The Meaning of Suicide Attempts by Young Adults

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ABSTRACT

Suicidal behaviour among young adults is a significant social and psychological problem, however, little research explores its meaning from the suicidal individual's perspective. A qualitative study identified common themes and personal meanings that characterized the experiences of young adults who had made one suicide attempt between ages 20 to 24. Six major themes identified were (a) family experiences, (b) adolescent interactions, (c) emotional experiences, (d) self-destructive behaviours, (e) depression, and (f) perception of control. Suicidal attempts were viewed from the perspective of a continuous process that encompassed the individual world view and experiences rather than as isolated events.

RÉSUMÉ

Le comportement suicidaire chez les jeunes adultes constitue un problème psychologique et social important. Cependant, peu de recherches ont été effectuées afin d'étudier son sens du point de vue de la personne suicidaire. Dans cet article, une étude qualitative identifie les thèmes communs et les raisons individuelles caractérisant les expériences de jeunes adultes ayant fait une tentative de suicide entre l'âge de 20 et 24 ans. On a pu dégager six thèmes principaux : (a) l'expérience familiale, (b) les interactions entre adolescents, (c) les expériences émotionnelles, (d) les comportements destructeurs envers soi-même, (e) la dépression et (f) la perception de contrôle. Les tentatives de suicide sont considérées du point de vue d'un processus continu qui comprend une vue du monde et des expériences individuelles plutôt que des événements isolés.

Suicide and suicidal behaviour among adolescents and young adults is a significant social and psychological problem. In a review of worldwide trends of suicidal behaviour, Diekstra (1993) found that the majority of suicide attempts are made by individuals below the age of 35. A study of suicide and suicidal behaviour in Canada found that ten percent of adults made a suicide attempt in their lifetime while thirteen percent made plans for suicide (Ramsay & Bagley, 1985). Despite these rates and the amount of research conducted in this field, surprisingly little is known about the experience of being suicidal. While demographic variables may be useful in identifying at-risk groups, they provide little in the way of meaningful understanding of the suicidal individual (Hendin, 1991; Lester, 1994; Shneidman, 1987). Kral (1994) and Strosahl (1999) encourage researchers to focus on the mind of the suicidal in an attempt to understand how

suicide becomes an option and to incorporate that information with the identified risk factors associated with suicidal behaviour.

Although suicide is the fifth leading cause of death across age groups, it is the second leading cause of death after accidents in young people aged 15-24 (Mazza & Reynolds, 1994). Statistics indicate that suicidal risk increases with age until age twenty four at which the highest ratio of attempted to completed suicides occurs (Bland, Newman, & Dyck, 1994). While Canadian suicide rates remained somewhat stable for both males and females between 1985 and 1992, the suicide rate for late adolescents has quadrupled in the past three decades (Health Canada, 1994).

Historically, research has focussed on risk factors and prediction of suicidal behaviour, (Beck, Steer, Beck, & Newman, 1993; Leenaars, 1990, 1997; Maris, Berman, Maltsberger, & Yufit, 1992; Shneidman, 1993a) and epidemiological data (Bland et al., 1994; Diekstra, 1993). While this emphasis increases the ability to identify factors and patterns associated with suicide at a categorical level, it unfortunately, has contributed little to increased accuracy of prediction (Hendin, 1981; Leenaars, 1999; Strosahl, 1999).

Unlike completed suicide, no definitive statistics about attempt rates are available as many suicide attempters receive no medical or psychological attention and there is no formal documentation of the attempt (Bland et al., 1994; Diekstra, 1993). Additionally, suicide attempts are often misclassified as accidental. It is estimated that 25 to 40% of persons who complete suicide have a history of a previous attempt (Health Canada, 1994) although the attempt to completion estimates vary from the conservative 10:1 (Bland et al., 1994) to a liberal 600:1 (Health Canada, 1994). Suicidal gestures are also estimated to occur 10 times more often than attempted or completed suicides (Mann, DeMeo, Keilp, & McBride, 1989).

Particularly rare is research focussed at a global level into the suicidal thoughts, behaviours, and affect of young adults (Leenaars, 1997). Understanding suicidal behaviour from a singular perspective is likely inadequate because psychological, interpersonal, and existential components contribute significantly to the interpretation and meaning given by an individual to their life experience; interpretations are unique and multifaceted. Understanding suicide and suicidal behaviour as multi-determined provides a broader spectrum from which to develop effective intervention strategies and therapeutic interventions.

The interaction of personality, environment, and learning processes from which suicidal behaviour is developed is increasingly being emphasized (Leenaars, 1997, 1999; Maris, 1981; Shneidman, 1985, 1987, 1993a). Suicidal behaviour is hypothesized to be a compilation of a painful situation, a constricted cognitive state, overpowering emotions, and disturbing relationships, and is conceptualized as adjustive but not adaptive. The distressed individual perceives suicide to be as the last available option. Death provides a solution to end the conscious awareness of pain.

Shneidman (1987,1993a, 1993b) proposed a model of understanding suicide comprised of three components: (a) unmet psychological needs that span a range from little to intolerable pain; (b) internal response and action to both internal and external events that ranges from positive to negative; and, (c) degree of distress or upset experienced as a result of internal and external realities. Leenaars (1990, 1997) contributed a developmental perspective to the understanding of suicide by emphasizing that suicidal ideation, suicidal behaviour, and suicide attempt ratios vary across the lifespan. Suicidal ideation has been shown to vary with age, with younger adults experiencing a higher level of ideation, while middle aged and older adults experience a lower level of suicidal ideation but a higher completion to attempt ratio.

Maris (1981) conceptualized suicidal behaviour within the context of suicidal careers. He theorized that suicide is rational, "an effective means of resolving common life problems" (p. 290). He also contends that suicide is not always intentional, that suicidal individuals tend to have ambivalent feelings about living, and that meanings of suicidal behaviour vary. He further presents the argument that non-suicidal alternatives have been either unavailable or unacceptable, that suicide is available as a resolution, that tolerance thresholds have been repeatedly breached, that self-destructive behaviours significantly lead to suicidal behaviour, and that negative interpersonal relationships contribute to suicidal behaviour.

Attempting or completing suicide is a meaningful and purposeful act for the person engaged in it and must be understood as such (Hendin, 1981). Hendin (1991) encourages the research community to pursue the meaning of actions and experiences, as does Shneidman (1993a) who argues that the focus on prediction and demographics has "missed the mark" because it bypasses the question of what psychological process or processes make suicide an acceptable option to an individual. Additionally, Leenaars (1997) clearly identified young adults as a population sorely neglected in the research and called for studies to address this deficiency.

In an attempt to address the deficiencies in the literature investigating young adult suicide attempters, a qualitative study was conducted. Individuals who had attempted suicide prior to age 25 were interviewed to obtain an understanding of the experience of feeling suicidal, making the decision, and attempting to end life. The purpose of this investigation was to identify common themes in answer to the question, "What was the experience of young adults who felt suicidal, made the decision, and attempted to end their lives?"

METHOD

The need to adequately understand the viewpoint of participants through accurately perceiving their reality has been identified as missing in the suicide and suicidal behaviour research (Hendin, 1981; Shneidman, 1987; Strosahl, 1999).

Qualitative methods are specifically designed and suited to studies in which there is an attempt to explore the meaning and nature of an experience (Colaizzi, 1978; Osborne, 1990; van Manen, 1990). Phenomena captured in experience are comprised of external events and individual perceptions or attributed meanings to those events. The nature of the data obtained in this study was based on past experiences as expressed by the participants and analyzed using an interpretive inquiry method. Interviews were audio taped and transcribed as text and the data was subject to both descriptive and interpretive analysis.

Participants

In an attempt to obtain a criteria-based selection (Morse & Field, 1995) of young adult participants who had recently engaged in suicidal behaviour but for ethical reasons no longer considered themselves suicidal, the following criteria for selection were used: both male and female participants were solicited; the attempt occurred within the past five years; only one suicide attempt was made between the ages of 20 to 24; participants considered themselves non-suicidal for a minimum of six months; and willingness was expressed to articulate perceptions and perspectives of the experience. Both urban and rural participants were solicited through public service announcements and advertisements on television stations and in regional newspapers. Volunteers contacted the researcher by telephone and a short interview was conducted to determine whether they met the criteria for participation. Of 19 potential participants, 9 were excluded because of histories of repeated suicide attempts or reluctance to discuss their experiences in depth, two were excluded because of ongoing suicidal thoughts and feelings, and three declined participation for unspecified reasons.

Five participants, four females and one male ranging in age from 24 to 27 at the time of the interviews were included in the study. Each had attempted suicide between the ages of 21 to 24. One participant was married, one had a child, and another was pregnant; three were single and lived alone; two lived with a partner. Four had completed high school; two participants held full time jobs, two worked primarily within the home; one was completing an undergraduate degree and two worked part time. Two participants had been involved in sexual relationships with family members; two had parents with diagnosed psychiatric disorders; and four had experienced the divorce and remarriage of their parents. Four had attempted suicide once between the ages of 10 to 15.

Data Collection

Individual in-depth interviews were conducted in which opening statements provided a standard way to begin each interview and were designed to facilitate an open and honest dialogue with the participant. The prompt used to begin each interview was "Can you tell me how you came to make the decision to attempt suicide?" The interview followed an semi-structured format which included prompts such as " When and how did you become aware of feeling suicidal?", "How did you attempt to deal with your suicidal feelings?", which

allowed the participant to describe their experience with minimal input or direction from the researcher. The interviews explored self-identified important personal experiences and the extent to which these influenced individual perceptions and cognitions, emotional responses, and attributions of meaning. Data collection interviews of approximately two hours per participant were audio-taped and transcribed into text.

Using an interpretive inquiry method, each protocol was analyzed for both description and meaning following the procedures outlined by Colaizzi (1978). The analysis of each interview involved repeated readings of the transcripts, focussing on the following topics: how each participant understood and interpreted the experiences relevant to their suicidal thoughts, feelings and actions; how feeling and engaging in suicidal behaviour affected their view of themselves and their world; the impact that feeling and acting on suicidal feelings had on interactions with others; and how their suicidal behaviour is understood in retrospect. The relevance of each statement and its association with the suicidal process was evaluated and analyzed individually for meaning. Significant statements, phrases, sentences, and paragraphs were extracted and recorded in a tabular manner. Paraphrases generated in an attempt to clarify underlying meaning were recorded for each statement. Themes were identified, then statements clustered based upon common themes. Clusters that fit together to clarify the fundamental and essential meaning of each protocol were generated in an attempt to define the nature and structure of the phenomenon. A written synthesis of each protocol was generated and analyzed, representing a within-person analysis.

Following the completion of each within-person analysis, a between-person analysis was conducted in order to identify themes that were common to all protocols. Irrelevant descriptions and unnecessary repetitions were eliminated and the remaining clustered themes were pooled between protocols. Second-order themes produced by clustering were compared to significant statements in the original protocols in order to validate the meaning of the themes, the clustering of the primary themes, and the clustering of the higher order themes. The thematic structure was refined and abstracted to illustrate the experiences described within the data. Although there were many similarities across accounts, unique features of personal experience were observed, noted, and incorporated in the refinement process to emphasize individual cognitive and affective meanings. In an attempt to ensure relevant and valid results following completion of the analysis by the author, a psychologist with an extensive qualitative research background audited the coding to verify the validity of the themes.

A one-hour follow-up interview was conducted individually with participants after the completion of the analysis and a written synthesis was generated. The written synthesis was validated by the participant in a discussion that focused on determining the accuracy of the researchers' understanding and interpretation of the data. Clarifications and inaccuracies were discussed at this time. Participants were given the opportunity to present additional information they considered relevant but may have overlooked in the initial interview. This procedure allowed

the participant to provide feedback regarding the accuracy and validity of the interpretation of their experience. New information and corrections were incorporated into the data.

Themes were categorized from the content that emerged from shared experiences of participants' situations, behaviours, and experiences. The major themes were placed into categories that encompassed childhood experiences within the family, adolescent interactions with family and peers, emotional experiences in adolescence and young adulthood, self-destructive behaviours, depression, and perception of control.

Childhood Family Interactions

All participants indicated that their family experiences as children contributed to their feeling suicidal and making the decision to end their life. Emotional difficulties began for all participants in middle childhood before the age of 10. Disruption of home life was a common source of strife and discomfort that contributed to a profound sense of uncertainty, fear, and self-doubt that reportedly increased with age. Each reported feeling separated from the safety and security typically associated with home life because of ruptured family structures or unpredictability of family interactions. Three participants described the family experience as one in which little interest, attention, or affection was perceived to be directed toward them. Despite this, each participant expressed the desire during childhood for a strong connection with a parent. The desire for a closer relationship seemed to be an unattainable goal and lack of communication with that parent was interpreted to mean lack of caring.

> I guess it would have to start way back. Ever since I was young, — my parents got divorced when I was 5 and I always kind of, I didn't really feel like I belonged anywhere. . . . I remember thinking how my Mom doesn't care, I don't want to be here.

Injustice and unfairness were routine observations and led to the belief that the family was not a safe place to be and contributed to a deep sense of separation and separateness. There was no specific role for the child as a result of lack of, or change in, family structure and each individual felt that s/he was viewed by the family as a burden. Disruptions and alterations in family structure were identified and expressed as losses. The following were common experiences: loss of the family unit, relocation that resulted in loss of support networks and/or extended family, loss of relationships, and loss of place within the family.

All participants recalled lives that showed a pattern of disruptions creating the ambiguous and unpredictable context within which they developed as individuals. The disconnected family home was the rocky foundation upon which these individuals built a perception that they were not valuable, valued, or important people.

Peer Interactions and Social Expectations

Four participants reported experiencing rejection and/or separateness from peers during childhood and early adolescence which impacted perceptions of personal value and self-worth. As attempts to be accepted within an established peer group were unsuccessful, the perception of "being different" from peers during childhood was profoundly disturbing. With increased age, the sense of alienation increased as the experiences of being ostracized, marginalized, and belittled by peers continued. It is noteworthy that these participants experienced some peer acceptance during high school. One participant felt connected to peers until the end of high school. The disruption of peer support at the end of high school was experienced by all participants as friends dispersed. Although each participant attempted to establish themselves in a new peer group, the attempts were unsuccessful. The meaningfulness of life was challenged as sense of isolation and alienation increased.

> I didn't fit in socially. . . . So I felt apart from them and that was getting me down and it got me down. I thought that I was really messed up and that there was something wrong with me. So the whole social picture was screwed up and the home picture was screwed up and academically I was a mess. So I think it was an amalgamation of all those things.

All participants attempted to meet and exceed self-imposed expectations as well as expectations imposed by others. In childhood and early adolescence, participants continuously tried to obtain adult support and attention, "to earn love" and to compensate for feelings of unworthiness and inferiority. Although some were more successful than others, each attempted to perform well academically, to function in socially appropriate ways, to be active within their school and community environments, and to live up to what they perceived to be the standards and expectations of family members. Failed attempts at obtaining recognition and acceptance were experienced as losses. Two participants gave up trying in mid adolescence while the other three continued to seek approval until their late teens.

Emotional Experiences

Predominately negative emotional experiences were identified as occurring throughout childhood, adolescence, and young adulthood which formed a gestalt in which feeling suicidal was an integral part. Feeling rejected, in addition to continual fear of being rejected, had a profound impact on feelings of self-worth, self-efficacy, and personal value. Rejection by parents, both real and perceived, was reportedly most impactful. All participants began to experience feelings of anger and resentment and to feel unworthy, unlovable, and unimportant. Paradoxically, rejection of others became a method of ensuring safety and personal protection as it was useful in developing and maintaining emotional distance from others.

Real and perceived rejections came to be understood as betrayals with the experiences of betrayal having a cumulative impact over time. As repeated failures

to deal with rejection and betrayal were experienced, a deepening sense of insecurity and futility ensued. In addition, betrayal reinforced the belief that the participant had little impact on the events that occurred in life or the people in it. Unable to find a meaningful or purposeful path through life contributed to a sense of being without resources.

> Again I felt everything that I felt in the first place. Totally betrayed and she was dishonest and she didn't love me. . . . I was just grasping for something, some sign of hope and there was nothing. So I was like well, I finally got to a point where I didn't care about anything. I'm like, well there's nothing there, I don't want to live my life being a failure.

In childhood, anger was directed initially toward others who were hurtful, but as resolution to ongoing problems continued to be elusive, the anger slowly turned inward to be directed toward the self. By adolescence, anger was used as a defense of the self, as protection from both self-inflicted pain and pain inflicted by others, and as a coping mechanism to maintain distance from potentially hurtful interactions.

> And I just got mad and it didn't hurt anymore. And really, right then I realized I can do anything now. As soon as I get angry, nothing hurts.

In all cases anger at family members was profound, and for three participants, anger at peers was disclosed. Lack of ability to improve the quality of life contributed to self-evaluations of personal inadequacy. As the level of anger increased, so did the intensity of depression and sadness. Anger toward others for actual or perceived betrayal or rejection provided the motivation for self-destructive actions.

Alienation from peers, from family members, and from the self were common experiences beginning in childhood. Feeling "separate from" and "separated from" was experienced as a chronic and inevitable condition that was perceived to be the result of a lack of support, primarily from family, but also from peers. Four participants indicated that they had felt alienated and unaccepted by peers since early childhood. As a result, a significant and meaningful grounding that would provide necessary meaning to their lives was missing. Alienation was increased by the observation that other siblings received different treatment from natural and step-parents, and as such, a slow and progressive alienation process had its roots firmly embedded in family relationships. During middle to late adolescence there was a temporary period during which a sense of alienation was overcome through finding a temporary peer group within which to function, however each participant returned to the state of feeling isolated from others in early adulthood when the peer group lost its cohesion after graduation from high school.

> I felt alienated and alone all those years. . . . I was searching for the closeness with my family. I've always wanted to feel like my mom loved me or that I sort of belonged somewhere I guess. I always felt like I was different in some way, that I never fitted in anywhere. And I never understood why.

Disappointment and emotional pain gave birth to a world view that served as the basis for subsequent action: self-protection was of primary importance. Distance provided protection; alienating oneself from hurtful interactions

achieved distance. Therefore, alienation became the course of choice to meet the need to protect the self by severely restricting the type and depth of interactions with others.

Self-Destructive Behaviours

In attempting to deal with the ever-increasing emotional pain and social distress in life, the participants slowly developed a penchant for, and became heavily involved in chronic risk-taking or self-destructive behaviours. These reportedly increased throughout mid-adolescence and into young adulthood as emotional pressure surpassed tolerable levels. Self-destructive behaviours included all or some of abuse of both prescription and illegal drugs, excessive alcohol abuse, self-mutilating behaviours, and multiple unsafe or abusive sexual encounters.

> I remember one night cutting my wrists with a blade and smearing the blood on the sheet, on the page that I was writing on. It wasn't an attempt at suicide 'cause I just wanted to injure myself.

These behaviours typically began unintentionally and were primarily motivated as a method of alleviating distress and emotional pain. As a sense of desperation increased, however, so did the severity and frequency of the risk-taking behaviours. Over time, self-destructive and risk-taking repertoires expanded, became more complex, and became routine coping mechanisms. The impact of these behaviours on family and peers increased emotional distance and contributed to an increasingly profound sense of alienation and loss. Behaviours initiated to alleviate distress quickly began to contribute to distress as they became established patterns of behaviour.

Depression

Beginning in childhood, depression appeared to be a constant in the lives of for four of the participants although the intensity varied over time. Regardless of whether separation, withdrawal, and alienation from significant others were identified as contributing factors to the depth of depression, or whether depth of depression contributed to separation and withdrawal, the subsequent sense of isolation contributed to experiences of despair.

> You're going to school, you're getting an education, but you're depressed. It screwed you up when you were younger, it's screwing you up once again and you're going to the doctors to get meds and the meds aren't working and what do you? What the hell are you supposed to do? Nobody understands.

Attempts to deal with depression in childhood and adolescence were reported to be inadequate as the issues underlying the depression were either not identified or not addressed in a helpful manner. As unresolved issues remained and new emotional tasks were added to personal loads, each found themselves less able to develop or implement useful resources. As depression increased, each reacted by withdrawing from interpersonal interaction and by expending less effort to re-

solve issues positively; actions taken would exacerbate, not alleviate, the depression. As failures accumulated on top of previous failures, resolution was seemingly unattainable; life became a larger and larger burden, eventually too heavy to carry. Each participant moved through depression from sadness, hopelessness, and desperation, to despair with both internal and external factors contributing to this progression. Depression was expressed by both acting out and self-destructive behaviours in addition to withdrawal from engagement with others. The future seemed to hold no promise of foreseeable change.

Self-Control

Suicidal behaviour is often interpreted as a form of attempting to control others, used by people who experience extreme levels of anger, despair, and futility (Carrigan, 1994; Hayes, 1993). Four participants disclosed a sense of desperation and lack of control. Not only were attempts to control others futile, but attempts to control personal emotional health seemed futile. Life was perceived as hopeless and meaningless as there seemed to be no possibility of improvement in the future; change could only be achieved when one was in control of one's own life, therefore, both control and change were absolutely necessary to successful living.

> Not being in control of your life , I guess I just had it. I thought if life is just going to keep on going like this, this isn't normal. . . . So there wasn't anything else to do. There wasn't anything else to control, just to call my own.

Acquiring and maintaining control of one's own life appeared to be a necessary but impossible goal. Each participant had tried a variety of methods to acquire control and was acutely aware of where and when they were unsuccessful. As the sense of having control eluded them, frustration and desperation grew. Life seemed to have them by the throat as their emotional pain increased to an unbearable level; they felt defenseless and completely vulnerable. Rejection, betrayal, and intensity of anger and alienation contributed to a sense of lack of control. Experiences of betrayal fostered the belief that control of one's own behaviours and own life were impossible to attain. A growing sense of futility ensued as depression deepened.

Summary

Participant's suicide attempts were precipitated by deep-seated feelings of rejection, betrayal, anger, and alienation, which contributed to depression and the belief that life was uncontrollable. The combination of distressing emotional experiences, negative personal interactions, and intensity of depression appeared to have a significant negative impact on feelings of personal value, worthiness, and ability to view life as meaningful and worth struggling for. The attempt to end their lives was a response to the overwhelming need to obtain final resolution to their struggles. The events, feelings, and thoughts that had preceded this decision were based on an increasing inability to cope with or find resolution to personal distress.

DISCUSSION

The participants in this study clearly indicated that suicidal behaviour developed from an accumulation of repeated stressors, and distressing thoughts and feelings which developed over several years. It was not a result of an impulsive reaction from an isolated moment of distress reached to address a specific, identifiable event. This finding is consistent with Pulakos (1993) who described a model in which suicidal behaviour is acquired over time, is integrated into a repertoire of coping mechanisms, and results from disruption or instability due to the lack of resolution to underlying personal issues and problems.

Shneidman (1985, 1993b) framed the study of suicidal behaviour by placing it within the context of psychache, or unendurable psychological pain. Using suicide as a means of escaping pain is a commonly accepted reason for completed suicides (Gibbs, 1990; Kral; 1994; Maris, 1981; Shneidman, 1993b). It is typically not discussed, however, within the context of attempted suicides. Interestingly, unendurable psychological pain appeared to be a critical factor in the experience of these participants. In addition to supporting Shneidman's concept of psychache, the results of this study also suggest that loss and grieving were the underlying experiences of emotional pain.

Consistent with Strosahl (1999) the need to protect the self from pain tended to motivate behaviour in which the individual felt required to withdraw from relationships while at the same time, they desired and envied the relationships observed in others. Lack of success at what were perceived to be goals easily achieved by others was experienced as loss, although not recognized as such at the time. For example, the inability to develop meaningful relationships with family or peers was experienced as a loss of connection. Losses were experienced as emotional pain that impacted all aspects of their personal life and experience.

Accumulated losses provided the framework within which the possibility of connection to others became an unattainable goal and contributed to the erosion of connections with others. Losses also played a significant role in contributing to each participant's perception that life held little meaning or significance. Particularly in childhood and early adolescence, change experiences were interpreted, and responded to, as losses. These included the loss of role within the family, loss of security and sense of safety, loss of connection with a parent or sibling, loss of belief in the inherent value of the self, and loss of belief in the ability to lead a healthy and meaningful life. Losses were cumulative; the impact of one was exacerbated by the onset of another before resolution to thoughts and feelings of a prior loss was achievable. Losses appear to have provided the fuel to drive a deep grieving process.

Connection to others or to something important in life, and the ability to express connectedness through interaction and communication, were identified by the participants as being of primary importance in giving meaning to life (Gibbs, 1990). The difficulty in establishing or maintaining connection and communication with others, particularly family members, was prominent in that it had a dramatic impact on each individual's perception of their own value and the

value of life itself. Failed attempts to develop or maintain intimate relationships contributed to a sense of oppressive isolation, alienation, and emotional distress.

The experiences of rejection, betrayal, anger, and alienation were consistently interwoven themes in each participant's account of their life experience that served to impair the development of effective emotional functioning. These intense and deeply disturbing feelings appeared to interact with depression and the belief that life was uncontrollable. More than experiencing depression and hopelessness (Beck et al., 1993), these individuals reported feeling increasing levels of despair (Hendin, 1991; Shneidman, 1993b) as they exhausted emotional resources.

As the level of stress and despair increased, unsuccessful strategies for coping were slowly eliminated. However, few coping strategies other than self-destructive behaviours used as a method of alleviating emotional distress and despair, were generated as replacements (Maris, 1981). Rather than facilitating problem resolution, these behaviours increased stressors, contributed to deteriorating interpersonal connections, and impaired effective emotional functioning (Maris, 1981). The events, feelings, and thoughts that had preceded severely restricted strategy options were based on an increasing inability to cope with life's demands, difficulties, and increasing complexities.

The accumulation of distressing life events required increasing expenditures of emotional energy. Each participant described "living in two worlds": a world of inner distress, despair, and personal loathing which competed with the world of effective emotional functioning and age appropriate behaviour. As one participant stated, "It was a battle between the real me and the mask me." Controlling emotional pain was an internal struggle whereas participants believed that controlling life required a balance of control of internal and external factors. Attempts to control external situations and forces were used to obtain internal control, and each believed that once external factors were different, internal reality would change. Control was considered imperative for successful living, however it seemed unattainable since control required that changes occur. Changes seemed unattainable therefore life was meaningless and unbearable.

Consistent with Maris (1981; Maris et al., 1992) during their suicidal state each participant grew to see themselves as fundamentally flawed. Each felt incapable of dealing with the stress and distress of their lives and believed that resolution to their problems was solely their responsibility, but beyond their grasp. Additionally, in support of Hendin's (1991) research, since each was unable to resolve personal problems and felt themselves to be a failure, they then came to see themselves as inadequate human beings.

Over time, each individual felt that they were unable to adequately or effectively cope with what life presented to them; their resources were exhausted and they felt repeatedly pushed beyond the brink of endurance (Maris, 1981; Shneidman, 1985, 1993a). The suicide option was not considered viable until available and accessible avenues to problem and emotional resolution had been unsuccessfully attempted. Eventually, a seemingly unimportant or recurring

event precipitated the suicidal act itself. Therefore, for the participants of this study, the accumulation of their own cognitive, emotional, and situational experiences significantly contributed to a slow and progressive process that culminated in the suicide attempt.

CONCLUSION

Exploring the intimate experiences of participants has been an attempt to contribute to a richer understanding of the process of becoming suicidal. Historically, there has been a tendency to examine limited components of suicidal behaviour rather than the whole person in the context of interaction with their world. While this approach contributes to an understanding of isolated factors sometimes associated with suicide, it does little to address the complexity of human experience. In addition, the pathologization of suicidal behaviour leads to a reinforcement of the societal belief that there is something inherently wrong with suicidal individuals, that they are flawed in some significant way.

Clearly, for those who participated in this study, cognitive, affective, and social processes interacted to impact the meanings attributed to life and personal value, eventually leading to the belief that suicide was a viable option. Over several years, participants came to believe that they were inadequate and incapable of successful living. Perceptions of lack of connection and control occurring in conjunction with cumulative losses contributed to the suicidal process. Rather than being a spontaneous reaction to a specific event, the suicide attempt was a culmination of lifelong, unfulfilled needs and emotional distress.

Strikingly, personal experience and the associated emotional responses could be conceived of as an accumulation of losses that resulted in grieving. It may, therefore, be constructive to conceive of suicidal behaviour as the end of a grieving process. This conceptualization could provide a valuable framework within which to develop an understanding of suicidal behaviour as a process of unresolved grieving, which, if left unaddressed during childhood and adolescence, may have a considerable impact on personal growth and development in young adulthood.

IMPLICATIONS FOR THE TREATMENT OF SUICIDAL CLIENTS

For those who are suicidal, the development of a sense of connection is critical and urgent. Responsiveness to the individual's needs within the context of adherence to basic counselling principles is the foundation of a strong therapeutic alliance. Developing a strong relationship can provide a safe and secure framework within which the client is able to connect and communicate with another person in a meaningful manner and begin to explore the available options to problem resolution. Therefore, rather than suspending the foundations for a strong relationship in an attempt to avert a crisis, emphasis should be placed on those elements that foster a strong therapeutic alliance despite the suicidal state.

The client's thoughts, feelings and behaviour can be explored and the client supported so that the courage necessary to deal with difficult and distressing issues can be enhanced and maintained. Effective coping and problem-solving skills are essential for successful conflict resolution, they are an inherent part of life. The larger the repertoire of strategies the client has to chose from, the more likely the challenges of life will be successfully negotiated. Therapy provides a supportive environment in which coping strategies, stress management, and problem-solving skills can be discussed, options explored, alternate interpretations examined, decisions made and implemented, and social support provided if initial attempts to resolve issues are unsuccessful.

Therapists must be prepared not only to assist in the development of a support system, but also to establish long term goals for resolving the underlying issues upon which the suicidal behaviour has developed. The impact of cumulative losses on life perspective may be an important focus as it can provide a framework within which treatment goals and tasks can be discussed and developed in a manner that allows the client to understand their personal process of becoming suicidal.

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