix B: Informed Consent Form



Institutional Review Board
315 Administration Bldg.
Memphis, TN 38152-3370
Office: 901.678.2705
Fax: 901.678.2199

Consent to Participate in a Research Study

Lived Suicide Experiences Study

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about living through suicidal experiences, specifically, what it's like to become suicidal and what it's like to recover from being suicidal. Lived suicide experiences include (but are not limited to) suicidal ideation (i.e., having suicidal thoughts or contemplating suicide), developing a suicide plan, making a suicide attempt, or recovering from being suicidal. You are being invited to take part in this research study because you are a consenting adult who has volunteered to share your experience about formerly contemplating or attempting suicide. If you volunteer to take part in this study, you will be one of about 50 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Taylor M. Binnix, Master of Arts Candidate at the University of Memphis, Department of Sociology. She is being guided in this research by Dr. Seth Abrutyn and Dr. Anna Mueller. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

By doing this study, we hope to learn about the factors and social forces that shape experiences with becoming suicidal and recovering from being suicidal. We are interested in understanding how individuals make sense of their suicidal experiences, and cope with the effects of being and recovering from being suicidal. The overarching goal of this research is to improve people's understanding about the complicated experience of surviving former suicidality, and raise awareness about how people can support one another through mental health crises.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

If you are younger than 18, then you should not participate in this study. If you have not formerly contemplated or attempted suicide, then you should not participate in this study. If you are not willing to talk openly about suicide or about your specific experiences with being suicidal and recovering from being suicidal, then you should not participate in this study.

Because of the sensitive topic of this study, it is possible that interviews may bring up painful or unhappy memories and emotions. If you feel the need to speak with someone about any distress you feel as a result of the interview, the person interviewing you can provide you with a list of local and national resources where you can get immediate help.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at a private location where you feel comfortable. A private office on campus at the University of Memphis campus is available for interviews. If you prefer that the interview be conducted in a different location, the researcher is happy to work with you to find a location where you feel comfortable. The interview will last between one and two hours.

WHAT WILL YOU BE ASKED TO DO?

You will be asked to participate in an in-person interview. With your consent, interviews will be recorded. At any point during the interview, you can request that we discontinue or pause the recording. If you wish to listen to a portion of the interview or to delete any portion of the interview, you will be able to. At any point you can discontinue the interview. You will have the option of filling out a brief demographic questionnaire, with no explicitly identifying information. The digital recordings of your interview will be transcribed. The digital recordings and the transcriptions will be stored on a password-protected computer; only the primary researcher and her faculty advisors will have access to the data. Once your interview is transcribed, all personal information linking you to the interview will be deleted and instead a pseudonym (a fake name) and a generic identification number will be attached to your interview. Personal information that will be removed from transcripts may include, but is not limited to, names of people, places, schools, or workplaces.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

You may find some questions we ask you to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings.

In addition to the risks listed above, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced a sense of relief or healing after sharing personal histories. Your willingness to take part, however, may, in the future, help society as a whole better understand this research topic.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide not to take part in this study, your decision will have no effect on the quality of care or services that you receive, should you choose to take advantage of any suggested resources. For student volunteers, if you decide not to take part in this study, your choice will have no effect on your academic status or grades in class.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep private all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. All data will be stored in secure files on a password-protected computer. The master list linking your identities to your assigned pseudonym, personal demographic information, and generic identification number will likewise be stored in a secure file on a password-protected computer.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you pose a danger to yourself or someone else. Also, we may be required to show

information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Memphis.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study, you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons.

ARE YOU PARTICIPATING OR CAN YOU PARTICIPATE IN ANOTHER RESEARCH STUDY AT THE SAME TIME AS PARTICIPATING IN THIS ONE?

You may take part in this study if you are currently involved in another research study. It is important to let the investigator or your doctor know if you are in another research study.

WHAT HAPPENS IF YOU GET HURT OR SICK DURING THE STUDY?

It is important for you to understand that the University of Memphis does not have funds set aside to pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, the University of Memphis will not pay for any wages you may lose if you are harmed by this study.

Medical costs that result from research related harm cannot be included as regular medical costs. Therefore, the medical costs related to your care and treatment because of research related harm will be your responsibility;

or may be paid by your insurer if you are insured by a health insurance company (you should ask your insurer if you have any questions regarding your insurer's willingness to pay under these circumstances);

or may be paid by Medicare or Medicaid if you are covered by Medicare, or Medicaid (if you have any questions regarding Medicare/Medicaid coverage you should contact Medicare by calling 1-800-Medicare (1-800-633-4227) or Medicaid 1-800-635-2570).

A co-payment/deductible from you may be required by your insurer or Medicare/Medicaid even if your insurer or Medicare/Medicaid has agreed to pay the costs. The amount of this co-payment/deductible may be substantial.

You do not give up your legal rights by signing this form.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Taylor Binnix at 410-693-0899 or tmbinnix@memphis.edu. You may also contact Taylor’s faculty advisor for additional information. Dr. Seth Abrutyn can be reached at 901-678-3031 or sbbrutyn@memphis.edu. If you have any questions about your rights as a volunteer in this research, contact the Institutional Review Board staff at the University of Memphis at 901-678-2705. We will give you a signed copy of this consent form to take with you.

WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?

If the researcher learns of new information in regards to this study, and it might change your willingness to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have joined the study. You may choose to stop the interview process at any time.

WHAT HAPPENS TO MY PRIVACY IF I AM INTERVIEWED?

Your identifying information will be deleted from transcripts of interviews; instead you will be identified by researchers in the transcript and in any subsequent publications by pseudonyms and generic identification numbers. The master list linking your identities to your assigned pseudonym, personal demographic information, and generic identification number will be stored in a secure file on a password-protected computer. All digital recordings and transcripts will likewise be stored in secure files on a password-protected computer.

WHAT ELSE DO YOU NEED TO KNOW?

By signing this form, you agree to the following:
I have been informed of any and all possible risks or discomforts.
I have read the statements contained in this consent form and have had the opportunity to fully discuss my concerns and questions. I fully understand the nature and character of my involvement in this research project as a human subject, and the attendant risks and consequences.

Signature of person agreeing to take part in the study _____ Date

Printed name of person agreeing to take part in the study

Name of [authorized] person obtaining informed consent _____ Date

Appendix C: Interview Guide

Natural History

1. Tell me a bit about yourself.
 - a. Possible probes:
 - i. What was your family like growing up?
 - ii. What were your friends like?
 - iii. Tell me about your family now.
 - iv. Tell me about your schedule on an average work day.
 - v. Tell me about your favorite things to do on weekend.

Lived Suicide Experiences

1. What was the first time that you knew what suicide was?
2. Tell me about what it was like for you to be suicidal.
 - a. If the person did not make an attempt, probe for:
 - i. What was going on at that point in your life?
 - ii. What were your thoughts like?
 - b. If the person made a suicide attempt, probe for:
 - i. What was it like?
 - ii. What happened next?

Resiliency/Recovery Process

1. How did others treat you/respond to you after they found out that you were suicidal?
2. How did you feel supported or not supported by others?
3. How do you feel now about that time in your life?
4. How would you describe yourself before/during/after your experience?

General Views on Suicide

1. How did your experience change the way you think about suicide?
2. How did your experience change the views of people you know about suicide?
3. How does society treat people who ideate or attempt suicide?
 - a. Is that different from how society responds when someone dies by suicide? If so, how?
4. Is there anything else that you would like me to know about your experience, or anything that we haven't talked about today?

Appendix D: List of Professional Resources

1. Local phone numbers:

The Crisis Center	(901)274-7477
Crisis Assessment Center/ Adult Mobile Crisis	(901)577-9400
Memphis Police Department/ Crisis Intervention Team	(901)545-2677 or 911
Youth Villages/ Youth Mobile Crisis	(901)320-6122
Suicide Anonymous	(901)383-1924

2. For students:

The University of Memphis Counseling Center counseling@memphis.edu	(901)678-2068
Rhodes College Counseling Center counseling@rhodes.edu	(901)843-3128
Christian Brothers University Counseling Center http://www.cbu.edu/depression--suicide-prevention	(901)321-3527

3. The Tennessee Suicide Prevention Network Resource Directory Downloadable from: <http://tspn.org/get-help-now>

4. American Foundation for Suicide Prevention <https://www.afsp.org/preventing-suicide/treatment>

5. National Institute of Mental Health <http://www.nimh.nih.gov/health/publications/suicide-in-america/index.shtml> Hard copies of the NIMH Suicide FAQ Sheet will be provided upon request.

6. National Suicide Prevention Lifeline <http://www.suicidepreventionlifeline.org/>



Appendix E: Demographic Questionnaire

RID: _____

1. What is your gender?

2. How old are you?

3. What is your race and/or ethnic origin? (Please circle all that apply.):

- a. White
- b. Black/African American
- c. Asian
- d. American Indian or Alaska Native
- e. Native Hawaiian or Other Pacific Islander
- f. Hispanic/Latina/Latino
- g. Other (please explain):

4. Please describe your sexual orientation.

5. What was the highest level of education that you have completed so far? (Circle one.)

- a. I did not graduate from high school.
- b. I have a high school diploma or GED.
- c. I have a degree or certificate from a community college, two-year college, or post-high school professional school.
- d. I have a four-year college degree (Bachelor's Degree, BA/BS).
 - i. What university or college did you attend? (Please list all that apply.)

- e. I have a graduate degree (such as an MA, EDD, MPH, MSW, PhD, MD, or JD).
 - i. What university did you attend for your graduate education? (Please list all that apply.)

6. Did at least one of your parents (or the people who raised you) graduate from college?

Circle one: Yes No

7. Do you own your home?

Circle one: Yes No

8. What is your religious denomination? (If atheist or agnostic, please indicate that.)

9. Over the past 12 months, how often did you attend religious services? (Circle one.)
- a. Once a week or more
 - b. Once a month or more, but less than once a week
 - c. Less than once a month
 - d. Never
10. How important is religion to you? (Circle one.)
- a. Very important
 - b. Fairly important
 - c. Fairly unimportant
 - d. Not important at all
11. Roughly, what is your total annual household income? (Circle one.)
- a. Under \$20,000
 - b. Between \$20,000-\$39,999
 - c. Between \$40,000-\$59,999
 - d. Between \$60,000-\$79,999
 - e. Between \$80,000-\$99,999
 - f. Between \$100,000-\$149,999
 - g. Over \$150,000
12. Using the scale below, how difficult would it be for you to come up with \$4,000 in cash within one week for an emergency expense (like a serious car repair or a medical bill)? (Circle one.)
- a. Not difficult at all
 - b. Somewhat difficult
 - c. I may not have the money, but I could borrow it from someone.
 - d. I do not have the cash, but I could put it on my credit card.
 - e. Impossible
13. Growing up, did you ever participate in your school's free or reduced lunch or breakfast program?
- Circle one: Yes No
14. Growing up, how often did you go hungry because there was not enough food in your home? (Circle the best answer.)
- a. Never
 - b. Rarely
 - c. Sometimes
 - d. Most of the time
 - e. Always
15. What is your occupation?
-

IRB APPROVAL

The University of Memphis Institutional Review Board, FWA00006815, has reviewed and approved your submission in accordance with all applicable statuses and regulations as well as ethical principles.

PI NAME: Taylor Binnix

CO-PI:

PROJECT TITLE: Suicide Experiences Study

FACULTY ADVISOR NAME (if applicable): Seth Abrutyn

IRB ID: #3677

APPROVAL DATE: 4/10/2015

EXPIRATION DATE: 4/10/2016

LEVEL OF REVIEW: Expedited

Please Note: Modifications do not extend the expiration of the original approval.

Approval of this project is given with the following obligations:

1. If this IRB approval has an expiration date, an approved renewal must be in effect to continue the project prior to that date. If approval is not obtained, the human consent form(s) and recruiting material(s) are no longer valid and any research activities involving human subjects must stop.
2. When the project is finished or terminated, a completion form must be completed and sent to the board.
3. No change may be made in the approved protocol without prior board approval, whether the approved protocol was reviewed at the Exempt, Expedited or Full Board level.
4. Exempt approval are considered to have no expiration date and no further review is necessary unless the protocol needs modification.

Approval of this project is given with the following special obligations: None.

Thank you,

James P. Whelan, Ph.D.

Institutional Review Board Chair

The University of Memphis

Note: Review outcomes will be communicated to the email address on file. This email should be considered an official communication from the UM IRB. Consent Forms are no longer being stamped as well. Please contact the IRB at IRB@memphis.edu if a letter on IRB letterhead is required.