TEEN SUICIDE:
EXPERIENCES IN THE EMERGENCY DEPARTMENT
FOLLOWING A SUICIDE ATTEMPT

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation of CARRIE E. B. HOLLIDAY find it satisfactory and recommend that it be accepted.

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who over the past 12 years has assisted me in my writing. Your gentle approach and amazing editing abilities were so invaluable; thank you very much.
The phenomenon of adolescent suicide warrants further investigation and research. Teen suicide is the third leading cause of death for 15-24 year olds. Shockingly, teen suicide has increased in recent years. Current treatment and prevention efforts have not been effective at decreasing suicide rates for the adolescent age group. Extensively studied in the adolescent suicide literature are the risk factors and prevalence related to the phenomenon but gaps in the literature remain. Research suggests that health care professionals do a poor job of treating, intervening and/or preventing adolescent suicide. It is well known that suicide attempters are at higher risk of completing suicide. Further, adolescents who visit the emergency department (ED) following a suicide attempt are a vulnerable group and report their experience as negative. The ED presents an opportunity for health care providers to intervene. A clear understanding of what the experience of being suicidal means to adolescents living the phenomenon has not been addressed in the research. The aim of this research project was to generate a comprehensive interpretation of the experiences of adolescents who visit the ED following a suicide attempt, using hermeneutic phenomenological methodology. Six adolescent suicide attempters were recruited from two northwest hospital EDs. They were each interviewed one time. Transcribed interview texts were analyzed using Heideggerian hermeneutic methods. Two patterns emerged:
Attempting as Communicating and Attempting as Transforming. Underlying themes are described in detail. The findings have implications for educating ED healthcare providers as well as other teens. In addition, findings are discussed in relation to nursing policy, practice and research.
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Dedication

This dissertation is dedicated to Casey Holliday

and the other young lives lost

far too early.
CHAPTER ONE

INTRODUCTION

Phenomenon

The phenomenon of interest is the experience of being suicidal as an adolescent. Adolescent suicide is a preventable public health problem. The abundance of research done on the topic is striking. One of the most staggering facts cite the fact that the suicide rates in the United States (U.S.) for youth have increased while the overall suicide rate for adults has remained unchanged over the past 50 years (Institute of Medicine [IOM], 2002). Few interventions and prevention efforts have proven to be effective in decreasing suicidal behavior. The role of the health care system in preventing and intervening in adolescent suicides is not well researched or understood.

Suicidal adolescents often visit the emergency department after a suicide attempt. The emergency department (ED) visit is an opportunity for health care providers to provide resources and appropriate follow up for suicidal adolescents. Research findings suggest that ED providers do not offer follow-up nor do they have appropriate resources to offer these teens in crisis. Further, teens do not follow up as recommended after an ED visit (Kennedy, Baraff, Suddath & Asarnow, 2004). An in-depth understanding of the thoughts, feelings and meanings surrounding the suicide attempt is needed before effective interventions and prevention programs can be implemented. A deeper understanding of the phenomenon could also help practitioners in their willingness and ability to address the problem attentively. Nurse’s must practice based on a shared understanding of patient’s experience. “The meanings that patients attribute to their experience help create the needs they have and how these needs can best be met…common meanings between nurses and patients will provide the most effective base for helpful nurse-patient relationships” (Cohen, Kahn & Steeves, 2000, p. 4). Little is known about adolescents’
experience in the ED following a suicide attempt; further research needs to be done and this study offers a beginning.

**Statement of the Purpose, Research Question and Specific Aims**

The purpose of this research is to fully describe and interpret the phenomenon of attempted suicide using a Heideggerian hermeneutic methodology in a sample of teens 15-19 years of age who visited a hospital ED following a suicide attempt.

The research question that guided this study was “What are the experiences of suicidal adolescents who visit the ED after a suicide attempt?” The specific aims of this research project are to generate a comprehensive interpretation of (a) the experiences of adolescents who attempt suicide and are admitted to the ED and (b) the meaning of being suicidal as an adolescent. The specific aims were accomplished through a Heideggerian hermeneutic analysis of transcribed verbatim interviews of six adolescent suicide attempters. An understanding of adolescents’ experiences will help to address issues yet to be uncovered in the teen’s experience. Consequently, testable preventive actions or interventions may ultimately lead to more appropriate and effective treatments.

**Locating the Researcher in the Research**

The process of conducting interpretive research and specifically Heideggerian hermeneutic phenomenology, demands that the researcher identify and examine personal biases and preconceived beliefs and to consider them as data is collectively analyzed. It is also useful to make the beliefs transparent to those reading the research (Annells, 1999). Following are my presuppositions regarding the phenomenon of teen suicide.
I am a psychiatric mental health nurse practitioner (PMHNP). I treat people with mental health issues of all ages. Adolescents present a challenge for me for many reasons. The first challenge is the issue of prescribing antidepressants to adolescents. In 2004, the Federal Drug Administration (FDA) issued a black box warning for adolescents and antidepressants because of the possibility of increased risk of suicidal behavior. I was left feeling uncertain about how to treat adolescents suffering from depression and suicidal thoughts. I have been educated to treat adolescents presenting with suicidal behavior with antidepressants and counseling. Antidepressants now were being removed from the equation. In addition, the lack of mental health providers educated to treat teens in the Spokane community presented a challenge for anybody attempting to find help for teens suffering. I was left feeling frustrated and at a loss about what to do with the teens who were asking for help.

I also worked as a registered nurse (RN) in the emergency department. I have come into contact with many people in different stages of suffering. Through my work in the emergency department, I have had the experience that, as nurses, we tend to support the stigma associated with those suffering from mental health issues. Arising from my experience in the emergency department, I believe that health care providers are missing a chance to intervene with this tragedy. As health care providers we come into contact with those that wish to die and our interventions and strategies to work with them are inconsistent and seemingly ineffective. This belief comes from the anecdotal evidence and the stories that teens tell me who have been referred to me after a suicide attempt. I believe that we are missing an important chance to make a difference and I wonder how our patients interpret their encounters with health care providers.

My personal beliefs come from my professional and personal experiences. I believe that completed suicides are tragic, preventable occurrences. I also believe that as adults we do not
spend enough time listening to what the younger generation is telling us, instead assuming we have nothing to learn from them.

For the reasons above, combined and interacting together, I am led to explore the phenomenon of adolescent suicide. Interacting with adolescents who have a desire to end their life strikes an emotional chord in me because of my experiences as a RN in the emergency department and as a PMHNP discouraged with the lack of options for adolescents. These experiences impact this project. While I do not believe in the ability to “bracket” one’s feelings, I do believe it is important to reflect on ones biases and preconceived beliefs, and how these beliefs might impact the research project and interpretation. Bringing the awareness to one’s consciousness is part of the interpretive process in Heideggerian hermeneutic research.

**Definition of Terms**

The literature on suicide is filled with various terms related to suicide such as suicidal behavior, suicide attempt, suicide ideation, suicide intent, suicide lethality, para-suicide, deliberate self-harm, self-inflicted injury and completed suicide. Separating behaviors into different terms implies differences within each concept. In suicide research, the lack of universally accepted terms seems to confound the state-of-the-science. There is inconsistency in the literature on how to operationally define the nomenclature used in suicidology. A perfect example of this inconsistency is the use of suicide intention in the literature.

Suicide intention is intended to describe the seriousness of the attempt. Some individuals intend to die, while others might be calling out for help; their intent is not to die. Intention is closely linked with the lethality of the method and whether the attempt was planned or unplanned (O’Connor, 2004). Lethality of the method refers to factors such as the method used,
knowledge of how to use the method chosen, physical consequences of the attempt and the
suggests that ascertaining the individual’s suicidal intention is a more accurate determination of
the seriousness of the attempt than identifying lethality. The Suicide Intent Scale (SIS) (Beck,
1990) is the most widely used scale to measure suicide intent yet, despite the frequent use of the
scale in research, the scales psychometric properties or performance has not been reviewed.
Freedenthal (2008) believes that it is imperative to accurately identify suicide intention as one of
the most effective proxy measures for suicide research. She reviewed 30 years of published
research on the scale and concluded that the scale needs to be refined or a new scale developed
due to the findings of (a) threats to the scales validity and (b) inconsistency between SIS scores
and suicide-related outcomes. Her review also shows that the scale is not reliable or valid when
used with adolescents.

Research using the SIS scale exemplifies the problem with the nomenclature used in suicide
research. Researchers have assumed that the terms related to suicide are discreet terms with clear
boundaries despite the lack of consensus on universally accepted terms. Perhaps the terms are
ambiguous in the minds of teens who are contemplating suicide or who have attempted suicide.
Moreover, the language used by teens to express their suicidal ideation may be at odds with the
discipline specific language used by ED personnel to diagnose and treat teens who have
attempted suicide. Ambiguous terms require researchers to re-conceptualize the methodological
approach to the topic and also require clinicians to talk in a language that teens understand. The
possibility that the terms are not distinct requires a more integral approach to researching the
phenomenon.

Despite the lack of clearly delineated terms, definitions have been used by current
suicidologists. Following are definitions used for the purposes of this research: suicidal ideation, suicide attempt and completed suicide.

**Suicidal Ideation**

Suicidal ideation has been defined in the literature as a “person who seriously thought about, planned or wished to commit suicide” (Beck, Steer, Kovacs & Garrison, 1985). Some suicidal ideators will go on to attempt and possibly complete suicide. One of the goals of research on suicidal ideation is to identify or predict those ideators who actually attempt or complete suicide.

**Suicide Attempter**

Suicide attempters were the target of this study. For the purpose of this study, a suicide attempt is defined as, ”a behavior with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some time to kill himself/herself. A suicide attempt may or may not result in injuries and may not be judged to be potentially lethal” (Kennedy et al., 2004, p. 458).

**Completed Suicide**

The definition of completed suicide for the purposes of this paper is a, “fatal self-inflicted destructive act with explicit or inferred intent to die” (IOM, 2002, p. 27). The term that encompasses all the suicide terms together, suicidality, is defined in the table below.

**Adolescence**

Adolescence is operationally defined as males and females 15-19 years of age. I chose to target this group because suicide is the third leading cause of death for this age group. In addition, this age group also has more emergency room visits for suicide attempts than any other age group (Doshl, Boudreaux, Wang, Pelletier & Camargo, 2005).

Table 1. Suicidology terms
<table>
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<th>Terms</th>
<th>Definition</th>
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<tr>
<td>Suicidal ideation</td>
<td>The act of thinking about, planning or wishing to commit suicide.</td>
</tr>
<tr>
<td>Suicide attempt:</td>
<td>A behavior with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some time to kill him or herself (Kennedy et al, 2004)</td>
</tr>
<tr>
<td>Completed suicide or suicide</td>
<td>Fatal self inflicted destructive act with explicit or inferred intent to die (IOM, 2002)</td>
</tr>
<tr>
<td>Suicidality</td>
<td>All suicide related behaviors and thoughts including completing or attempting suicide, suicidal ideation or communications (IOM, 2002)</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Males and females 15-19 years of age</td>
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While there is inconsistency and debate about the terms used in the suicidology literature, the definitions here provide a background to the study, informing recruitment choices and interpretive findings. The findings challenge the definitions used for this study as well as some of the extant literature on this topic.
CHAPTER TWO

REVIEW OF THE LITERATURE

Theories Informing Suicidology

In qualitative research, theoretical frameworks are used to inform the study. The theories explaining suicidal behavior are described here and offer a broad understanding. The theories presented are not guiding the present research study and are not necessarily endorsed by this researcher. Rather, the theories offered here are intended to provide a background for the literature review on suicide and an explanation for the direction suicide research has taken. In hermeneutic phenomenology, pertinent theories are woven into the findings depending on what presents itself in the data analysis.

The background and framework for suicide research comes from psychology, sociology, medicine, nursing and other disciplines. The theories that inform suicide construct an understanding of how scientists research the phenomenon. However, for a phenomenon that kills millions, the theories attempting to explain the topic are scant and no overarching theory exists to adequately explain suicide. Included in the following paragraphs is a discussion about how psychology, sociology and developmental theories have shaped our thoughts and beliefs about suicide and contributed to how scientists research the phenomenon. The theories also shape how clinicians approach and treat suicidal behavior.

Several theoretical perspectives of suicide are replete in the literature. These historical theories can be classified as psychological, developmental, and sociological. However, another perspective is gained from more current theories. Historical and modern theories of suicidality are now reviewed.
Psychological Theories

There are many psychological theorists who have attempted to explain the behavior of suicide and it is beyond the scope of this paper to mention all of those whom have impacted our current understanding of the phenomenon. However, there are three theorists that stand out and continue to gain attention in the literature: Sigmund Freud, Karl Menninger, and Aaron Beck.

Sigmund Freud. Psychoanalytical theories posit that suicide is anger or hate turned inward. Freud (1856-1939) is known in psychology for beliefs about the importance of the unconscious and how the unconscious impacts human behavior. Although Freud did not specifically theorize about suicide in depth, his theories continue to influence the suicide research. Freud believed humans have a death instinct or an inner wish to die. Suicide and suicidal behavior is evidence of this death instinct. Suicide is the appearance of the death instinct but turned towards self. Murder and other forms of aggression manifest as the death instinct acting away from ourselves.

Karl Menninger. Karl Menninger (1893-1990) influenced by the writings of Freud, also has theorized about suicide and suicidal behaviors and addressed the phenomenon more directly than Freud. Menninger was a psychoanalyst who believed suicide and homicide were related through three wishes that are inherent in everybody; the persons wish to kill, the wish to be killed and the persons wish to die. In Menninger’s book, Man Against Himself (1966), he posits that in every suicide all three wishes are present. The instinctual destructive tendency is turned inward instead of outward which is the difference between suicide and homicide. Menninger was concerned with the unconscious motives of the person and in his book he walks the reader through each inherent element and how the element relates to the unconscious. Menninger’s basic premise is that when self-destructive tendencies or impulses exceed constructive impulses the result is self-destruction, i.e. suicide. The work of Freud and Menninger and the concept of the death instinct
continue to gain attention in the literature but the theoretical propositions have not been researched specifically. What have been researched extensively are the tools that Aaron Beck devised regarding depression and suicide.

Aaron Beck. Aaron Beck (born in 1921) is an American psychiatrist who is widely known as the father of cognitive therapy. Clinically, he observed that depressed people who exhibit suicidal ideation viewed their life problems as too serious with no way out. Beck believed that the construct of hopelessness was the link between depression and suicide (Beck et al., 1985). Beck, with the help of others, developed many reliable and valid tools specifically to measure depression (Beck Depression Inventory), suicide (Scale for Suicidal Ideation, Suicide Ideation Scale), and hopelessness (The Hopelessness Scale) (Beck, Steer, Beck & Newman 1993). Beck was one of the first and perhaps most prolific researchers to operationally define terms related to suicidology. Beck et al. (1993) found that hopelessness is 1.3 times more important than depression at explaining suicidal ideation. Beck’s research on hopelessness has contributed greatly to our understanding of factors related to suicidal behavior. Research continues to demonstrate that hopelessness is a predictor of suicidal behavior (Bonnor & Rich, 1991; Dixon, Rumform, Heppner & Lips, 1992; Swedo et al., 1991). However, there is abundant research suggesting other contributing factors in suicide as will be described in the pages that follow. Hopelessness may be part of the answer to the mystery of suicide but it is not the only answer.

Developmental Theories

Perhaps the most influential developmental theorist that has contributed to the field of suicide is Erik Erikson. His theory is now described in relation to the age groups that pertain to adolescent suicide.
**Erik Erikson.** Suicide is a phenomenon occurring across the life-span and it is natural to have developmental theorists study the phenomenon. Erik Erikson (1902-1994) is well known for his construction of the eight stages of psychosocial development. Erikson (1968) believed in the concept of epigenesis. Epigenetics affirms that there are psychological crises or critical steps related to each stage of development and that in order to move onto the next stage one must resolve the psychological crises or master the challenges presented in the current stage. Erikson identifies the critical steps according to age ranges. Between the ages of 8-12, the child is going through what he terms, “industry versus inferiority.” At this stage the child is concerned with doing things right and doing them good. Children learn responsibility and attempt to gain independence. Early and late adolescence (ages 13-22) is marked by “identity versus role confusion.” The teen is concerned with asking the question “Who am I?” The teen is also concerned with how they appear to others or what others think of them. When the teen’s outer appearance matches their inner meaning/feelings, then the stage is considered mastered. Following this stage is the transition into early adulthood which Erikson termed “intimacy versus isolation.” The suicide rate is the third leading cause of death for those 15-24 years old and the fourth leading cause of death for those 10-15 years old. Through the lens of a developmental theory, suicide in teens begins during the “industry vs. inferiority” stage and continues throughout the “intimacy vs. isolation” stage. A developmental theorist would posit that those who exhibit suicidal behavior are developmentally stagnated or stuck. Therefore, adolescents who commit suicide have difficulty making the transition into the next developmental stage (Maris, 1981).

**Sociological Theories**
Emile Durkheim is the leading proponent of sociological theories of suicide. His theory is now described.

**Emile Durkheim.** Psychological and developmental theories examine the phenomenon through the lens of the individual. Sociological theories, in contrast, take into consideration the influence or role of society (including media, economics, class, politics and culture) as it relates to the phenomenon of suicide. Emile Durkheim (1858-1917) wrote *Le Suicide* in 1897 and his theory continues to gain attention in suicide literature. Durkheim was one of the first scientists to attempt to explain suicide through the use of statistics. Through his use of statistics, he believed suicide could be better explained through examining social phenomena or the integration of individuals into society, rather than studying psychological or biological components of the individual. Durkheim did not believe that suicide stems from within but rather suicidality is imposed or constructed within the context of society. Suicide is seen as the result of an imbalance between individuals and society (IOM, 2002). Through his research he developed four types of suicide, egoistic, altruistic, anomic and fatalistic.

Durkheim proposed that egoistic suicide happens when the person is not properly integrated into society or when people are poorly socially regulated. In contrast, altruistic suicide happens if the individual’s “social integration is too strong” (Durkheim, 1951, p. 217). Anomic suicide occurs when society has somehow eroded or societal order has disappeared such as during war or financial crashes. During periods of drastic change, society’s moral regulation has failed and Durkheim believed people commit suicide more frequently because of a sudden societal change. Lastly, fatalistic suicide is seen when part of the population is overly oppressed or constrained such as in slavery or imprisonment. People would prefer to die rather than live controlled or incarcerated. Durkheim also proposed that persons who are properly integrated into society will
be less likely to commit suicide (Durkheim, 1951). For example, persons who are Catholic, married and have strong family ties will be less likely to take their own life. This thread continues to arise in current research as described below (see protective factors). While Durkheim’s assertions seem to ignore individual behavior and other factors that play into personal behavior, there is still much to be learned by a sociological theory of suicide.

**Suicidologists.** Over the past 30 years, researchers have moved away from thinking about suicide from a singular psychoanalytical or sociological perspective and instead now view suicide through an interdisciplinary lens. Until recently, the positivistic paradigm has been the lens for how scientists view and research suicide. Suicide researchers have been concerned with the general and not the individual. But this approach has been questioned by modern day suicidologists such as Edwin Schneidman and Antoon Leenaars. As Leenaars (2002) asks “has any study about the general made us come closer to preventing Mary’s suicide?” (p. 1). The answer is a resounding “No” as the suicide rates have increased.

There has been a push in the suicide literature to begin looking at the problem from an idiographic approach. Even after the hard measurable facts are reported and the risk factors are clarified, there is still undoubtedly a portion of the phenomenon left unexplained. Topics such as suicide, that appear well researched and seemingly well understood but still leave many with the feeling that there is part of the phenomenon that remains a mystery, demands researchers approach the phenomenon with new and different ideas. The notion that suicide is truly dynamic and a “symptom that changes with the life story of the patient” (Gerisch, 2002, p. 44) shifts the way the phenomenon must be understood and studied. As Schneidman (1996), a modern suicidologist that spurred the direction of current research to turn towards the specific, reports so pointedly,
…our best route to understanding suicide is not through the study of the structure of the brain, nor the study of social statistics, nor the study of mental diseases but directly through the study of human emotions described in plain English, in the words of the suicidal person (p. 6).

Schneidman (1996) believes that key to understanding suicidality is through *lingua franca*, the everyday words used by those experiencing the phenomenon. Schneidman (1996) calls scientists to study suicide from the individual perspective and although he does not specifically call for phenomenology as the approach to study the phenomenon, the method appears to answer his call. Heideggerian hermeneutic phenomenology is a method that can uncover the meaning in phenomenon through interpreting the everyday words of those that experience it. Despite this call to look at suicide through a new and different lens, few researchers have chosen to research suicide in this way. The current proposal answers Schneidman’s call to study the suicide attempt experience from the words of the teenager.

Sociological, psychological and developmental theories contribute to our understanding of suicide. Briefly examining the concepts and ideas of each theorist across disciplines exemplifies the complexity of the topic. Exploring historical beliefs and theories about the topic is needed in order to move suicide research forward. However, not one, singular theory will sufficiently or adequately explain the phenomenon of suicide.

The purpose of this research study is to add to the body of knowledge with a more in-depth understanding of the suicidal adolescents’ experience. The suicidal adolescents’ experience in the ED is described through the everyday words of the participants and translated hermeneutically by the investigator. The intent is to shift the focus from the general to the
specific. It is only through the specific that we can come to a greater understanding of the phenomenon. As nurses, if we do not properly understand the patients experience we cannot properly and effectively treat our patients. The shared understanding of the experience, between the nurse and the patient, will lead to effective and meaningful nursing interventions.

Adolescent Suicide

Prevalence and Factors that Influence Suicide Prevalence

Concepts in suicidology. The terms in the suicidal literature can be overwhelming to keep straight as shown in Table 1. In many studies researchers conceptualize and operationalize terms differently, making for generalizing and comparing outcomes across studies difficult (Silverman, 2006). There is some debate in the literature about how to define the complex terms in suicidology such as, suicidal ideation and suicidal behavior. It would seem that the definition of the term suicide would be straight forward; however, this is not the case. Silverman (2006) reviewed the suicide literature and found a total of 15 different definitions of suicide. The definitions represent the different theoretical perspectives from psychology, sociology and other disciplines, as briefly reviewed at the beginning of Chapter 2. The definition of suicidal ideation is also not clear. Occasionally some researchers leave out the term death in the definition of suicidal ideation (O’Carroll et al., 1996) while other researchers include the term death, dead or wishes to kill oneself (Lewinsohn, Rohde & Seely, 1994). The questions regarding how to define terms related to suicide become important because researchers often use scales to measure the concepts and without operationalizing the terms it is difficult to know what is being measured. Standardized scales are the preferred method to measure the concept in most of the studies described in this chapter.
So confusing are the terms in the suicide literature that the topic has become a research focus. Yoder, Whitbeck and Hoyt (2008) were interested in determining whether thoughts of death and suicide form one construct or two distinct but related concepts. Through exploratory and confirmatory factor analysis they concluded that the two concepts did represent one overarching construct. The researchers highlight the need to examine the construct of suicide on a continuum. Thoughts of death are at the lower end of the suicidal continuum followed by suicidal ideation, suicide attempts and then completed suicide.

Miranda et al. (2008) compared multiple suicide attempters with single suicide attempters and ideators. The authors suggested that multiple attempters are different than single attempters in regards to their underlying psychopathology. The researchers interviewed teens at baseline and then 4-6 years later. Their findings were that the attempters that went on to become multiple attempters were different in a number of ways. First, multiple attempters report wishing to die more often, their attempts were timed so it was less likely to receive interventions, they regretted surviving and they most often had an anxiety disorder. The authors suggested that multiple attempters have an underlying problem such as a psychiatric diagnosis and in contrast, single attempters are attempting to resolve a crisis. Based on findings by Miranda et al. (2008), distinguishing multiple attempters from single attempters, screening for suicide becomes important for developing follow up referrals and treatment plans.

Gould, Shaffer and Greenberg (2003) reported that in general the psychiatric problems of suicide attempters are similar to those who complete suicide, however, suicide attempters are different in regards to their psychiatric problems than suicide ideators. This point highlights the problem of research in the suicide literature in regards to how the information is reported and collected. Suicidal behavior is most often self-reported and each self-reporter is self defining the
terms related to suicidal behavior. The Youth Risk Behavior Surveillance Survey is frequently cited in the suicide literature as the source of information regarding the suicidal behaviors for adolescents, such as suicide attempts (CDC, 2008). However, self-reporters could be defining the suicide attempt as a life-threatening intent to die or as a cry for help with no intention of dying (Silverman, 2006). The self-reporter is never asked what they actually mean by answering yes to questions about a history of suicide attempts.

The self-reporters are using different definitions as are the experts. Wagner, Wong and Jobes (2002) administered a vignette about an adolescent exhibiting self-harm behavior to 73 experts. The experts could not agree on whether the behavior could be classified as a suicide attempt. O’Carroll et al. (1996) believe that the term ‘suicide attempt’ is overused and misunderstood and conclude that “Because the term ‘attempted suicide’ potentially means so many different things, it runs the risk of meaning nothing at all” (p. 238).

The definitions of terms related to suicidal behavior are confusing and poorly defined. The poorly defined terms leads to difficulty in measuring the behavior which leads to a disadvantage for researchers as well as clinicians attempting to address the public health problem. The problem regarding standard nomenclature in suicidology is just one example of the complexity of the problem. Prevalence and factors that influence prevalence are also an example of the complexity of the problem.

**Overall statistics.** In the United States, suicide is the third leading cause of death among adolescents age 15-24 (National Institute for Mental Health [NIMH], 2007). Extensive research has been done regarding the prevalence, incidence, risk factors and various other descriptions of adolescent suicide; however, no research has led to a decrease in adolescent suicide. In fact, from 1950 to 1990, suicide rates for adolescents increased 300%. The largest increase since that
time was during the year of 2003-2004, a time when suicide rose nearly 14% (Morbidity & Mortality Weekly Report, 2007; NIMH, 2007). The Center for Disease Control and Prevention (CDC, 2008) questioned United States youth about risky behaviors through the Youth Risk Behavior Surveillance and reported that for the year 2007, 28% of youth thought about suicide and 6.9% attempted suicide. An objective of Healthy People 2010 is to reduce suicide attempts among adolescents (Office of Disease Prevention and Promotion, 2000), a goal that will not be met. Therefore, it is important that research on suicide continues.

The statistics on suicide are alarming but not well disseminated. The overall rate of completed suicide is 30,000 per year in the United States. In order to put this number in perspective, 58,000 service people lost their lives during the Vietnam War (1968-1973), during the same period, 220,000 US citizens suicided (IOM, 2002). Another alarming statistic is that the number of suicides out numbers homicides by a ratio of three to two, a ratio that has remained constant over the past 100 years (Minino & Smith, 2001).

**Age and gender.** Being female and reaching puberty increase teenagers risk for suicide attempts and risk for becoming depressed (Burt & Stein, 2002; Crowe et al., 2006). Depression in childhood is rare but after puberty is reached there is a steep rise in depression for both sexes (Steele & Dooey, 2007). However, in puberty the rate of depression doubles for females as compared to males (Costello et al., 2003). With this rise in the rate of depression, females have an increased rate of suicidal behavior but do not complete suicide as often as males.

Males have higher suicide rates than females in the US at a rate of 3 to 5 fold (World Health Organization [WHO], 2001). And for males, there is steep increase in suicide from the ages of 11-21, a fact that the literature has attempted to explain but to no avail (Conner & Goldston, 2006). Biological and developmental factors have been suggested as the reason for depression
and the suicide increase for the sexes in puberty but the research has not demonstrated this belief (Costello et al., 2003). Another suggestion as to the reason for the sharp rise in suicidal behavior in adolescence, is the idea that the concept of death does not develop until later in childhood (after age 12) so serious suicidal behavior could not happen until the concept is understood (Apter & Wasserman, 2003).

**Geographical location.** Suicide rates vary across the United States. The western states generally have higher suicide rates then the east coast states. Population density has been suggested as the factor behind the difference. Suicide rates are higher among rural areas as compared to densely populated cities (IOM, 2001). The difference in suicide rates across the country has been linked to issues regarding access to health care and the proportion of psychiatrists to the overall population (Tondo, Albert & Baldessarini, 2006).

**Culture.** The phenomenon of suicide must be examined from a cultural context as well. Race and ethnicity play a role in understanding suicide. When taking into consideration all age groups and both males and females, White and Native Americans have the highest rates of suicide (CDC, 2003). African American males aged 10-19 are the group in which suicide rates are increasing rapidly, whereas African American adolescent females have the lowest rates for completed suicide and have remained that way for some time (IOM, 2002). The rates across cultures do not correspond to the number of risk factors for each group. In China, women commit suicide just as often as men, whereas in other parts of the world, men are three times more likely to commit suicide (Joiner, 2005). Many have attempted to theorize the cause for this cultural suicide difference but the explanation is beyond the scope of this paper.

**Risk Factors**

**Depression.** Risk factors in suicide are perhaps the most widely researched area in the field
of suicidology. Health professionals suggest that if researchers could identify those teens at risk for suicide, the suicide rate could be decreased. The focus in research has been to identify the underlying psychopathology of teens exhibiting suicidal behavior. Major Depressive Disorder has been targeted as a common diagnosis in relation to suicide. Depression and suicide are obviously related, as suicide is potentially one of the criteria to meet the diagnosis of depression as outlined in the *Diagnostic and Statistical Manual IV-TR* (American Psychiatric Association [APA], 2000). According to Evans et al., (2005) and The American Academy of Pediatrics [AAP] (2007), 90% of suicide attempters have a mental health disorder such as depression. Chabrol, Rodgers and Rousseau (2007) also found that depression, and the intensity of that depression, is the major risk factor for suicidal behavior (ideation, attempts and completed). Beck and colleagues (1985), in their prospective 10-year study with a small sample of people (n= 14-16) admitted to the hospital for suicidal ideation, found that the degree of hopelessness predicted completed suicide. In fact, they suggest that hopelessness was more predictive of future completed suicide than depression.

**Anxiety.** In addition to depression as a risk factor for suicidal behavior, the presence of anxiety has also been implicated as a possible risk factor. The research suggested that anxiousness, uneasiness, or agitation is related to suicide (Busch, Fawcett & Jacobs, 2003; Haberman, 1977). However, most of the research related to suicide and anxiety has been in the context of studying mood disorders. Kessler et al. (2005) research suggested that anxiety disorders are more common in completed suicides than the presence of mood disorders, which is in direct contrast to the literature reported above regarding depression. Diefenbach, Woolley and Goethe (2009) differentiated between anxiety symptoms and anxiety disorders and considered depressive symptoms and diagnoses confounding variables. The researchers found that the
presence of anxiety symptoms increased the likelihood of reported suicidality 2-fold. Mental health disorders such as depression and anxiety often occur together, making the risk factor literature difficult to interpret and translate into practice.

**Self-concept.** The literature also examines the construct of self-concept. Self-concept is important to understand when discussing teen suicide. Self-esteem is self-evaluation. Low levels of self-esteem have been found to predict suicidal ideation and attempts (Groholt, Ekeberg, Wichstrom & Haldorsen, 2005; Lewinsohn et al., 1994). Other researchers have found that when one controls for depression then self-esteem is no longer predictive (Wagner, Rouleau & Joiner, 2000). Groholt et al. (2005) compared 65 suicidal and 390 non-suicidal adolescents with their measurement on the Global Self Esteem Scale. The researchers found that the suicidal adolescents had lower self esteem than the non-suicidal participants. However, depression was the main contributor to low self-esteem in the suicidal group. When dealing with such complex constructs as self-concept and depression, research does not identify a strict linear predictive relationship.

**External factors.** Firearms in the home are associated with higher risk for adolescent suicide (NIMH, 2007). Brent et al. (1999) found that loaded guns in the home increased the risk of suiciding by 30-fold. Guns in the home are the most important risk factor for the younger individuals. Sloan et al. (1990) researched gun control and found that when there were no laws about gun control, the suicide rates increased 10 fold.

There are other external factors that place youth at increased risk for suicide. Gould, Fisher, Parides, Flory and Shaffer (1996) found psychosocial factors such as being unemployed and out of school, places youth at risk for suicide. In addition, interpersonal and legal problems have also been found to increase ones risk of completing suicide. Thompson, Moody and Eggert (1994)
found that teens considering dropping out of school are a suicide vulnerable group. The researchers believe schools should identify teens at risk for dropping out and implement suicide prevention interventions. Research has not been completed regarding potential high school dropouts, however. Additional psychosocial risk factors for suicide include; history of abuse or neglect, death of parent, learning disorders, physical or emotional abuse, chaotic home environment, and substance abuse in the family, (Shugart & Lopez, 2000; Whetstone, Morrissey & Cummings, 2007).

**Alcohol and substance abuse.** Another significant risk factor for suicide among youth is alcohol and substance abuse. In fact, alcohol and drug use is sometimes cited as the reason for the increase in youth suicide (Rich, Young & Fowler, 1986), although other researchers believe this relationship is not that explicit (Neeleman & Farrell, 1997). King et al. (1993) examined 54 female adolescents and found that alcohol consumption and family dysfunction were the factors that predicted suicidal ideation and behavior. The abundance of researchers citing various risk factors as predictive of suicidal behavior, make it difficult for people working with teens to know what research to translate into practice.

**Family and friends.** Teenage years are often identified as stormy, moody and full of relationship conflicts (Dundon, 2006). Unfortunately, this identification goes beyond a stereotype. Teens with disrupted relationships are at risk for attempting and completing suicide. Conflicts with parents (family discord), parental divorce (family instability), or impaired parent-child relationships, place youth at risk as well as does the dissolution of a romantic relationship or arguments with friends (Beautrais, 2003; Gary, Baker & Grandbois, 2005; Gould et al., 2003; Weller et al., 2001). However, separating these relational conflicts from psychopathology is difficult. Youth who are depressed but have not attempted or completed suicide also report
disconnection from others and relationship problems as part of their depression (Hetherington & Stoppard, 2002). Depressed adolescents withdraw from friends and family as part of the disease, possibly leading to distressed parent-child communication. Less frequent and less satisfying communication between parents and suicide victims is cited as risk factors in the New York Study conducted by Gould and colleagues (1996). The presence or history of physical and sexual abuse also place youth at risk for suicidal behavior (AAP, 2007). Of course, abuse happening in the home could reasonably lead to family discord and instability.

Loss of a romantic relationship is a stressful life event associated with completed and attempted suicide (King et al., 2003). The dissolution of romantic relationships in adolescence is common. The literature does not address the question of why do some adolescents who experience a break up with significant others see suicidal behavior as a response while others do not. The literature on family and friends continues to be an important topic to research and will also be discussed in the protective factors section of this chapter.

Many factors place youth at risk for attempting and completing suicide but not all of the factors have been explored in this chapter. The purpose of this description of risk factors is to introduce the reader to the wide range of research that has been completed. Not one study has been able to describe a predictive linear relationship between risk factors and suicidal behavior. The amount of risk factors that a youth has does not correlate with the degree of suicidality. The abundant literature on risk factors related to exemplifies the point that suicide is a complex topic. Examining risk factors is useful and important for prevention programs but research on the topic should not stop here. It is not enough to identify risk factors, there is more to know about the phenomenon. Risk factors can produce a false sense of security, providing the perception that the topic is well understood, when in fact there is much more to learn.
A gap in knowledge in the current suicide literature regarding risk factors and prevalence of suicide in teens is the understanding of what a suicide attempt means to teens that experience the phenomenon. Interviewing teens about their suicide attempt experience, including the context surrounding the experience, begins to fill the gap in knowledge. Researchers cannot continue to measure a concept that is reportedly so ill-defined, complex and multifaceted and expect to expand the state-of-the-science.

**Protective Factors**

**External protective factors.** Risk factors are identified in the literature; however, there is a gap in knowledge regarding factors that protect against suicide. Research has been unable to clearly identify protective factors for adolescents (Steele & Doey, 2007). Perhaps the most impressive finding in the protective factor literature is regarding connections with others. This external protective factor is identified in the research as “perceived connectedness” and family closeness or cohesiveness (Halle-Lande et al., 2007; Portner, 2001; Ackard, Neumark-Sztainer, Story & Perry, 2007).

One of the strongest protective influences was a feeling of connection with family, particularly against suicide attempts in socially isolated adolescent; whenever family connectedness was included in the model, the relationship between suicide attempts and social isolation was no longer significant in either boys or girls (Hall-Lande et al., 2007, p. 285). Connection to school or other institutions (church) are considered protective factors. In addition, social skills related to decision making and problem solving may also be protection against developing depression and attempting suicide (Evans et al., 2005).
**Internal protective factors.** Researchers have also studied internal protective factors such as personality traits as possible protection against suicidal behavior. In a study with college aged students, Hirsch, Conner and Duberstein (2007) measured optimism using the Life Orientation Test and suicidal ideation was assessed using the Beck Scale for Suicide Ideation. Using multivariate regression, the researchers found optimism to be inversely related to suicidal ideation. The researchers suggest that promoting “positive future orientation” may be valuable for suicide prevention efforts. However, considering that optimism is identified as a personality trait, promoting widespread education about keeping a positive outlook toward the future would seem difficult to implement.

**Instruments.** Few instruments measuring positive protective factors related to suicide are available. In fact, 95% of the suicide instruments assess risk factors (Goldston, 2000). Over the past 25 years, researchers have attempted to create instruments measuring strengths and protective factors but the instruments have not progressed and the usefulness of such instruments in practice has not been researched. In 1983, Linehan and colleagues developed the Reasons for Living Inventory. The instrument was adapted for adolescents by Osman et al. (1998) and ultimately resulted in adding the concept of resilience to the inventory in 2004 which was called the Suicide Resilience Inventory (*SRI*-25). The concept of resilience is a complex construct that has been researched for decades and continues to arise in the suicide literature. The question of when to administer such resilience instruments is questionable and the usefulness of a single instrument to prevent or intervene in adolescent suicidal behavior is not supported (Rutter, Freedenthal & Osman, 2008).

Whether studying internal protective factors, external protective factors or resilience in adolescence, research highlights the fact that the topic is complex and difficult to research.
Researching protective factors should continue and does add useful information to the scientific body of knowledge. Identifying strengths and factors that keep people alive is helpful. Understanding the many concepts or parts that contribute to the phenomenon of teen suicide is most effective when examined in perspective of the whole experience.

**Prevention and Intervention**

**Primary prevention programs.** The development of programs to prevent suicide is the intended outcome for the majority of completed research, however, few programs exist to prevent teen suicide, and the programs that are in place have lacked evidence regarding their effectiveness. Little research has been done on what strategies work to prevent teen suicide.

**Crisis and community based programs.** Primary prevention programs are aimed at preventing people from attempting and completing suicide. Primary prevention programs to reduce suicide are mainly public education and awareness messages or campaigns aimed at people in the community but such messages can also be school based. Crisis lines or other resources available for suicidal teens reaching out for help are also considered primary prevention strategies. However, evidence is lacking about the effectiveness of crisis lines and community based prevention programs (Gould, Greenberg, Velting & Shaffer, 2003). The community programs and education campaigns have not been evaluated as to their effectiveness in reducing suicide (Mann et al., 2005). Eggert, Thompson, Randell and Pike (2002) found that brief school based interventions are successful at decreasing depression and suicide but the research is in need of replication. In fact, Mann et al. (2005) reported that none of the research reviewed in their systematic research review regarding school based intervention programs aimed at decreasing suicide were shown to be effective. The programs were helpful at increasing self-esteem, increasing problem solving abilities and improving education and awareness.
Regarding the phenomenon but not at decreased suicides (Mann et al., 2005).

**Educational training for health professionals.** Educational training programs aimed at health professionals are also part of primary prevention strategies. The majority of people who complete suicide have visited a health care provider in the previous month of their suicide (Luoma, Martin & Pearson, 2002); therefore, it is logical to target healthcare providers to intervene and watch for warning signs of mental health disorders. Because depression is a common risk factor for suicidal behavior, educating providers about screening for depression is important. Educational training programs for health professionals’ increase the chances of professionals asking young people about suicidal ideation but repeated interventions are needed to maintain this (Rey, Grayson, Mojarrad & Walter, 2001). Interestingly, Mann and colleagues (2005) reported in their systematic review of the suicide prevention literature, that educating physicians about depression recognition and treatment decreases suicide rates. The researchers believe that this education increases the use of prescriptions to treat depression and this “represents the most striking known example of a therapeutic intervention lowering suicide rates” (Mann et al., 2005, p. 2067). However, the authors do call for continued research in regards to the understanding the relationship between antidepressants and suicidal behavior in adolescents, particularly in light of the FDA black box warning on antidepressants for persons under the age of 24 years.

**Secondary prevention.** Secondary prevention is aimed at preventing those that have attempted suicide from going on to complete suicide. Emergency departments (ED) have been called the gateway to the community and the location can serve as a possible link in the suicide prevention field. Unfortunately, this gateway has not been adequately studied in the adolescent suicide context.
Adolescent Suicide Attempts and the ED

Approximately 650,000 people visit the ED annually after a suicide attempt in the US (Public Health Service [PHS], 2001). According to Olfson et al. (2005), the annual rate for 15-19 year olds who visit the ED for a suicide attempt is 341.8 per 100,000. Olsen et al. date also identify that the most common method reported for those adolescents attempting suicide is poisoning (67.2%). Identifying people who deliberately harm themselves is important because research suggests that deliberate self-harm is a risk factor for subsequent suicide (Olfson et al., 2005) and ED visits for suicide attempts or deliberate self-harm are positive predictors of future completed suicides (Doshl et al., 2005).

ED treatment and follow up. Researchers report that mental health follow up after a suicide attempt can reduce the rate of future attempts, which should exemplify the need for identifying appropriate intervention and prevention strategies in the ED. However, little research has been done on follow up after an ED visit. Rotheram et al. (2000) developed an emergency room intervention targeting female suicide attempters. The intervention consisted of an educational video highlighting the need for follow up, a family therapy session and staff training. The researchers concluded that the specialized emergency room intervention lowered depression scores for those suicide attempters. In addition, the mothers of suicide attempters were emotionally less distressed and, interestingly, were impacted more than the suicide attempters. Rotheram et al. did not report an impact on reducing the suicide rate but did report that the patients that received the intervention attended more outpatient therapy visits. Improving follow up after an ED visit for suicide attempts is critical, and this study highlights the need to replicate the ED intervention in other hospitals. As with other research, translating findings into practice is a gap that needs to be addressed in nursing science.
While Rotheram et al. (2000) identified an intervention that was successful in improving follow up for their sample, the literature suggests that implementing interventions is not that easy in other hospitals or locations. In order to create appropriate suicide prevention programs in the ED, current ED practices across the country need to be identified. Baraff, Janowicz and Asarnow (2006) surveyed providers in California ED’s and found that 23% of the ED providers send patients with suicidal ideation home without a mental health evaluation. Fifty percent of the respondents do not have personnel trained to provide psychiatric/mental health evaluations in the ED and the majority of those responding to the survey report that they would like improved access to mental health personnel for evaluation and for patient disposition.

Baraff, Janowicz and Asarnow (2006) highlighted the lack of adequate resources available to appropriately treat suicidal behavior in the ED. There are little resources allocated by states and the federal government to properly treat psychiatric emergencies. For example, psychiatric emergency room visits increased by 150% over the past 13 years (Bruffaerts, Sabbe & Demyttenaere, 2005). The increase in ED visits could possibly be related to mental health programs being cut and less psychiatrists available to treat the mentally ill (Larkin, Claassen, Emond, Pelletier & Camargo, 2005). As mentioned previously, the lack of psychiatrists in proportion to the population is a problem impacting mental health treatment availability (Tondo et al., 2006).

What is happening after adolescents visit the emergency room visit for mental health reasons? Hulten et al. (2000) reported that in nine European countries most adolescents did not receive follow up recommendations after an emergency room visit for suicide attempts if the attempt was a first attempt and if the chosen method of attempted suicide was self-poisoning. Adolescents who choose more violent methods and had previously attempted suicide were more likely to
receive a follow up referral to mental health providers. According to Olfsen et al. (2005), the United States does not have equivalent data to report due to the lack of research regarding ED referral and follow up after a suicide attempt.

Patients seeking care for mental health problems in the ED are viewed by health care providers as consuming the providers time, taxing the department staff, reducing resources needed for other emergencies and result in ambulance diversions because of boarding psychiatric patients in the ED (Baraff, Janowicz & Asarnow, 2006). Most serious suicide attempts are seen and treated in the ED but the actual numbers of those being seen compared to the overall ED patient visits is relatively low (one percent of ED visits are for suicide attempts and self inflicted injury).

Perhaps because of this perspective that persons being seen in the ED for suicidal behavior are taxing to the staff, the care that psychiatric ED patients receive is poor (Baraff et al., 2006; Doshl et al., 2005; Rotheram-Borus, Piacentini, & Roosem, 1996; Spirito, Valeri, Boergers & Donaldson, 2003). The intended outcome for depression and suicide research is ultimately to prevent and reduce the rates for each of the problems, an outcome current prevention programs have not demonstrated.

Summary

The literature on adolescent suicide is abundant and paints a complex picture of the phenomenon. Research about the incidence, prevalence, risk factors, protective factors and prevention programs in regards to teen suicide are all very important topics to understand. Research should continue in all of those areas. However, a fundamental question remains unanswered in the literature. The unanswered question surrounds the meaning of being a suicidal teen. This question needs to be addressed so that health care providers can develop interventions
that work to reduce suicide attempts in teens. Exploring the phenomenon from the ontological perspective of phenomenology can advance the scientific and clinical understanding of suicidal adolescents’ experiences in the ED. A deeper understanding of the complexity of the experience through the stories of those who live it is warranted. When examining issues of meaning in experience, the structure of the phenomenon as well as the thoughts and feelings that surround the event emerged, thus providing a new understanding of the suicide attempt.

The purpose of this research was to fully describe and interpret the phenomenon of attempted suicide using a Heideggerian hermeneutic methodological approach in a sample of teens who visit an ED for a suicide attempt. The specific aims of this research project were to generate a comprehensive interpretation of (a) the experiences of adolescents who attempt suicide and are admitted to the ED and (b) the meaning of being suicidal as an adolescent. The purpose of this study was to fully describe and interpret the phenomenon of teen attempted suicide which adds to the body of knowledge that will help reduce teen suicide and expands understanding of the concept of suicide within a healthcare context as experienced by teens.
CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

Methodology

The positivistic scientific approach cannot fully answer all research questions. There are questions asked that demand a different empirical approach to broaden and deepen the understanding of nursing phenomena. Phenomenology, as an approach that uncovers the meaning of phenomena, was chosen to answer the research question related to adolescent suicide. The branch of phenomenology that was chosen for this study due to the consistencies and congruency with my own philosophical beliefs was Heideggerian hermeneutic phenomenology. The interpretive methodological approach of Heideggerian hermeneutics was used to answer the research question, “What are the experiences of suicidal adolescents who visit the ED after a suicide attempt?”

Phenomenology can be described as a method of “inquiry into human meaning” (van Manen, 2002). It is a fitting method to uncover previously overlooked or otherwise hidden aspects of a phenomenon (Diekelmann & Ironside, 1998). The purpose of choosing phenomenology and hermeneutic interpretation, in general and for the purposes of this study, was to achieve a deep understanding of a phenomenon as it occurs in the world (Fleming, 2002). Because there are many different branches of phenomenology, understanding the philosophical underpinnings of the methodology are important so that the method can be rigorously applied to research. Therefore, a brief history and philosophical background of phenomenology will be provided. Then, an introduction of Heidegger’s philosophical beliefs and an explanation of how hermeneutics fits into the method will be described.
History and Philosophical Background of Phenomenology

The history of phenomenology dates back to Franz von Brentano in the 1800’s whose ontological and epistemological beliefs regarding internal and external perception forged the phenomenological path. He believed internal perception is true and exists, external perception cannot be proven (Cerbone, 2006). This philosophy stems from the Cartesian school of philosophy and exemplifies the philosophical argument that still continues today regarding distinctions between the mind and body. Edmund Husserl was a student of von Brentano and is considered the father of phenomenology. However, Husserl’s influences are based in the Cartesian philosophy. Husserl was concerned with describing the meaning of the lived experience and understanding how we know what we know. Husserl approached the study of phenomena through an epistemological perspective by recognizing personal experience as the grounds for knowing (Mackey, 2004).

Husserl’s phenomenology is sometime called descriptive phenomenology. Three important terms used in the descriptive phenomenology literature are Epoche, reduction proper and bracketing. Although the terms are used frequently in the literature, they are often not well defined. The terms are important concepts to understand when discussing, describing and comparing descriptive phenomenology to other types of phenomenology, particularly Heideggerian hermeneutics. The three terms are techniques or moments in the process of phenomenological reductionism. Epoche is a Greek term that describes the theoretical moment that all belief in the existence of the real world is suspended (Cogan, 2006), essentially coming to the moment where all preconceived ideas are eliminated. Husserl asserts humans are held captive by all they take for granted including language, culture and what we know. Epoche is the
moment when we no longer accept this captivity, “we free ourselves from the unquestioned acceptance of the everyday world” (Cogan, 2006, Section 5, para 6). Reduction proper is the other component of phenomenological reductionism referring to the moment we realize that our acceptance of the world is actually relative.

The third important term related to descriptive phenomenology is bracketing. Bracketing is directly related to the idea of Epoche. Bracketing is a technique used in descriptive phenomenology whereby the researcher suspends all judgments and assumptions about the phenomenon of interest or research question (Koch, 1995). The three terms described, as related to the reduction, are points of disagreement among phenomenologists that followed Husserl, such as Martin Heidegger.

**Heideggerian Hermeneutics**

Just as all philosophies change and grow with each scientist’s input and perspective, so did phenomenology. Husserl’s idea of phenomenological reductionism was the departure point for Martin Heidegger (Cerbone, 2006). Heidegger believed that in order to understand the meaning of experience, scientists should not erase the context of the individual, including the cultural, political and sociological context. He believed that researchers bring their own pre-understanding to the table of understanding, which adds to the meaning of being; this is movement away from Husserl’s beliefs about suspending all pre-conceived ideas or judgments. Heidegger proposed that phenomenologists cannot strip away everything from the subject leaving just the experience; the world as context is important. Heidegger also believed that the technique of bracketing was not essential to interpreting and understanding a person’s experience in the world. Heidegger believed the fore-structure or background of the researcher will
influence the understanding and interpretation of the narrative but this should be part of the
process, not set aside as Husserl suggested (Geanellos, 1998). Dasein (Heidegger, 1962), defined
as “being in the world,” is the experience Heideggerian phenomenologists are hoping to
understand. Instead of Husserl’s epistemological perspective (i.e., what it is to know), Heidegger
shifted the philosophical question in phenomenology to what it is to be Dasein an ontological
perspective. Some critics report that this shift is the most important differentiation between the
two phenomenology camps and many weaknesses surrounding nursing phenomenological
research stem from misunderstanding this important point (Koch, 1995). Because Heidegger was
attempting to understand the meaning of being and the everydayness associated with being
human, the concept of hermeneutics, although not specifically defined by Heidegger, is linked
with the method. Heidegger asserted that we can only come to understand what it means “to be,”
through language. With language comes interpretation. Without language there can be no
understanding. As humans, we interpret what is said or written through the lens of our pre-
understanding, and the result is a new and deeper understanding. Hermeneutics represents this
interpretation.

The term hermeneutics in the description of the method and methodology signifies to the
reader the branch of phenomenology being used. Hermeneutics is the term used for interpreting
the written word, originally used with interpreting the words of the Bible. In phenomenology,
interpretation comes from the transcript of narrative data and from the written text of the
researcher. As Benner (1994) stated, “the interpreter seeks to give greater access and
understanding of the text in its own terms” (p 101).

Hermeneutics in phenomenology means something beyond just interpreting text, however.
The translation of the word hermeneutics has occurred throughout history. As is the case with all
translations, we should understand from where the root of the word originates. This starting point will lead to greater understanding of how hermeneutics is being used in interpretive phenomenology today. Hermeneutic roots come from the Greek verb *hermeneuin* “to interpret” and the noun *hermeneia* “interpretation” (Palmer, 1969). Hermeneutics is the “process of bringing to understanding especially as this process involves language, since language is the medium par excellence in the process” (Palmer, 1969, p. 13).

Palmer discusses how, from ancient times, the meaning of hermeneutics has sprouted into three different directions: to express, to explain and to translate. Explanatory interpretation and translational interpretation are important concepts to understand when discussing hermeneutics in interpretive phenomenology. Context plays a role in explanatory interpretation. There is no understanding without context. Events or phenomenon have no meaning if taken out of context. Understanding happens only when we take into consideration what is already understood or taken for granted. Thus enters the concept of pre-understanding. Heidegger uses the terms fore-structure, fore-having, fore-sight and fore-conception (Diekelmann & Ironside, 1998). These are terms used to explain the many ways people come to understand or interpret phenomena. The Heideggerian terms underlie the complex structure of understanding. The many facets of understanding combine with the situation attempting to be interpreted. This combination is called the hermeneutical circle. We interpret through language, oral or written language. The meaning of hermeneutics can also be translational, which is most likely what lay persons believe the term to mean. However, explanatory interpretation and translational interpretation are not really separate. “There are always two worlds, the world of the text and that of the reader” (Palmer, 1969, p. 31); therefore, there will always be a need to translate. When these worlds collide the result is interpretation, translation, explanation: the hermeneutic circle.
The hermeneutic circle is an idea laced throughout the literature in phenomenology and refers to an interpretive process. Without the hermeneutic circle there can be no understanding of phenomena. The hermeneutic circle directly relates to Heidegger’s concept that the researcher brings their assumptions and experiences to the table of understanding experiences and co-creates meaning with the persons attempting to be understood (Dowling, 2004). “Understanding will appear through the fusion of the horizons of participants. Horizon is the field of vision which includes and comprises everything that can be seen from one perspective “(Fleming, 2002, p. ). Understanding can never be achieved completely (Gadamer, 1982; 2001). Understanding is transient because we are always conversing and with every conversation our understanding changes. We cannot study phenomena without taking into consideration our pre-understanding. The meaning surrounding phenomena cannot be illuminated without first interpreting the phenomena and this is done through the lens of pre-understanding.

In summary, interpretive phenomenology reveals, illuminates or explicates hidden meanings in phenomena. Researchers can reveal these hidden meanings using various phenomenological methods depending on the question being asked and the philosophical stance of the researcher. I have chosen Heideggerian hermeneutic phenomenology because this philosophy and research approach fits my research question and resonates with me. The narrative texts were interpreted using a way of thinking and a process informed by philosophical hermeneutics. Heideggerian hermeneutic phenomenology is a methodological approach appropriate to study issues relevant to nurses. As described above, this branch of phenomenology is used when attempting to understand human experiences. Understanding and being involved with human experience is uniquely describes the nursing profession and explains why nurse researchers have gravitated towards the method.
Evolution of Heideggerian Hermeneutics in Nursing

Since the 1980’s, phenomenology has been incorporated into nursing research. Nurse researchers have used the method to study a wide array of topics. Not only have nurses used the method to study nursing topics relevant to the field but nurses have also incorporated the philosophical underpinnings into education through the development of pedagogies as well as attempting to understand how nurses practice nursing. Following is a brief description of the many nurse researchers whom have incorporated phenomenology into their role as researcher, educator and practitioner.

The nurse scientist who forged the path was Patricia Benner. Benner (1985) began using phenomenology in an attempt to understand the movement from novice to expert in nursing. In her book, *Interpretive Phenomenology* (Benner, 1994), she laid multiple interpretive research studies alongside each other. The topics covered by interpretive phenomenologists deal with a range of phenomena beginning with everyday phenomena to concepts difficult to define. Phenomenology has been used in the nursing field not only to understand the meaning of experiences but also as a philosophy or approach to educate nurses.

Nancy Diekelmann supports the use of narrative pedagogy in nursing education. Narrative pedagogy is a method of teaching that emerged from interpretive phenomenology. Pedagogy can be defined as the “art, practice or science of teaching” (Merriam-Webster On-line dictionary, 2009). Diekelmann (2001) conducted a 12-year study researching the lived experiences of students, teachers and clinicians. Through the texts of the interviews from the participants, she identified the Concernful Practices of Schooling Learning Teaching, she named this new pedagogy Narrative Pedagogy. Reforming nursing education has become interpretive phenomenology’s place in nursing.
Pam Ironside, a student of Diekelmann’s, researched narrative pedagogy using hermeneutics. For example, in her study about nursing educators using new pedagogies, she used Heideggerian hermeneutics to understand how nursing educators move beyond teaching memorization and move into teaching students how to think (Ironside, 2005). In addition, she also explores the students’ experiences in courses in which the educators use narrative pedagogy (Ironside, 2006).

Other nurse researchers well known in the field of nursing for interpretive research include scholars such as Darbyshire, Dickerson, Vandermause and Smythe. These interpretive researchers provide a wide range of research topics but also present threads of commonalities.

Darbyshire (2005, 2001) has researched a wide range of children’s issues using interpretive phenomenology. The issues range from how children live with a gambling parent (Darbyshire, Oster & Carrig, 2001), to understanding the perceptions of homeless adolescents with mental health problems (Darbyshire, Muir-Cochrane, Fereday, Jureidini & Drummond, 2006). In addition, during his career as an interpretive researcher, his writings have addressed the quality of qualitative research (Darbyshire, 1997; Thorne & Darbyshire, 2005) and, with Diekelmann, defended the method against critics (Darbyshire, Diekelmann & Diekelmann, 1999).

Using Heideggerian hermeneutics, Dickerson has researched women’s experiences after being diagnosed with breast cancer (Boehmke & Dickerson, 2006). Dickerson has also researched the experiences of patients who use continuous positive airway pressure (CPAP) devices (Dickerson & Kennedy, 2006). In addition, she has studied the everyday meanings of how people with an implantable cardiac defibrillator seek help in a support group (Dickerson, Posluszny & Kennedy, 2000). Dickerson appears to have a wide variety of research interests but is able to use interpretive research to examine all her topics of interest.

Vandermause (2005, 2007) used interpretive phenomenological research to study the
experience of nurse practitioners and their identification of alcohol use disorders in women. In addition, she has written about how health care providers question women on their alcohol use. Vandermause (2008), in her article about the poiesis of the question, educated readers about the importance of understanding how questions are generated, what influences the formation of the question and how questions are posed. She brought to light the issue of questioning in research and in practice. Vandermause (2011) also addressed the question, “What does it mean to experience methamphetamine addiction,” using hermeneutics to interpret while generating a transmethodological approach to examine the issue.

Zinsli and Smythe (2009) analyzed the differences (and sameness) in the experience of what it means to be a humanitarian nurse working internationally using the method of Heideggerian phenomenology. Smythe has also attempted to educate nurse researchers about qualitative research (Smythe & Giddings, 2007). With Ironside and others, Smythe wrote about the experience of “doing” Heideggerian hermeneutic research and the process of the method (Smythe, Ironside, Sims, Swenson & Spence, 2007). In addition, using Heideggerian phenomenology she wrote quite poetically about violence in healthcare (2002), an understanding of practice not often considered in the focused attention to protocols of care.

A common thread throughout the interpretive literature is that nursing scientists are researching topics ranging from the very specific to the general and including poorly understood topics, sensitive topics and topics perhaps not suited using traditional lines of inquiry. Another common and pertinent thread is that the cited nurse researchers all educate nurse researchers and scientists about the method and approach of interpretive phenomenology, offering a new way of thinking about familiar topics.
Design and Methodological Limitations of Prior Suicide Research

Suicide, a sensitive topic with deadly consequences is a fairly rare event and thus difficult to study quantitatively. The number of participants needed to power a quantitative study is often difficult to obtain. Moreover, researchers often enroll participants of all ages and mix people who have suicidal ideation with actual suicide attempters in order to better understand suicide; however, this only confounds our understanding of the continuum of suicidal behavior by assuming that all the experiences encompassing the phenomenon are the same. To address some of the methodological limitations of prior research, this study enrolled only teenagers who actually attempted suicide and used case-intensive interviews as the single method of inquiry.

There are ethical issues regarding quantitative studies of attempted suicide. Questioning teens through the use of standardized tools about their emotional distress surrounding their suicide attempt without personally talking and listening to their story creates an ethical dilemma for this researcher. In addition, the current plethora of quantitative studies using a positivistic framework has failed to further the state-of-the-science, leaving the phenomenon of teenage suicide conceptually unelaborated. Heideggerian hermeneutics offers another empirical method to advance the state-of-the-science further. Gadamer (1976) wrote, “There is always a world already interpreted, already organized in its basic relations, into which experience steps as something new” (p. 15).

Research Design

The study used a qualitative, descriptive, cross-sectional design that employed face-to-face interviews and a Heideggerian hermeneutic methodological approach. A single interview was conducted to collect narrative data from six adolescents who visited an ED following a suicide
attempt. The purpose of choosing phenomenology or hermeneutic interpretation is to achieve a deep understanding of a phenomenon (Fleming, 2002) in order to help those confronting a phenomenon to better understand its relevance. Phenomenology was chosen as the method to solicit the stories of teens that attempt suicide and subsequently visit the ED. Attempting suicide is a unique experience and a sensitive topic both for those living the experience and for the health care providers who seek to help the person who attempts to end their life. An explication of some of the design and methodological limitations of prior research on suicide is now provided.

Sample and Sampling Plan

Recruitment and selection. The research participants were identified through the use of purposeful or snowball sampling. Six participants ranging in age from 15-19 were recruited over an 18 month time period. A hospital in northern Idaho (hospital A) was specifically targeted for recruitment based on the number of teens admitted through the ED for suicide attempts (n= 3). After one year of recruiting at this site, another hospital in central Washington (hospital B) was added for recruitment in order to gain further participants (n= 3). The second hospital was chosen based on geographical location.

The purposeful sampling employed the following inclusion criteria: adolescents 15-19 years of age, English speaking, male and female, all ethnic and racial groups, attempted suicide one or more times within the preceding six months, and admitted to the ED for their attempt. This age group was specified because researchers found that teens aged 15-19 years old visit the ED more often for suicide attempts than other adolescents (Doshl et al., 2005). The exclusion criteria included teens not deemed emotionally stable either during the inpatient stay or after discharge as determined by their mental health providers. In addition, teens diagnosed with a psychotic
disorder or other cognitive disorder that would make interviewing difficult, were excluded.

Low recruitment was a barrier encountered with this study. Numerous reasons for this are probable and include: geographical distance between the researcher and the hospital, change of staff at the hospital and the fact that the researcher relied on others to deem whether participants met the inclusion criteria.

**Data Collection**

Data was collected using face-to-face interviews. The interviews ranged from 45-75 minutes in length. Each participant was interviewed once. The time between the interview and the participants’ suicide attempts ranged from 5 days to 6 months. The interviews were digitally recorded and then transcribed verbatim by a research transcriptionist educated in research ethics and in hermeneutic transcription. The participants assigned themselves a pseudonym to maintain confidentiality. All identifying words, names and locations were removed from the transcription by the transcriptionist.

**Interview.** The setting for the interview for inpatient participants was a room identified by staff as comfortable and private. For participants interviewed after being discharged, the setting was an office used by the researcher. A conversational strategy, open ended and unstructured was used for the interviews. A conversational strategy is an unstructured approach that allows “maximum flexibility to pursue information in whatever direction appears to be appropriate depending on what emerges” (Patton, 2002, p. 342). This is an appropriate approach when using Heideggerian hermeneutics. The trained qualitative interviewer can expertly explore other pertinent areas of interest as they become clear during the course of the interview. Kral, Burkhardt and Kidd (2002), in their study on youth suicide with Canadian street youth found that
asking fewer questions resulted in more information and allowed the teen participants some control over the direction of the interview.

The critical incident question (Benner, 1994; Wertz, 2011) in this study was “Was there something from your story that stands out for you?” The interview began with an opening statement explaining the study to the teen and then a question was asked, “Tell me about your experience?” Next came a series of potential prompts followed by prompts: “Tell me more about?” “What was that like?” And, “Can you give me an example?” (See Appendix A). The participants were prompted to describe the situation that surrounded the experience, prior to going to the ED, during and after. They were also prompted to relay their thoughts and feelings in regard to the experience. The participant’s story and experience was evident and the conversational, unstructured interview allowed the experience to emerge. Further questions depended on the direction the adolescent took during the interview such as, “Can you tell me what was going on prior to the event?” “What was it like for you in the emergency department?” “What did you find helpful?” “What was not helpful?” “What would you want the emergency department staff to know?” And, “What do you want people to know about your story?”

**Procedure.** The research project was presented to both hospital ED providers and other staff responsible for admission and psychiatric evaluation of the teens. Flyers describing the study were given to the health care providers at each hospital and posted in the ED. The recruitment procedure was as follows:

- In hospital A, the case-manager approached the teens and family about the possibility of participating and asked for contact information from the family. The family was then contacted by the researcher immediately, while the teen was still a patient in the psychiatric unit
• In hospital B, the psychiatric provider who assessed the teen in the ED asked the potential participant and their family permission to be contacted by the researcher. The participants recruited from hospital B were interviewed while receiving outpatient treatment after their suicide attempt.

• The researcher contacted the parent or the teen and arranged for a time to meet so that the consent could be reviewed and signed.

• Consent forms were signed prior to having assent forms signed and prior to the interview being conducted (See Appendix D, E and F).

• Written consent was obtained for teens 18 and 19 years of age. For teens less than 18 years of age, written consent was obtained from parents first and then written assent obtained from the teens.

• The first interview was conducted within 1-5 days after initial contact.

Data Analysis

There are varying processes by which interpretive phenomenologists analyze data depending on the specific type of phenomenology being used. For my purposes, I have chosen the analytical techniques described by Diekelmann, Allen and Tanner (1989). The process is based on Heideggerian philosophy and is an appropriate analysis when using the interpretive hermeneutic approach. The process usually involves a team of researchers so as to address the issue of validity, discussed in detail below. However, for the purpose of the dissertation, the chair of the committee and other doctoral students studying qualitative research acted as team
members for data analysis (See Appendix C). Following are the data analysis steps outlined by Diekelmann, Allen and Tanner (1989):

(a) The interviews were read for an overall understanding

(b) Each team member wrote interpretive summaries and identified emerging themes

(c) Selected transcripts were analyzed as a team to identify themes

(d) Relational themes were identified

(e) Texts were compared and contrasted in order to identify shared practice and common meanings

(f) Patterns were identified that linked the themes, and

(g) Responses and suggestions were elicited on a final draft from the interpretive team.

The goal of the analysis was to identify the meaning from the input, experience and understanding of all researchers analyzing the data (example of the hermeneutic circle) in addition to the interviews. The process of interpretation became part of the data analysis. The meaning of the human experience of attempting suicide came from the multi-layered data collected. The multi-layered data or text included, (a) a research log kept by this researcher, (b) the interview texts and (c) the written interpretations. In combination, the layers symbolize or are a metaphor for the phenomenon of interest (Cohen et al., 2000). Writing and rewriting summaries of the interview shape the interpretation process (Crist & Tanner, 2003). Writing and rewriting was a reflective process of the researcher and required moving back and forth between the text, the interpretation and the overall picture. Gadamer (1976) used the term “fusion of
horizons” to signify this movement of understanding. To start the process, team members read the text carefully, and noted pertinent concepts. Team members then wrote a 3-5 page summary of the interview, also called data reduction or data transformation (Cohen et al., 2000). As the process continued, the whole transcript was used less in the interpretive process. The findings are presented as patterns and themes and were recognized across informants, interviews and texts. Results were also presented as exemplars which are defined as “bits of textual data in the language of the informant that capture essential meanings of themes” (Cohen et al., 2000, p. 80). Understanding evolves as the researchers go beyond the literal meaning of the words to obtain the thematic meanings (Mackey, 2005). It is important to note regarding the steps outlined above that the analysis of data was a continuous, simultaneous, non-linear process as relayed by Crist and Tanner (2003). Included in Appendix B is a more detailed data analysis outline (Vandermause 2011). Vandermause’s (2011) Heideggerian hermeneutic approach expands on the seven steps of data analysis by Diekelmann, Allen and Tanner (1989). The systematic approach to data interpretation outlined in Appendix B guided this research during the data analysis process.

The data analysis occurred over approximately 18 months as interviews were completed and transcribed. The research team met bimonthly. During these meetings, team members brought their interpretations. In between these meetings the researcher analyzed each team member’s writings and reinterpreted the findings. Therefore, the final analysis was a culmination of multilayered text. There was a consensual recognition of repeating ideas among team members.

Because of the large amount of data generated through hermeneutic analysis, a software system should be used to manage the data. Microsoft folders and subfolders were used to manage
the data for this research study.

**Evaluation and Trustworthiness**

> Whatever the subjective role in interpretation may be, the object remains object and an objectively valid interpretation of it can reasonably be strived for and accomplished. An object speaks and can be heard rightly or wrongly precisely because there is an objectively verifiable meaning in the object. If the object is not other than its observer and if it does not of itself speak, why listen? (Palmer, 1969, p. 56)

Establishing validity criteria in qualitative research is a complex topic. Validity in regards to qualitative research differs from quantitative research because of the subjective nature of the work. Interpretive research addresses the subjectivity and contextual life experiences rather than the generalizable objective concerns with which quantitative research is concerned. The evaluation criteria chosen for this study was the primary criteria outlined by Whittemore, Chase and Mandle (2001). They developed four primary qualitative evaluation criteria and six secondary criteria from a synthesis of the literature on trustworthiness and evaluation in qualitative research. Lincoln and Guba’s (1985) criteria for validity are sometimes called the gold standard (credibility, dependability, confirmability and transferability). However, Whittemore et al. (2001) wrote that despite the work by Lincoln and Guba, tension continues in the scientific world regarding what validity means in regards to qualitative work. The tension points toward the possibility that it is time for validity in qualitative research to be re-conceptualized or time for researchers to use different language. Whittemore and colleagues (2001) did re-conceptualize the concept of validity and their synthesis resulted in the primary and secondary criteria described below. Other researchers have also attempted to re-conceptualize
rigor and proposed further frameworks for evaluation (De Witt & Ploeg, 2006) but Whittemore et al.’s (2001) re-conceptualization is thorough and appropriate for this study. All four primary criteria and three of the six secondary criteria interface nicely within the philosophical framework detailed throughout this paper.

**Primary criteria for credibility.** The first of the primary criterion is credibility. Assuring credibility addresses whether the findings are believable. The second criteria is authenticity which speaks to whether all participant voices are heard, paying attention to subtle differences of the participant’s experiences. Whittemore et al. (2001) believe that the ability to answer the question “does the research process demonstrate evidence of critical appraisal?”(p. 534) addresses the third criteria of criticality. The last criterion is integrity. One can assure the integrity criterion is met by repetitive checks of validity. The four primary criteria should be met in all qualitative work but depending on the type of design and research question further secondary criteria should also be met.

**Secondary criteria for credibility.** Explicitness, vividness and thoroughness are the secondary criteria that need to be addressed based on the Heideggerian hermeneutic method chosen (Whittemore, Chase & Mandel, 2001). Addressing the researcher’s bias, decisions and interpretations are part of meeting the criteria of explicitness. In addition, Heideggerian hermeneutic research should portray participants experience clearly, artfully and with thorough dense descriptions, thereby addressing the vividness criteria of trustworthiness and evaluation. Lastly, thoroughness addresses the question of whether saturation was reached and all questions asked were answered completely and thoroughly. In phenomenology, the phenomena under study should be addressed completely and thoroughly. However, saturation is an elusive concept in that there are always new ways to approach the data over time. The study ensued until
complete, thorough and enlightening understandings were believed to be obtained.

**Techniques to ensure trustworthiness.** Techniques used to assure both primary and secondary criteria are met included requesting and receiving feedback by meeting with the dissertation committee chair regularly and through constant dialogue with the research team about whether the findings were believable and rang true after reading the transcripts. Dialogue with other research team members facilitated that the criticality and integrity criteria were addressed. In addition, keeping a journal outlining experiences and biases provided another check for validity. Repetitive questions by the chair of the committee regarding biases were also used to check for validity. In the end, the test for validity will be whether the results or findings are believable, not only by those reading the findings but by those who have experienced similar phenomena. A final check for validity was conducted by the other two dissertation committee members as they read the results of the analysis and interpretation of data.

**Limitations**

As this is a qualitative phenomenological study, the intention was not to generalize the results to the larger population of teenagers who attempt suicide and visit the ED. The small sample size is a limitation. Recruitment was difficult for a number of different reasons. Geographical location of the hospital in relation to the researcher made recruitment difficult. In addition, the procedure for obtaining consent and assent was problematic for this population. The reliance on the use of staff intermediaries to ascertain if a teen was interested in the study added an additional layer of complexity to the consent process. At times it was difficult to contact the parents prior to the teen’s discharge from the hospital, yet obtaining consent in a timely manner was important. Three other potential participants’ parents were contacted but did not consent to
have their teen interviewed. One other participant was recruited but not interviewed because of a report of psychotic symptoms associated with his attempt.

**Human Subjects**

This research project was approved by the Washington State Universities Institutional Review Board. In addition, approval was also obtained by the two participating hospital’s offices of research compliance.

The transcribed data was kept in a password protected computer in the investigator’s office at Washington State University Spokane. The printed transcripts and all products of analysis were kept in a locked file cabinet in the investigator’s locked office at Washington State University Spokane. The audio tapes were stored for three years and then incinerated. The de-identified transcripts will be kept indefinitely. The master code book that linked personal identifiers to the tapes and transcripts was kept in a separate locked filing cabinet. All electronic files were encrypted as required by Washington State University’s Office of Research Compliance. Only the investigator and members of her supervisory committee had access to the original interview tape recordings, the transcribed data and electronic files generated during analysis. The consent form contained a second signature line that required the participants to acknowledge that the interview was being audio tape recorded. Informed assent or consent was obtained prior the interview. The participants were told that the information obtained would be kept confidential unless plans to harm him/herself, plans to harm others or abuse of a child were disclosed. The participants were also informed about their right to terminate the interview at any time or for any reason.

**Risks and Benefits**
Benefits included allowing the teens to share their experiences which could be therapeutic itself. I recognized the fact that the research interview itself is not for therapeutic reasons; the purpose was for data collection. A debriefing question, added to the end of the interview, allowed the participant to talk about what benefit, if any, they received from the interview. Three out of the six adolescents identified that sharing their story was beneficial to them and that it was important for them to do so in order to help other teens.

The potential risk of participating in this study was emotional distress for the adolescent. Because of this potential risk, it was important that all teens being interviewed were enrolled in treatment. During the interview with Nathan (pseudonym) and based on the information obtained during his interview, I made the decision to contact his counselor and psychiatrist immediately following the interview. The teen was notified of this decision and consented to this contact. In addition, I made a follow up phone call to Nathan later that day and the following day to determine if he contacted his providers as directed and remained free from harm. Interestingly, he contacted me weeks after the interview to discuss his improvement.

None of the teens felt the need to stop the interview due to emotional distress. Although the nature of the research ensures the confidentiality of the adolescents to the extent of Washington State law, the consent forms specified that any participant who talked about imminent or future planned suicide attempts would be referred immediately to their mental health professional or to other appropriate follow up.
CHAPTER FOUR

FINDINGS

This interpretation addresses the meaning of adolescent suicide attempts, as constructed from the hermeneutic analysis of the accounts of six teens. Each teen recalled their experience before, during and after their suicide attempt. Interpretive findings were derived from analyses across the verbatim de-identified texts of interviews with these participants. The participants may be understood as representative voices for adolescents who have visited an ED following a suicide attempt, in that the deconstruction and iterative review of these texts led to common understandings across storied representations. Through the interview process, the teens constructed the story, bringing to the forefront the essence of the experience for them. The findings help clarify the experiences of suicidal adolescents, a critical factor to help health care professionals design and implement more effective interventions in order to help attempters during ED visits and through the recovery process. An interpretation of participants’ accounts comprises the results that follow.

The interpretations indicate that teens needed to negotiate through their conflicted minds in order to recover from their suicidal self. Sharing their private struggles was imperative in order to recover, a finding that has multiple implications for nursing. Despite the fact that suicide has been called an action that involves a conscious process (Michel & Valach, 2001), these teens did not necessarily understand the reason for their actions. The suicide attempt was not a cognitive, purposeful, help-seeking behavior though the attempt did result in ED treatment and subsequent psychiatric care. Rather, the attempt was a semi-conscious or subliminal help-seeking behavior and challenged the idea that suicide attempts are attention seeking, a common perception of
adolescent suicidal behavior. Recovery involved strengthening and forging new relationships.
The findings motivate healthcare professionals to reframe our thinking and expand our understanding about the meaning that underlies teen suicide attempts.

**Participant Background Information**

The participant sample consisted of six adolescents, Jennifer, Taylor, Sara, Ilana, Erica and Nathan, who have attempted suicide through various means. The names are self-chosen pseudonyms to maintain anonymity. The participants ranged in age from 15-19 years old. Five out of the six participants were female. Four out of the six teens attempted suicide more than once. All six participants had visited the ED and all had at least one psychiatric hospitalization as a consequence of their attempt. Three out of the six participants described engaging in deliberate self-harm such as cutting themselves. All three participants described the deliberate self-harm as very different than their previous suicide attempts. The participants were not asked specifically about their self-harm behavior but rather spontaneously shared this information in relation to their suicide attempt(s). After disclosing self-harm behavior, interview questions exploring the behavior were introduced. Three participants were interviewed during the psychiatric hospitalization that followed the suicide attempt and three were interviewed 3-6 months after discharge.

The six participants were recruited over approximately two years. Age was the only piece of demographic information collected. The teens were asked about their drug use, suggested by the literature to be a major risk factor predicting suicide (King et al. 1993). Two out of the six participants acknowledged having used drugs in the past. None of them shared whether or not they were under the influence of drugs or alcohol at the time of their suicide attempts. The
participants were questioned about their mental health diagnosis, another common risk factor associated with suicide (Evans et al. 2005). The researcher recognized that the participants may not have known their specific diagnosis, according to their mental health provider or as defined by the DSM-IV-TR criteria, but significantly, they all reported having been diagnosed with a psychiatric disorder. The teens were asked about their diagnosis at the end of the interview and all reported a bipolar or depression diagnosis. The interviewer did not ask specifically about Axis II diagnoses (personality disorders), as described in the DSM-IV-TR (APA, 2000) and no participants provided a history of such diagnoses. In addition, the participants under the age of 18 would not have met the criteria for Axis II diagnoses. The description below is provided in order to give the reader a collective image of the group.

**Brief Images of the Teens**

Jennifer is a 16-year-old female. The interview took place in the hospital psychiatric unit five days after her first suicide attempt by overdose on her antidepressant. Jennifer has attempted suicide only once. She denied illicit drug use.

Taylor is a 15-year-old female. The interview took place in the psychiatric unit one week after her attempt to commit suicide by cutting her wrists. Prior to her suicide attempt, Taylor admitted engaging in cutting, a deliberate-self harm incident. Her cutting behavior did result in a psychiatric hospitalization but she denied this self-harm was a suicide attempt. Taylor admitted to smoking marijuana.

Sarah is a 16-year-old female who has had two psychiatric hospitalizations; one was a deliberate self-harm incident and the other was a suicide attempt by overdose. She was interviewed in the psychiatric unit after her suicide attempt. Sarah denied any illicit drug use.

Ilana is an 18-year-old female who reported two suicide attempts with two hospitalizations;
both included an ED visit. Ilana overdosed on prescription medication both times. The interview
took place three months after her last suicide attempt. Ilana admitted to “cutting”, a self-harm
behavior that started at the age of 10. She denied drug or alcohol use.

Erica is an 18-year-old female. She attempted suicide two times, each with ED visits and
hospitalizations. Her first attempt was at the age of 16 and the most recent was six months prior
to the interview. Both attempts were overdoses on prescription medication.

Nathan is a 19-year-old male. He admitted to three suicide attempts over a three month
timeframe. He attempted suicide by cutting his wrists, overdosing on medications and was
interrupted prior to jumping off a bridge. He has had one psychiatric hospitalization. He was
interviewed two weeks after his discharge from the psychiatric unit. He was receiving outpatient
treatment at the time of his interview. He denied drug use.

Following is an introduction to the patterns and themes identified through the analysis. It is
pertinent to note that the patterns and themes describe the essence of all the experiences;
consequently, there may be some degree of overlap among the patterns.

**Patterns and Themes**

Teens shared their story after having lived through a suicide attempt and their stories were
rich in detail and depth. One of the interpreters on the research team described the suicide
attempts as a “collision of words, thoughts, feelings and experiences.” The analysis is an attempt
to deconstruct the “collision” and form a new understanding from the interpretation of these
thoughts, feelings and experiences. Two patterns emerged across interviews and text, *Attempting
as Communicating* and *Attempting as Transforming*. Subsumed under these overarching patterns
are themes (See table 2).
Table 2. Patterns and Themes

<table>
<thead>
<tr>
<th>Pattern 1: Attempting as Communicating</th>
<th>Pattern 2: Attempting as Transforming</th>
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<tbody>
<tr>
<td>Theme 1: Ambiguity: The Battle in My Brain</td>
<td>Theme 1: Being Unconnected as Spiraling Down: Alone in My Suffering</td>
</tr>
<tr>
<td>Theme 2: My Cry of Pain: Telling/Not Telling</td>
<td>Theme 2: Connecting as Climbing Up</td>
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The patterns and the associated themes are described below. Exemplars from the transcribed interviews show how the patterns were derived.

**Pattern 1: Attempting as Communicating**

*Attempting as Communicating* was an overarching pattern that emerged from the transcripts. Under this overarching pattern was the theme *Ambiguity: The Battle in My Brain*. The participants expressed confusion surrounding their behavior and described a battle in their heads. The message teens sent through their suicidal behavior was that they wanted others to hear their pain, but that they struggled sharing the pain with others. The suicide attempt for this cohort of teens was a form of communication. The teens were confused about what it was they wanted others to hear. The confusion was evident but did not necessarily come to the forefront of their understanding; however, confusion permeated their stories. The teens also struggled with telling about their private suffering versus not telling. Ultimately the suicide attempt was their “telling.” The experiential process of attempting suicide precedes language. Prior to the attempt they could not share their suffering through language. Only through the attempt did they communicate their
cry of pain. Only after being asked questions surrounding their experience did the participants begin to use language and share their story. Following is a description of the two thematic patterns under Attempting as Communicating.

Theme 1: Ambiguity: The Battle in My Brain

*I believe that suicide is a matter of the mind. The mind- that mysterious microtemporal substance-free “secretion” of a unique organ made up of billions of specialized cells, called consciousness-has a minds of its own; the main business of the mind is to mind its own business.* (Schneidman, 2001, p. 201)

Language is required in order to interpret meaning. The language we use is also filled with pre-understandings or fore-understandings (Heidegger, 1971). Through language and our own experiences we come to interpret the world around us. The language associated with suicide is filled with underlying assumptions which distort our current understanding of teen suicide and interfere with our ability to provide effective interventions. However, it is only through the teens’ language that we can begin to uncover the meaning in their experiences.

Intention behind a suicide attempt refers to the individual’s understanding of the consequences of his or her attempt (Maris, Berman & Silverman, 2000). It is defined as the “extent to which the suicide attempter wished to die” (Brent, Poling &. Goldstein, 2011, p. 53). There are several suicide intention scales available to clinicians to measure this construct. Linehan (2000) cites the importance of assessing suicidal intent when looking at suicidal behavior. At the same time, suicidology lacks an operational term for suicidal intent recognized by all researchers (O’Carroll et al., 1996; Kidd, 2003). Freedenthal (2008) suggests that ascertaining the individual’s suicidal intention more accurately determines the seriousness of the
attempt than identifying the lethality. However, in this study, the participants expressed
uncertainty about their intention thus challenging Freedenthal’s suggestion that suicide intention
is one of the best proxy measures for suicide research.

The participant’s language brought up questions often posed in the literature surrounding the
intent: “Is the event an attempt to end one’s life, a ‘wanting to die’ or a form of escape?” The
participants shared their intent when discussing their emotional pain. The interpretations showed
intention to escape from the pain and included a desire to die. The purpose of questioning a
suicide attempter’s intention is to ultimately prevent completed suicides and to intervene with
appropriate follow up care. The findings of this study suggest that the suicide attempt is intended
as an escape. When asked if all three of Nathan’s suicide attempts were “attempts to end your
life” Nathan replied, “yeah.” After further story sharing, Nathan described his attention as:

  And you don’t really want to deal with it anymore. It’s the only escape you have (l. 33-35).
  It’s not so much you want to die. It’s more that you want to get away from the pain that
  you’re dealing with (Nathan, l. 37-39).

Some clinicians would interpret Nathan as less likely to complete suicide based on the intention
idea to get away or escape. As described; however, Nathan’s suicide attempts were becoming
more lethal. Quite possibly the suicide intent scales would not have captured Nathan’s ambiguity
about the intention; but, perhaps Nathan would not describe himself as ambiguous.

Jennifer, who claims she felt tired and wanted to get away, used the same escape language in
her description of the intent behind her attempt:

  And um, it was just so hard getting up in the morning. I was so weak and I was tired. And
  I just wanted to get away from everything. And so that’s when I decided- I was thinking
  everyone would be better off without me (Jennifer, l. 46-49).

All the participants desired to end their pain and suffering. Erica shared that her intention behind
her attempts was to die. She did not think about what death was like or what death meant to her,
but, that she wanted her pain and suffering to stop. Erica, just as Nathan, described death as an escape.

The findings place into question whether or not a scale would be the best way to address suicide intent. What is the best way to identify suicidal teens? Are the questions we are asking the right questions to elicit the pain and intention? Clinicians know what they mean when they use common suicidology terms, but are the teens using the same language? Researchers agree, however, that having a more in-depth understanding of the people who are suffering can lead to more individualized interventions.

The findings suggest the participants’ confusion over suicide intent prevented an in-depth understanding of the attempt. The participants communicated ambiguity and lack of control over their minds or thoughts. The teens reported they believed their minds were playing tricks on them. The battle going on in their minds worsened the uncertainty and confusion about their suicidal intent. Nathan described his brain “throwing” suicidal thoughts at him, while feeling as if he had no control over the thoughts. When asked if suicide was the only solution, Nathan replied,

It’s the only option it throws at you. It’s more of an emotional trigger, yes. But it’s-it tries to fight it with logic and your own mind turns against you pretty much. They’ll say think positively and say you think positively, they say think positively but your own thought process is constantly being attacked by thoughts like that. They’re constantly popping in.

Interviewer: So it’s like a fight in your head?
Exactly (Nathan, l. 76-92).

Nathan described that during his first attempt he felt as if the logic was destroyed in his head. In one form or another he addressed the fight going on in his mind with each of his attempts.

All participants described a feeling of something going on in their brains that they could not quite grasp. Sarah shared that when she ran away prior to her attempt she believed that she was
“trying to run away from myself cause I was just feeling all these things and I didn’t know what
to do. And it was scaring me. And having those thoughts scared me” (Sarah, l. 253-256). Jennifer
also verbalized that her mind might be playing tricks on her. She expressed having trouble
making sense of her suicidal thoughts:

I was like I want to go to a place where nothing matters. I just want to go. Like and
that’s when I decided I was going to take the pills. And like so many emotions go running
through your body that you don’t’ know what to do. And then your mind’s not clear
enough to think in reality, and that’s how it was with me. My mind wasn’t thinking in
reality that everyone-that’s why I thought everyone would be happier without me
(Jennifer, l. 372-379).

All the participants expressed the feeling something was not right in their minds, they expressed
feeling isolated and described themselves as outcasts. The mental battle facilitated questions
about what was wrong with them:

And like- when people are like walking down the street and they’re happy, you’re like
“why can’t I be like them? What’s wrong with me that I can’t be like them?” And you get
so angry with people that are like happy all the time. You’re like “Why can’t I do that.
Like what’s wrong with me that I can’t be happy.” And you just –you go so hard on
yourself. And like it’s just really hard.
Interviewer: It’s a struggle.
Jennifer: Yeah. Like you’re it’s a constant battle inside your brain (Jennifer, l. 220-237).

Later Jennifer states in regard to the suicidal thoughts:

But once you’re at- to that point, like it feels like there’s no going back. Like you
can’t stop the thoughts. They just come rushing in at you. Like-
Interviewer: You don’t have control?
Jennifer: Hum-um. Like they just come rushing in (l. 448-452).

Jennifer’s statement reflects a common pattern expressed by participants that the thoughts
flooded their brain making it difficult for them to “think in reality” and that such thoughts
enhanced the confusion and ambiguity around their experiences. The exemplar from Taylor’s
story is perhaps the best expression of Ambiguity: The Battle in My Brain:
So I don’t- I don’t know why I would even- I don’t- like people ask me “Why would you do that?” And like I don’t really have a good enough answer anymore. Because I don’t-I don’t know. I just- I didn’t want to feel that way anymore. But they’re like, “then why didn’t you try something else?” I don’t know. I didn’t know that—I didn’t—You know? (Taylor, l. 252-257)

This excerpt sums up the interviews effectively in that all participants shared their thoughts and feelings before, during and after the attempt, but uncertainty lay at the core of the experience. The pauses, and the “I don’t know” statements, pointed to the fact that Taylor was confused and did not have an adequate answer as to the reasons for her attempt. As healthcare providers we assume there is a definitive indicator or a definite intervention, so we ask black and white questions. With such ambiguity present many of the questions we ask are unanswerable to teens. Suicide attempters are unable to answer the why question practitioners routinely pose.

When the participants were asked to share their experience about their suicide attempt each told a story about how their minds played tricks on them. They identified the battle in their brain after getting help and after going through the process of reflection through questioning. Thus, the experience was pre-conscious. The experience came first and then the language followed. As Heidegger (1972) suggested, “And only when man speaks does he think, not the other way around” (p. 381). Through the interpretive process the theme, My Cry of Pain: Telling/Not Telling emerged. This theme further describes what the teens in this study were trying to communicate.

Theme 2: My Cry of Pain: Telling/Not telling.

The teens did not tell people about their suicidal thoughts prior to the attempt. The participants described wearing a mask to hide their true feelings of being uncared for and alone. Their sadness and hopelessness was hidden. Healthcare providers assume that if we ask the question, “are you thinking of harming yourself?” clients will be able to answer the question
and/or they are consciously aware of and can verbalize their thoughts. However, this study highlights the fact that this assumption may not be the case for this population.

Jennifer did not tell anybody about her suicidal thoughts and stated: “And you feel betrayed cause no one’s helping you. No one’s seeing the little signs you put out (l. 324-331)…I’m drowning. Please someone help me” (l. 334). She did not verbally tell anyone but she inferred that perhaps she was exhibiting something through her behavior she called “little signs.”

The emotions described so well through participants’ narratives were hidden from others and kept private, yet the attempt itself was a form of communication that called out “I’m trying to tell you something.” My Cry of Pain: Telling/Not Telling refers to the contradictory qualities of the attempt. The participants wanted to hide their suffering but the attempt itself was what placed their pain in a social context, viewable to others. As O’Connor, Armitage and Gray (2006) found in their research, the attempt had previously been called a cry for help but instead healthcare professionals should conceptualize an attempt as a “cry of pain (affective) rather than a cry for help (instrumental) and that the predominant motivation for many suicidal individuals is the cessation of their psychological pain rather the manipulation of others” (p. 476). The current language used in healthcare to describe an attempt is “a cry for help.” Moreover, when professionals talk about teens in crisis this cry for help is often interpreted as a call for attention. An alternative explanation proffered by the participants is that a teen suicide attempt is a “cry of pain” driven by the desire to end the unutterable suffering.

It is a misinterpretation to classify suicidal behaviors as “attention-seeking” rather than a “cry of pain”. Merriam-Webster’s Dictionary (2012) defines attention as “awareness, consideration and or interest”. The teens want others to consider them, to be interested, to be aware of their suffering, and to hear their cries of pain. Mental health providers have used the phrase “attention-
seeking behaviors” to identify manipulative behaviors. This phrase has a negative connotation and suggests we should not be paying attention to “attention-getting” behaviors.

Nathan shared the following when asked whether or not he shared his suicidal thoughts with others:

Not really. No. That is more of a way to tell the serious ones from people that are just doing it as a joke or attention-getting. If you are attention getting, you let everyone know about it. If you are actually serious, you don’t want anyone to know. You don’t let on. There may be subtle hints thrown in, but you will never outright say it. You lie right through your teeth (Nathan, l. 144-156).

Nathan’s reference to attention-getting attempters had a negative connotation. The idea expressed in the mental health field that suicide attempters are attention-getting people, leaves one to wonder about the message being sent to patients such as Nathan. Taylor mentioned wanting more attention from her family:

Because like-like I knew my family loved me, but I didn’t really know like- I knew they did, but I didn’t realize- they didn’t show it. And I wanted them to show it. I guess I wanted more attention from my family
Interviewer: So by attention you mean love?
Taylor: Yeah. I wanted more love from my family (l.471-477).

Erica and Jennifer’s stories included a desire for others to be aware of their suffering, yet they self-identified that they considering calling for attention as negative. Erica described fighting with her whole family and then taking over 20 pills of her medication. She then texted “I love you guys,” (l. 21) which could be interpreted as attention seeking behavior. She attempted two times by overdose and her attempts were considered medically serious. Jennifer shared how her mother and stepfather were arguing after her suicide attempt. The police told her mother that Jennifer would need to be taken to the hospital because of her attempt. Her mother offered to drive, “And then they got into a big fight. Like cause he’s like, ‘oh now you’re showing her attention because she tried to kill herself’ ” (Jennifer, l. 173-173). Of course “attention” is
imperative after a suicide attempt. However, others interacting with Jennifer interpreted her behavior as attention getting and not worthy or appropriate behavior to get attention of others. This message was clearly sent to Jennifer. Making this substitution in regard to the excerpt from Jennifer would read “oh now you’re just showing her love because she killed herself.” The sentence reads absurdly and changes how the behavior is interpreted. Jennifer hid her thoughts and feelings from her family. After her attempt, her private struggles of wanting to tell versus not wanting to tell were made public as described in Sarah’s story below:

I don’t think my mom realized how sick I was. I- I would always tell her when I felt happy, but I’d never tell her when I felt sad or depressed. I feel like that’d make her disappointed or-I didn’t want her to worry.

Interviewer: So you were hiding it
Sarah: Yeah
Interviewer: What was that like for you to-
Sarah: Um well I –I would hide it at school too. I’d always put on a mask and be really super bubbly-fake happy. And it-it was hard (l. 376-385).

The private story was hidden and while participants wanted to share it, at the same time they did not. They struggled with wanting to tell versus not wanting to tell. Sarah shared that she would not talk to her mother about her feelings. Sarah was asked if she had ever told anybody about wanting to hurt herself prior to coming to the hospital. She related she was asked by her mother and psychologist, but she did not tell them about her suffering. “I lied” (Sarah, l. 465).

Erica also reported she did not tell because she was afraid of what they would do to her or the “label” they would put on her. At age 18, Erica was afraid of the stigma and being placed in the group of mentally ill and suicidal. The following is Erica’s response to being questioned about why she did not tell anyone about her suffering, “I was always afraid what they would say. Always what they would do me or what kind of med they would put me on or what kind of
label I would have on me now” (Erica, l. 207-209).

Jennifer also did not want to share her feelings with her family:

He kept asking me like “Are you having thoughts of like hurting yourself?” Or, “Are you hurting yourself?” And I would say, “No. What are you talking about? I have no reason to. Like why would I be depressed...Like seriously, I’m not depressed. Like I have everything going for me.” But on the inside, like little part of you wants to scream out and say help, but a bigger part of you is like, no, you have to like be stronger than this. And like for me, I had to hit rock bottom before I could climb back up (l.105-108).

Jennifer was in the hospital after her attempt. She was not asked by the staff in the hospital specifically about her attempt. Nobody asked about her feelings or what the intention was behind her suicide attempt. Even waiting for treatment in the ED, thoughts of ending her life continued:

It’s like you want them to go away. You want them to go away so you can just like finish yourself off. You’re just like “Go away. I don’t’ need your help. I am going to kill myself going to do it” (l. 235-239).

Later in her story, when asked if she would have shared her suicidal thoughts with the provider that prescribed her antidepressant Jennifer stated;

I’m not sure Um probably- I probably would’ve gone to her and been like “yeah, I’m having these’ –cause she asked me- she said, um, “Are you having suicidal thoughts?” And I said, “No”, cause I didn’t want her to know. Like and when you have suicidal thoughts, you think if you tell someone you’re weak (l. 572-579).

Being seen as weak and vulnerable was not an option for Jennifer. During her interview for the study Jennifer shared that this was the first time she had cried since being admitted to the psychiatric inpatient unit.

Um, I think just like actually- cause I’ve never told anyone what it actually felt like when I was depressed. And like I’ve never shared it in a group. I’ve never shared it with anyone (l. 600- 604).

Jennifer did not share her feelings with anyone before, and only after being questioned about her thoughts and feelings during the interview for this study did she share her experience. In fact,
Jennifer cried once during the interview. She stated it was because somebody was listening to her story. Taylor also did not share her feelings,

…you get up in the morning and you put on a mask like and pretend to smile at yourself and be like, okay, we can do this today. And then you get to school and you pretend to all your friends that you’re fine and act-act in front of your friends and act in front of your family (l. 227-232).

The idea of wearing a mask to hide their pain was a common idea central to the theme of My Cry of Pain: Telling/Not Telling. In order to progress in their recovery, they need to take the mask off and share their experience with others. They wore a mask but were surprised that others could not see behind the mask. Ilana did not share her suicidal thoughts until after the attempt:

Not until I did it….and it’s like you know, I was surprised my parents didn’t’ ask me. Like ‘cause I was like, “how can you not notice? This has happened before. Why aren’t you noticing this?” (l.341- 346).

None of the teens told anybody about their suffering and suicidal thoughts but the suicide attempt was a form of communications saying, “Hear my cry of pain.” They were crying out for help and calling for others to hear their pain, hoping someone would notice, but when asked directly, they did not tell. They were not using language to communicate with those around them. Ilana asked, “How can people around me not notice?” Nathan threw out “subtle” hints that he thought people should pick up on; Jennifer wanted to scream she was drowning. However, when asked specific questions about suicidal thoughts they remained silent.

Not telling others about their suffering but at the same time making an attempt that cried “hear my pain.” could be seen as ambivalence, a concept used in the literature regarding suicidal behavior (Cardell, 2008; Maris, Berman & Silverman, 2000). At first glance the teens in this study could be identified as being ambivalent. They shared that they did not want to tell others so they hid their feelings and put on a mask. They truly were suffering and mentally battling
confusing feelings while hiding from others that they were considering suicide as an option. However, feeling conflicted about attempting was not part of their narrative. They did not verbalize the wish to die versus the wish to live as Freud suggested in his theory explaining suicidal behavior (Mitchell & Black, 1995). Of course, non-verbalization does not mean that teens do not suffer from ambivalence. The question about whether teens suffer from suicidal ambivalence was left unanswered by this study. Clarifying if, or how, ambivalence differs from adult suicide attempters would require further research.

The findings from this study leave one wondering if primordial thoughts and feelings can be put into language at all. The teens in this study highlight the fact that their attempt was a form of communication. Although not a conscious intentional communication, they were sending a message. Despite the battle in their minds and the ambiguity associated with their attempts, the teens expressed they wanted others to hear their cry of pain. The teens in this study were struggling with taking off their masks so that others could see their pain. Understanding that teens are confused and have problems expressing their vulnerability and feelings of weakness are important points for health care providers to understand. Efforts to address the pain and fear of sharing expressed by participants should be included in post-attempt treatment.

These findings highlight the fact that researchers are trying to understand confusing and perhaps multiple meanings about an event. The teens talked about what was helpful and how they had been transformed, as told in the following pattern: Attempting as Transforming. The suicide attempt was the beginning of the transformation.

**Pattern 2: Attempting as Transforming**
Analyses of transcripts across all texts revealed a foundational pattern, manifested through language and story structure: *Attempting as Transforming*. All transcripts demonstrated evidence that the attempt itself created a division or a shift between life before and after the attempt. The participants described their way of life prior to the suicide attempt, discussed the attempt itself and then talked about how their thoughts and feelings began to change. The dramatic event of a suicide attempt transformed the participants. The suicide attempt changed social connections. The participants described their experience prior to attempting suicide. They described life events and problems with relationships, mainly problems with family and friends. In the initial parts of the interviews, the description included feelings of being unconnected. Each participant shared spiraling down as reflected in the theme: *Being Unconnected as Spiraling Down: Alone in My Suffering*. The feeling of being unconnected was transformed after their suicide attempt and the participants described climbing up in order to recover and heal. Recovering and healing involved first-time connecting or reconnecting. The theme was named, *Connecting as Climbing Up*. The suicide attempt was a reset button, transformative in nature. The teens expressed an inability to exist in the state of being suicidal, and the attempt was an expressed desire to change.

Erica represented a paradigm case (Benner, 1994) in relation to the transformative nature, as observed in the following exemplar of the overarching pattern, *Attempting as Communicating*, identified in all the interviews:

I know if I wouldn’t have done those I wouldn’t be where I am today with all three counselors and having the help I have
Interviewer: say that again, if you wouldn’t have
Erica: Done it
Interviewer: If you wouldn’t have attempted those two times
Erica: Yeah
Interviewer: You wouldn’t be where you are
Erica: Yeah. Cause nobody would believe me. Cause I’ve went to the doctor multiple times saying I’m suicidal and depressed, and they tried to put me on pills. And they didn’t do anything for me so I stopped taking them and then a few years later just tried to kill
myself. *I know each time that I’ve tried to kill myself it’s brought me one step further to where I need to be* (l. 334-345).

Erica would not have received the treatment she needed if she had not expressed herself through her suicide attempts. Erica, like the other participants, did not want to share her feelings with others. Her suicide attempt was a cry of pain and it was the only communication she felt people heard.

Ilana also described the transformation between being suicidal and recovering and the drastic change after her attempt. Like Jennifer and Taylor’s recovery, Ilana’s transformation occurred during her hospitalization.

I’m doing a lot better. I mean, you wouldn’t recognize me from when I first got in the hospital until now (l. 269-270), I mean, like I was such a different person. And that was just like a couple months ago (l. 276-277).

Prior to the attempt all participants expressed a common thread of feeling unconnected throughout the events that led to the attempt. The events that led to their attempt were not necessarily the same for each participant; however, relationships were consistently a part of each participant’s story. The structure of their story had a beginning, middle and end. The beginning of the story for all participants included descriptions of feeling alone and uncared for, an outcast from their social group and/or family and a disappointment to their parents. The middle story transformed from feeling unconnected to the realization that they are able to connect. Participants recognized there had been a connection there all along and that people cared for them. The inpatient treatment helped facilitate the realization the connection had been there all along. After they attempted suicide the end story described a reconnection with family and initiation of a connection with counselors. Transforming this state of being is not a cognitive process, but rather a pre-conscious event intended to cause a shift in one’s life. Erica, Ilana and
the other participants identified being in a different state after the attempt and others helped them be “where I need to be” (Erica, l. 345).

**Theme 1: Being Unconnected as Spiraling Down: Alone in My Suffering.** The theme of being unconnected as spiraling down was described by the teens through their sharing of feeling alone, uncared for, and hitting rock bottom. These two ideas were connected in their stories. There was not a clear idea that one was the cause of the other but the themes were tied undeniably together as part of the experience of what it means to be a teen attempting suicide.

*Spiraling down.* Emotional pain was expressed in all of the participants’ stories as part of feeling unconnected and unloved. The emotional pain sent them “spiraling down” or had them hitting “rock bottom.” Nathan described the emotional pain: “It engulfs your entire being especially during a depression…then it will just keep pushing it downward and going down and down and down “(Nathan l. 55-58). Taylor used the term *rock bottom*:

> Being down at the bottom is just like you have nothing-you feel like you absolutely have nothing. You feel like you’re in the bottom of a hole and its all black and you don’t see nothing…you’re just trapped (l. 122-126). You’re just to the point where everything you hear- like if somebody says anything bad to you, you- it breaks you. It just- you feel totally worthless. And nobody, nobody feels- you can’t feel nothing less than that. And it hurts. It feels like you’re being spit on by a thousand people (l. 136- 139).

Taylor felt broken and the feeling of “being spit on by a thousand people” captured the pain and suffering that she was living through. Nathan described his experience of spiraling down in the following excerpt of the interview:

> Yeah it never really goes away. You’ll have days where, yeah, it’s better, but it’s still there. Any one little setback, any one little thing can trigger it off into a spiral. No amount of medication can fix that. It’s pretty much without forcibly shutting your brain off and turning it into a vegetable, it still passes through (l. 76-81).

Nathan’s retelling of his story was different than the other participants accounts in that he referred to himself in the second and third person. Through his use of “you” he was distancing
himself from the group of suicide attempters. He explained that to be identified as part of the
group or be identified as mentally ill would lead him to feel even more like than outcast and
worsen the problem of being unconnected.

**Alone With My Suffering.** One of the most striking aspects of all the participants’ stories
was their descriptions of feeling alone or lonely, rejected, uncared for and unloved. They
depicted these thoughts and feelings very vividly and did not hesitate in their narrative to recall
this portion of their story. Feeling alone was a common theme throughout the stories. Erica told
her story about feeling alone and uncared for:

> And I called my sister, but she didn’t answer. And I just wanted to say goodbye to
them. Tell them I loved them. And that’s when I took the pills. You feel so alone when
you’re depressed. Like you just feel so lonely like no one’s there for you. No one
understands. No one knows what you’re going through. No one knows how bad you’re
drowning. And you feel betrayed ‘cause no one’s helping you. No one’s seeing the little
signs you put out. …”I’m drowning. Please someone help me” (l. 324-331).

Erica described being alone and feeling lonely, but yet loving her family. This connection was
important to her. She reached out to her sister for a connection but could not get through. She
knew the connection to her family was important and she wanted to say goodbye. She took the
pills after she failed to share her feelings. One wonders what would have happened if her sister
had answered the phone.

Participants described believing that no-one else understood their feelings or could possibly
suffer as they had. Feeling as if they were the only ones experiencing this emotional pain was
part of being unconnected and pushed them farther down the spiral as Nathan described:

> And that you look around and go, “No one else feels this way”.
Interviewer: Other people have said that as well. Like you’re the only one.
Nathan: Basically yeah. You don’t see anyone else around you feeling that depressed, so
you think you’re a bit of an outcast. And those same thoughts make you feel even more
alone (l. 265-271).
Sarah also described it in this way. Prior to her hospitalization she felt “…really alone and lonely before I came in” (l. 403-404). She described herself as an outcast and continued to feel this way in her treatment: “Alone. An outcast” (l. 413). Erica also described that in her hospital stay, “I felt like I was the outcast and the staff really didn’t care” (l.390). The feelings of being alone continued even after the attempt and during the recovery process. Healthcare providers must understand the prevalence of feeling alone and like an outcast for suicidal teens. We need to identify teens who feel unconnected. The teens were in psychiatric treatment for their attempt but even in the hospital, surrounded by others who had similar thoughts and feelings, they reported feeling like an outcast and alone in their suffering.

In addition to being alone, being a disappointment to parents also left the teens feeling unconnected. Sarah perceived she was a disappointment in her father’s eyes and she stated, “I feel like I’m not good enough and stuff” (l. 175) and she felt “really rejected” (l. 302). Jennifer also talked about being a disappointment to her mother. After her attempt Jennifer was taken to the ED and she recalled the interaction with her mother while waiting for treatment:

I couldn’t look at her. I kept having to look away. I couldn’t make eye contact with my mom. I think I was scared that if actually looked at her, I would- cause I was in my own little world. And I was afraid if I looked at her, I would feel that disappointment …And I would feel that fear that she has and I would come back to reality. And I was finally in that place where I – like I didn’t have to worry about anything (l. 400-411).

The literature identifies connection as one of the most important external protective factors (Halle-Lande et al., 2007; Portner, 2001; Ackard, Neumark-Sztainer, Story & Perry, 2007). Whereas the literature describes connectedness as a protective factor that prevents teens from attempting or completing, this study highlights the fact that connection is a dynamic process. The teens in this study did not necessarily lack connection to others but they most certainly needed help reconnecting. They needed this transformative event to come to a new understanding of
what connections they had in their lives. Thus, understanding the meaning of connection to these teens, through their language and words, was necessary in order to provide effective interventions and/or enhance the protective factor of connectedness. The first part of the teens’ stories included rich descriptions of what it was like to feel “at the bottom” and of their perceptions of being unconnected.

Feelings of being unconnected, like an outcast, alone and disappointing family are reminiscent of Durkheim’s (1951) theory on suicide. “Largely left to themselves, victims of egoistic suicide are neither connected with, nor dependent on, their community” (Berman, Jobes & Silverman, 2006, p. 47). People who are socially integrated are less likely to complete suicide. One of Durkheim’s conclusions after his study was “suicide varies inversely with the degree of integration of the social groups of which the individual forms a part” (Durkheim, 1951 p. 209). Connectedness is most certainly related to social integration, as Durkheim suggested, but the idea that suicide can be explained solely within a sociological theory obviates the dynamic nature of connection that the teens in this study have identified. Moreover, modern day suicidology theories, such as Joiner’s (2005) and Schneidman’s (1996) address the limitations and inconsistencies apparent in Durkheim’s research.

Being Unconnected as Spiraling Down is a subtheme of the overarching pattern Attempting as Transforming. Within this theme all participants described the pain and suffering as part of the experience of spiraling down. The description of emotional pain was to be expected. Schneidman (1996) coined this suffering as “psychache.” People suffering psychache may believe that escape through death provides the one avenue to free them of the pain. Desperation hides other foreseeable ways out of a painful emotional state. As the teens communicated, “that is the only option it throws at you.” Joiner’s (2005) theory on suicide combines emotional suffering and
disconnectedness, which he calls “thwarted belongingness” to explain suicide. The teens in this study described both concepts in their experience of being suicidal. What was unique in their stories and contrasted starkly to their descriptions of emotional pain and feeling unconnected was their description of what helped them climb away from their suicidal thoughts as the theme Connecting as Climbing Up describes.

Theme 2: Connecting as Climbing Up. A catalyst acts to transform the experience of “going down” to an upward transition of “going up.” Despite the ambiguity, the battle in their brains and the struggle of telling/not telling, the participants related they could recover. What was important in their recovery after their suicide attempt was having someone to listen to them. Connecting to others helped them to climb up the ladder and recover from suicidal thoughts. The six participants were all searching for connections to others. The teens recognized that they needed help and knew that they could not recover alone.

Nathan knew he needed to reach out and described what this was like:

you’re so focused and determined on the negative that trying to pull yourself up-people say “just pull yourself back up.” It’s – it’s not just one person can pull yourself right back up ‘cause you have to have something to reach to, and you can’t see it (l. 69-72).

Nathan had not yet climbed up; he was in the process, but was still able to identify what would help. Nathan was looking for someone to listen to him, “It seems people are more focused on themselves and their own interests than actually taking five minutes to ask you what’s wrong” (l. 210-211).

Nathan’s request to be listened to was similar to the suicide attempter described by Simon (2007) who shared that he was waiting for a smile from a stranger in order to not jump off the Golden Gate Bridge. “A smile or friendly word may tip the balance toward life, countering an impulsive urge toward a lethal act” (Simon, 2007, p. 721). Nathan stated all he wanted was five
minutes of somebody’s time.

Prior to her suicide attempt Ilana thought that she had lost all her friends and was feeling isolated: “I didn’t feel like I could talk to my parents” (l. 78-79). Ilana had two suicide attempts. During her hospitalization after the first attempt, she found that neither staff nor patients had talked to her about her emotional pain. Fortunately, she found that the greatest impact for her after her second suicide attempt was the fact that one person, the attending psychiatrist, took time out to sit and talk with her. “So I actually felt like what I had to say mattered. And you know, I felt like I could actually get help from this place” (l.250-251). Validating and acknowledging the adolescent’s personal narrative is important in recovery. Nurses must take time to acknowledge the patient’s stories.

Jennifer’s narrative included thick rich descriptions of what it meant to climb up the ladder of recovery. Jennifer was asked about what helped her recover after hitting rock bottom:

Um I think realizing that I can deal with it and I can beat it. And like having a counselor. And most people are like “oh well, um, I couldn’t hurt myself like that.” When you’re depressed-like when you’re really depressed, you don’t care what you do to yourself. You don’t care at all….but you gotta realize you’re not in it alone…And that’s what I realized after I hit rock bottom. I’m not in it alone. I have my mom. My mom loves me (l. 253-261). I think hitting-like to me, it felt like I hit rock bottom. There was no downfall. There was only up (l. 672-673).

In Jennifer’s construction of her recovery she identified she had never really been alone. She felt as if she was alone but realized the connection to her mother was always there. She believed she could recover with the help of her counselor and her mother. Jennifer’s connection and reconnection helped her climb up. Jennifer also urged others to get help. In regard to having thoughts that people would be better off without her she shared; “Like once you have those thoughts-or even before then, you need to get help. You need to buck up and say ‘I need help’”
Jennifer talked about the help she was getting and how she was beginning to see things differently:

I’m feeling happier, and it’s just a great feeling to like feel like you’re almost there of overcoming it. Just like someone with breast cancer. When they overcome it, they feel so good. It’s the same way with me with depression when I get over it. ‘Cause well you can’t necessarily get over it all the way. There will still be a little bit there, but you have to learn to cope with it (l. 651-655).

Jennifer’s experience of overcoming and recovering from her suicidal thoughts transformed during her hospitalization. When she equated her mental health problems to physical illness she was able to understand that depression and suicide are conditions to recover from, to “overcome.” Just as Nathan used the second and third person to separate himself from the stigma and prevent himself from being further ostracized, Jennifer needed to relate her illness to an understandable condition in order to separate herself from the group of mentally ill.

Sarah described a recovery and a realization that her family did love her and had all along. She did not want to be in treatment but had to accept the help. “And my mom and I went through a bit of a rough patch when I ran away, but despite how bad it was for me to do that, it’s made us closer. And I realized how much she really cares about me” (Sarah, l. 361-363). Sarah had learned to accept help and enjoyed the one-on-one time with her therapist. In general, she learned to “look into myself and get to know myself better” (l. 221-222).

Taylor also included in her narrative the process of climbing back up in recovery. She described building herself back up again:

But I’m like focusing on myself and making myself better and stronger. That way when I go home, I don’t snap. I’m building myself up again. And I’m starting from the ground up. That way I can build myself up better. I had to back down to the ground and I broke myself all the way down to completely—to zero. And I’m building myself back up (l. 98-103).
She shared this information while recovering in the hospital working on building herself up. Suicidal thoughts had broken her down and she felt the need to build herself back up. She felt “spit on by a thousand people” but she was able to identify that climbing up was possible. Taylor recognized that she had changed:

I don’t’ want to be that same person I used to be. I don’t want to be that person that’s like, oh, whatever. Your life sucks. I don’t care anymore. I do care and I know that people out there care about me (l. 536-538).

At first Taylor described not feeling loved or cared for by her family, she perceived that her sister wished she wasn’t her sister and her mother wanted to send her away. When questioned about her recovery:

I want to be home with my mom…Like she was like ‘whatever’. She didn’t care. But now she’s showing me that she cares and she’s snapping me back into reality. And it’s like-it just feels like she’s goin whish with a whip. And it feels great because I know that I have people out there that care about me. Because being hospitalized, yes, it sucks but at least I know I have people out there that care about me (l. 191-198).

Taylor expressed her perception of the inpatient treatment program, “it feels great climbing this ladder. Just finally getting help and finally seeing the light. It’s actually helping out a lot” (l. 139-141). She stated she realized that her mother and her therapist were there for her:

Because those two people have been there for me for a long time and like they will tell me how it is. And so I know its like-I think they’re- they’re helping me. They’re not going to run away from me. They’re going to help me. I know they haven’t given up on me yet (l. 112-115).

Taylor described her motivating factor in recovery was getting to be home with her family and wanting to “be better for them” (l.77.)

Prior to her suicide attempt, Erica felt she didn’t belong and that her mother and sister “don’t want me there” (l. 148). Erica described reconnecting and identified the relationships that helped her in her recovery. Erica had a psychosocial rehabilitation (PSR) worker as well as a counselor
and psychiatrist. Erica stated “I just love my PSR worker. She’s like another mom to me” (l. 410-411). When asked what else helped she stated, “I feel like my meds have helped. The counseling has helped. I feel like my mom understands a lot better” (l.423-424). Erica also urged others to get help and not try to go through the experience alone “I suggest them to get help. If you haven’t already got help, I suggest you get help. You don’t want to go through this alone” (l. 228-230).

Participants expressed a desire to connect with others as they found new people with whom to connect during their hospitalization and during their outpatient treatment. Participants also experienced a reconnection by returning to their family and re-understanding that others loved and cared for them. Their attempt transformed their understanding from feeling uncared for to understanding others have always cared for them and that they had the ability to form new connections.

The teens talked about recovering from their suicidality. The participants wanted to share what helped them. They began their stories with spiraling down but then talked about climbing the ladder up to recovery. The idea of recovering naturally came out in their story and everybody except Nathan described what helped them recover. Nathan was unique. At the time of the interview he was still in the spiraling down stage. He did not yet use the recovery language the other teens expressed.

The participants highlighted the important fact that healthcare providers can help to re-establish connection and firm up social support. Thus, nurses should focus efforts on enhancing protective factors after a suicide attempt. The teens in this study perceived their social support to be lacking and they felt alone. Murray and Wright (2005) also found that the participants in their study were unconnected and alone. What was important for the current study’s participants was
to know that someone cared about them. Focusing our efforts to help teens identify that people care for them and they are not alone is imperative to helping them recover from suicidal behavior. The teens needed help and relied on their therapists and or family to help them through the process. Recovery involves reconnecting. Recovery starts when teens identify that despite the spiral down there is a “climbing up.” The nursing role should include helping teens reconnect with others. Nurses can be the one person that teens identify as wanting to connect with in the hospital; unfortunately the nurses were not identified by the participants as someone with whom they connected.

Recovery does not imply that patients are cured or fixed or that their minds will not return to suicidal thoughts, but it suggests that recovery is a process and that effective interventions are possible. Healthcare providers must help patients understand the nature of the recovery process in relation to suicidal behavior.

The purpose of this study was to describe the participants experience of being suicidal in the ED after a suicide attempt. The teens were told prior to the interview that we wanted to understand what the ED experience was like for them. Even with this introduction, the teens did not include the ED experience as part of their narrative. Only after specific questions about the ED did they share their ED experiences.

**Experience in the ED**

When analyzing texts hermeneutically it is important to note what is left out of stories as well as what is said. “To focus purely on the positivity of what a text explicitly says is to do an injustice to the hermeneutical task. It is necessary to go beyond the text to find what the text did not, and perhaps could not, say” (Palmer, 1969, p. 234). None of the participants openly
described their ED experience without being asked specifically about their experience. The ED experience was missing from their narratives, so perhaps the ED experience did not stand out for them. However, the ED, sometimes called the gateway to healthcare, may be the first contact that suicidal teens have, so healthcare providers in the ED must become part of the story. When suicidal teens are taken to the ED, their private story becomes public, making interventions more possible.

**Summary**

When specifically asked about the ED, participants shared their experience. Nathan described the ED as, “Same routine…they do vital checks, they ask you all the questions and the doctor sees you and you go from there. Nothing really out of line” (l. 163-166). After her overdose, Erica described her ED visit as “kind of scary” (l. 123)…”they just checked my heart and said everything was fine” (l. 129-130). Taylor and Erica shared that the staff were nice and tried to lighten the mood for their patients. Ilana also reported that the staff made some jokes and one nurse “made small talk with me” (l. 162-163). Ilana was embarrassed because she started to cry in front of the doctor. She reported the staff asked about her physical well-being but never questioned about her mental well-being or discussed her attempt while in the ED. Jennifer and Sarah also reported feeling embarrassed and ashamed. Sarah described her ED experience as “really intimidating.” She was “ashamed and embarrassed” and used both words in her interview three times when talking about her experience in the ED.

Interviewer: Going back to the emergency department-do you think there’s anything that could’ve been done differently for you in there?
Sarah: Um, I just like- I like talking about how I feel now. Um, and they didn’t really talk to me that much. They didn’t seem very welcoming. They-they were more like businesslike than actually caring about me….I was just another client trying to get-get through. And I felt like they looked down on me since I came in cuffs.
Interviewer: What was that like being cuffed when you feel like you felt? Sarah: It was hard. And they had to clear the hallway before I came in ‘cause I was considered a delinquent. And it was really hard….it seemed like they were really condescending…I felt really uncomfortable. And I was already ashamed and embarrassed (l. 501-520).

Taylor described being handcuffed and taken to the ED as very embarrassing:

Well I had to walk in through the lobby. Like they- to the emergency room. And we couldn’t go through the gateway-like the back way into the place. So we had to go in through the emergency department. And I had everybody looking at me, and everybody knows I was there because I tried to commit suicide. And that was like really embarrassing both times, so it was really really embarrassing. And it just made me feel really upset (l. 307-312).

None of the teens reported that they were ever engaged in a conversation about their current state of mental health with any of the nurses. Nurses should be concerned that the teens narratives excluded references to the nurses and other healthcare providers in the ED. ED professionals could play an integral role in the recovery of suicide attempters. Valente and Saunders (2004) found that there are many barriers to nurses intervening, including a lack of knowledge and feeling uncomfortable with the topic. Marynowski-Tracyk and Broadbent (2011) interviewed six nurses and found the nurses cited time and the ED environment as not conducive to providing proper care to those with a mental illness. Pallikkathayil and Morgan (1988) found that caring for suicide attempters sparked angry feelings toward the attempters, a finding that Suokas & Lonqvist (2007) also reported; attitudes of emergency room nurses towards suicide attempters is mostly negative.

*Attempting as Communicating* and *Attempting as Transforming*, two patterns identified through analysis of the transcribed interviews, can help healthcare providers understand the meaning of attempting suicide for teens. In this study, teens were unable to verbalize or put into language their suffering and pain. The suicide attempt was a form of communication for them that let others know of their inner struggles, including psychache, feeling alone, feeling like an
outcast and feeling people did not care about them. They battled the suicidal thoughts that rushed into their heads and tried to ward them off. The experience confused them and worsened the feelings with which they struggled. Their experience included a description of feeling as if they hit rock bottom and spiraled down into a hole. They felt unconnected to those around them. The attempt was the beginning of a transformation from their current state of being in psychache to being in recovery. Connections mattered to them and were important in their recovery. This study has implications for education, practice, policy and research, Implications are discussed in chapter five.
CHAPTER FIVE

IMPLICATIONS

The purpose of this study was to explore what it means to be suicidal as a teen in the ED in order to assist healthcare professionals in the understanding of the experience. The suicide transformed most participants. After the act, the teens identified that their minds are tricking them, confusing them. Suicide became the only option. Recovery led to personal transformation and a discovery that there are other options. All of the teens reported they remained silent; fearing others would label them or they would disappoint family members or they would be seen as weak and vulnerable. However, participants’ advised others who might be contemplating suicide to, “get help.”

Education about depression and suicide is obviously needed for this vulnerable population. Education about suicide and depression should be integrated into the public school’s curriculum. However, the stigma behind suicide overcomes this call for education. The teens identified the stigma and reported this stigma as one of the reasons they did not tell others. The implications as they relate to education, practice, policy and research are discussed below.

Teen Education

The findings highlight that teens need more education surrounding the topic of depression, suicide and communicating emotional pain. As identified in some of the prevention program literature, the effectiveness of prevention programs has not been supported. However, further research needs to be done to examine the effectiveness of educating teens about this serious issue. Several studies support educating teens. King, Strunk and Sorter (2010) evaluated the
effectiveness of a prevention program called, Surviving the Teens Suicide Prevention and Depression Awareness Program. The researchers found that teens who reported a behavior change were more likely to seek help. Forno et al. (2005) qualitatively studied Mexican American adolescents’ knowledge about depression and suicide and found that participants knew very little about the treatment for depression. The researchers concluded that a school-based, peer-facilitated depression awareness program would be beneficial. Educating teens in school will not only help those suffering identify ways to get help; but, it will also educate peers to help identify those around them who may be suffering. Just as researchers Owens, Lambert, Donovon and Lloyd (2005) found, family and friends play a large role in urging those with suicidal thoughts to get help.

Not only does this vulnerable population need education regarding depression and suicide, but the findings highlight the fact that healthcare professionals should also be educating teens about communicating their pain. Levi et al. (2008) found that attempters who made medically serious suicide attempts had problems communicating their mental pain when compared to those with non-serious attempts. The researchers concluded that when a suicidal person is unable to communicate their emotional distress or is unable to communicate socially they fail “to gain the proper mental perspective on their behavior” and the lack of social support and loneliness leads to suicide (Levi et al., p. 248). The participants in this current study would most certainly be classified as having trouble communicating their mental pain. They wear a mask each day, hide their pain from others and attempt to express their mental pain through suicide.

The findings from this study suggest that teens need to a) learn how to communicate and self disclose and b) be educated about depression and suicide. “Suicidal individuals with depression
and hopelessness who cannot signal their pain to others are at high risk of committing a medically serious suicide attempt” (Horesh, Levi & Apter, 2012, p. 1).

**Nursing Practice**

Dealing with suicidal teens requires nurses to change the language of their assessments and interventions. The term ‘attention-seeking’ can be eliminated due to its negative connotations. Using such language reinforces the negative stigma associated with suicidal behavior and mental illness in general. In addition, nurses need to return to the foundation on which the nurse-client relationship was built as described by Peplau (1948).

Suicide attempts by teenagers should be considered a form of communication and interpreted as a cry of pain. The suicide attempt is a form of “help-seeking” behavior; yet, health care professionals are not paying attention to this message as evidenced by the fact that the majority of suicide completers have visited a healthcare provider within the month of their death (Luoma, Martin & Pearson, 2002). The current study highlights the fact that providers are not listening for the cries of pain. Teens have trouble communicating and self-disclosing their pain. Simple yes and no questions such as “are you thinking of hurting yourself” may not be adequate to clearly identify teens in crisis.

In addition, healthcare providers further the stigma associated with mental illness and suicide by not talking or asking about it. Texts of participants’ interviews imply that nurses are not the healthcare providers with whom to discuss thoughts and feelings associated with suicidal thoughts. However, nurses can be facilitating care and reinforcing the teen’s disclosure through a positive, caring, accepting approach. The nurse-patient relationship is central to nursing. These teens’ stories suggests that psychiatric nursing needs to return to the foundations of nursing
practice as Peplau (1948) identified years ago. This foundation …… Draucker (2005) found that a barrier for teens to seek help for their mental health problems was the belief that they would be called crazy and not be understood by the clinicians treating them. She stated, “Some young adult participants indicated that they wanted to avoid treatment so badly they hid their distress from, or pretended to be ‘normal’ around, anyone who might insist they get treatment” (Draucker, 2005, p. 159). This finding was very similar to the teens in this study who wore a mask to hide their suffering. The teens in this study were very concerned about being labeled and did not want to be included in the group of mentally ill. The nurses role can be to promote help-seeking behaviors in this vulnerable population not perpetuate the stigma.

The teens in this study recognized that others with similar problems should get help, and nurses are often the first professionals to encounter teens in crisis. However, nurses are not rising to meet the need. More than ten years ago, Nirui and Chenoweth (1999) found in their qualitative study that family and close friends of those that had completed suicide perceived healthcare interventions as negative and or completely absent. It can be argued that we have not come much farther in the last decade. Validation, empathy and acknowledgement of their hidden suffering can be provided to teens who attempt suicide. The teens in this study did not identify caring and empathy as part of the care they received in the ED. In addition, caring and empathy were absent in the stories about the nursing care they received in the inpatient units. The mainstay “protective factor against suicide” (Simon, 2011, p.36) is the therapeutic alliance; the psychiatric healthcare provider’s most powerful tool.

The findings from this study leave the question, “Why are nurses not addressing the emotional pain of teen suicide attempters despite many opportunities to do so?” If nurses are not addressing emotional suffering after an attempt, how can we likewise address the patient’s
psychache in any other setting? Implications for healthcare practice and policy are closely tied together.

**Policy**

Hospital policies surrounding nursing care of the suicidal teen must be examined. Nurses could intervene differently with the adolescent suicide attempter population. Buston (2002) interviewed teens who were receiving psychiatric care and found that one of the most important aspects of care involved having an understanding and supportive care team. The teens in this study reported that they did not receive any extraordinary care in the ED or inpatient units. Whether or not these inpatient units had specific policies in place relative to treatment of suicide attempters is unknown. What we do know from this study is that both Nathan and Ilana wanted someone to validate them, acknowledge their suffering, and take time to listen to them. Jennifer shared during her interview that no-one had yet asked about her mental health and her feelings associated with attempting suicide. Validating suffering and taking time out to talk to patients about their emotional health is part of basic nursing care. However, nurses were not the people in this study identified as having been helpful. I find this concerning. Our current lack of concern and seeming inability to address the emotional pain at any point in the post-intervention process perpetuates the problem of a teen’s ability to seek help. Hospital policies that address how we provide care to inpatient psychiatric patients should be examined to determine that the most effective care is, in fact, being provided.

**Research**

Further research is needed in the area of adolescent suicide. Future plans for this line of study include expanding to include more stories of teens that have attempted suicide. In addition,
further information is needed in order to identify the barriers nurses encounter in providing effective post-attempt treatment to teens.

As identified in the implications for teen education, further research is needed about effective prevention programs. It would seem that teens in “recovery” would be helpful in educating and talking to teens that are currently dealing with emotional pain and confusing thoughts. Teens in recovery can identify and could be involved in prevention, however, further research is needed.

Other researchers recommend tackling the tragic problem of suicidality using a resiliency approach (Galligan, Barnett, Brennan & Israel, 2010) and this study reinforces this idea. Bostik and Everall (2007) asked the specific question, “How do adolescents perceive attachments relationships as helping them overcome suicidality?” (p. 80). They found that there was at least one supportive relationship central to their healing. The teens in this study also identified that connections help them. The resiliency approach includes reinforcing, promoting and strengthening connections that teens already have in their life. Further research is needed to determine the effectiveness of resiliency approaches in preventing teen attempted suicide.

**Conclusion**

Teen suicide is a preventable public health problem. Prior to identifying effective nursing interventions nurses need to listen to teens. Listening to the language of teens can convey the meanings associated with the experience of teen suicide. The “cry of pain” can be heard if one listens for it. The language healthcare providers’ use with this vulnerable population should reflect an understanding of the experience. This study provides a beginning to understanding the meaning of the experience, but further research is needed. The findings suggest that teens are confused about their thoughts and feelings. They are suffering from emotional pain but are afraid
to share with others because of the stigma associated with mental illness. Teens identified that connections were important to them and nurses can begin to strengthen existing connections as well as promote new ones.

This study highlights the fact that suicidal behavior is a complex phenomenon and reducing the language to common terms may not be working. Teens face developmental struggles; they have fewer coping abilities solely based on life experience than do adults. Listening more closely to the stories and the language teens’ use could possibly save a life. The teens were asking for someone to listen to them and take time to be genuine and caring. As nurses we need to return to our empathetic, caring and healing foundational qualities and provide an environment that promotes teens’ abilities to express their feelings and begin to heal.
CHAPTER SIX

EPILOGUE

Personal Narrative

In chapter one I acknowledged my prior biases, assumptions and experience in regard to the topic of adolescent suicide. Placing my personal narrative in chapter one felt awkward and I considered that it might influence readers’ interpretations of the study, entering the hermeneutic circle at an inappropriate time so to speak.

Shortly after I started data collection, my 13 year old daughter, Casey, took her life, March 9th 2010. Life stopped. The study was put on hold. I learned there was another side to suicide, that of a survivor. From a practitioner’s point of view I had always thought “survivor of suicide” referred to people who attempted suicide but survived, however, I soon learned that this was not the case. I became a survivor of suicide and as a result the lens through which I viewed suicide changed. To write about my personal journey of grieving and picking up the shattered remains of life after losing a child is not the purpose of this additional chapter. The purpose is to let the readers know about the aspects of conducting research when the content becomes so personal. My experience has impacted my interpretations of course. The experience of the researcher enters the hermeneutic circle; it becomes the process of understanding. Although I cannot place my experience to the side, with each interpretation I did examine my own thoughts and wondered how Casey entered the picture and influenced my thinking. Over the past two years, I have identified differences between the teens in this study and Casey. One important difference was that the participants only attempted and Casey completed; two very different things. The teens in this study were getting help. Casey did not get help; she was one of the sufferers in
hiding. Because of Casey’s death, I believe I was able to enter the hermeneutic circle with more of an open mind and a desire to understand. Losing her made me realize how little I really understood. Losing her made it impossible not to want to know more about suicide and understand more about those suffering through the pain. Many questioned my ability to continue with this study as did I. However, as my friend and colleague Linda Ward said to me, “How can you continue….but how can you not?” I am thankful to my committee members who all urged me to continue and felt it was important. My interest is now no longer just professional but personal.

I am thankful to the healthcare providers that provided care to the teens in this study, those in the hospital as well as the outpatient providers. All involved were able to save the lives of the six teens in this study and all helped prevent the tragic preventable loss of another life.

I would also like to thank my family and friends for their support and understanding. At many points there were numerous desires to quit and give up. However, I had to finish for Casey. I hope this study leads us one step closer to preventing any suicide.
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Company.


Thank you for your willingness to talk to me and share your experience. I am attempting to understand your experience by listening to your story about what you went through before, during and after your suicide attempt. I want other adults and health care providers to understand the unique experience so that we can better help teens like you. There is no right answer, nothing you can say will be wrong. There might be lots of pauses and that is fine. Take whatever time you need to think or reflect. If you feel uncomfortable or want to end the interview at any time that is no problem, just let me know. This is completely confidential, but I will have to share information if I find that you might still be suicidal or want to attempt suicide so that we can get you the necessary help. Do you understand everything or have any questions?

Opening question
Tell me about your experience in the emergency department?

Other open ended questions
Tell me more about…..
What was that like for you?
Anything else about that?
What else was going on?
Can you give me an example?
Others have said….is that ring true for you?
What stands about that?
What were you thinking or feeling during that time?
APPENDIX B
DATA ANALYSIS USING HEIDEGGERIAN HERMENEUTICS

developed by Roxanne Vandermause (2011)

Steps in analyzing text (de-identified and line coded transcripts with assigned pseudonyms)

1) Read the transcript carefully, start to finish
2) Re-read the text line by line
3) Make notes about concepts or situations that stand out
4) Review notes and observe the general categories, noting frequency of related ideas, position in text, response to interview questions, style of response (halting, stuttering, slang, affect conveyed)
5) Re-read line-by-line with repeating ideas in mind
6) Devise rudimentary list of emerging categories
7) Review transcript with these categories in mind
8) Revise categories or make comments, ideas for naming themes
9) Write a summary of the transcript with as much detail or support as time allows, including a basic summary of events, and/or a summary of emerging categories or themes, and/or interpretations, any or all with as much textual support (line references, exemplars) as time allows

These summaries will build with each transcript. After several transcript analyses, summaries and interpretations will combine. As texts are read across one another and across summaries and interpretations, themes revise and naming themes will become part of the iterative process. During this process, repeated readings of transcripts and developing interpretations are done. As research team members or others review transcripts, their interpretations are added to the developing summaries and interpretations and the iterative analysis is enriched.

Managing data

1) After several transcripts are analyzed, working themes are created and storage units set up using preferred software or paper files
2) Text is deconstructed according to themes, noting areas of overlap
3) Verbatim, line-coded pieces of the transcript are chosen for their representation of the ideas/emerging categories identified in the interpretations
4) Excerpts (labeled by pseudonym and line locations) are placed into storage units that exemplify or represent ideas signified by the working themes; excerpts may be placed in more than one storage unit
5) All written interpretations are collected and filed together as interpretations.
Managing interpretations

1) As new transcripts are analyzed, all written interpretations are reviewed.
2) Storage units are reviewed in their entirety and considered against interpretations.
3) Consideration is given to relationships among ideas; overall patterns that represent all ideas and/or themes and subthemes that describe essential meanings are renamed.
4) Patterns and themes are determined, always subject to revision, and writing begins.
5) Written results include a summary and interpretation of each theme.
APPENDIX C
Research Team Members

Main team members

Roxanne Vandermause Ph.D, RN, C.A.R.N.
Associate Professor Washington State University
Content expert Heideggerian Phenomenology

Susan E. Fleming Ph.D, RN, Perinatal CNS
Assistant Professor Washington State University
Content: Perinatal
Method: Heideggerian Phenomenology

Erla Champ-Gibson, MDiv, RN
Instructor of Nursing, Seattle Pacific University
WSU: PhD student
Content: End of life focus on family presence during resuscitation
Method: Philosophical Hermeneutics

Billie M. Severtsen, Ph.D, RN
Associate Professor, WSU College of Nursing
Qualitative Researcher: Heideggerian Hermeneutic Phenomenological Inquiry.

Ira Kantrowitz-Gordon, MN, CNM, ARNP
Lecturer, University of Washington School of Nursing
Content: parental distress after preterm birth
Methods/methodology: discourse analysis
Research Study Consent Form
Study Title: Teen Suicide: Experiences in the emergency department following a suicide attempt

Researchers:
Principle Investigator: Roxanne Vandermause PhD, Assistant Professor College of Nursing 509-324-7281
Co-Investigator: Carrie Holliday, PhD Student, College of Nursing, 509-570-8205
24 hour phone number: First call for help 509-838-4428

You are being asked to take part in a research study carried out by Carrie Holliday. This form explains the research study and your part in it if you decide to join the study. Please read the form carefully, taking as much time as you need. Ask the researcher to explain anything you don’t understand. You can decide not to join the study. If you join the study, you can change your mind later or quit at any time. There will be no penalty or loss of services or benefits if you decide to not take part in the study or quit later.

This study has been approved for human subject participation by the Washington State University Institutional Review Board.

What is this study about?
This research study is being done to learn about the experience of teens that have visited the emergency department after a suicide attempt. You are being asked to take part because you were identified as having visited the emergency department for that reason. Taking part in the study will take about 60 minutes for each interview for a total of 2 interviews. The interviews will be approximately 1 week apart. You cannot take part in this study if you do not speak English, are under 15 years of age or do not want your voice recorded during the interview.

What will I be asked to do if I am in this study?
If you take part in the study, you will be asked to participate in an interview where you will be asked to share your story about your emergency department visit.
☐ You will be asked to participate in 2 interviews approximately one week apart
☐ Carrie will ask you questions about what happened to you at the emergency department and what you thought about it and how it made you feel.
☐ Each interview will last no more than 60 minutes and you are free to end the interview at any time.
☐ An example of some of the questions that will be asked: Tell me what it was like to visit the emergency department. What happened before you emergency department visit? How did you feel when that happened?
☐ You do not have to answer any questions that you do not want to answer.
☐ Your voice will be recorded during the interview and this is required to participate in the study.

Are there any benefits to me if I am in this study?
There is no direct benefit to you from being in this study but it might help us to learn how to better care for those teens that visit the emergency department following a suicide attempt. If you take part in this study, you might find that just talking about your experience makes you feel better.

**Are there any risks to me if I am in this study?**

The potential risks from taking part in this study are:

- Psychological or emotional discomfort may occur after talking about your thoughts and feelings surrounding your experience.
- If you are experiencing current thoughts of harming yourself or other people this information will be shared with your health care provider (counselor, nurse or psychiatrist). If at the time of the interview Carrie feels you are in danger of hurting yourself, the interview will be stopped and your counselor/psychiatrist/provider will be contacted immediately. Carrie will stay with you until a plan for safety has been established.
- If you do not have a counselor a list of counselors will be provided to you at each interview.
- The interviewer’s phone number is provided if you choose to ask questions about the study prior to or after the interview.

**Will my information be kept private?**

The data for this study will be kept confidential to the extent allowed by federal and state law. No published results will identify you, and your name will not be associated with the findings. Under certain circumstances, information that identifies you may be released for internal and external reviews of this project.

- Each person that participates in the study will be given another name by the interviewer so that you can remain anonymous.
- Any information with your name on it will be kept separately from the recorded and written form of the interview.
- The interview will be recorded. Before each interview we will ask your permission to record the interview.
- The person that listens to the voice recording and types up the interview will be required to remove any identifying information, such as names of people your parents, name, the names of any friends, places such as schools, hospitals and towns
- We are required by law to report any potential of suicide, homicide or abuse of a child
- The voice recordings will be kept on a password protected computer in a locked office at the college of nursing. The transcribed interviews will be kept in a locked cabinet in a locked office at the college of nursing. The consent that has your signature and the key to the data will be kept in a separate locked cabinet in a locked office at the college of nursing (room 406)
- The following people have access to the voice recordings and typed anonymous interviews: All researchers and research staff (Carrie Holliday, Roxanne Vandermause, and the transcriber) Institutional Review Board (IRB)
- When we tell other people or write articles about what we learned in the study, we would not include your name or that of anyone else who took part in the study. The voice recording for this study will be destroyed immediately after transcription is completed and verified. The anonymous paper copies will be kept indefinitely for teaching purposes.

**Are there any costs or payments for being in this study?**

There will be no costs to you for taking part in this study.
You will receive __$20__ for taking part in this study. The money will be given to you prior to the interviews.

If you receive payment for taking part in this study, you may be asked to provide your home address or social security number.

**Who can I talk to if I have questions?**

If you have questions about this study or the information in this form, please contact the researcher Carrie Holliday at 509-570-8205 or holliday@gonzaga.edu or by regular mail: 4348 S. Greystone Lane Spokane WA 99223. If you have questions about your rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3005.

**What are my rights as a research study volunteer?**

Your participation in this research study is completely voluntary. You may choose not to be a part of this study. There will be no penalty to you if you choose not to take part. You may choose not to answer specific questions or to stop participating at any time.

**What does my signature on this consent form mean?**

Your signature on this form means that:
- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has responded to your questions and concerns
- You believe you understand the research study and the potential benefits and risks that are involved.

**Statement of Consent**

I give my voluntary consent to take part in this study. I will be given a copy of this consent document for my records.

I understand that my voice will be recorded ______ (Initials).

__________________________________ _____________________
Signature of Participant Date

__________________________________ _____________________
Printed Name of Participant

**Statement of Person Obtaining Informed Consent**

I have carefully explained to the person taking part in the study what he or she can expect. I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation. I also certify that he or she:
- Speaks the language used to explain this research
- Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her
- Does not have any problems that could make it hard to understand what it means to take part in this research.

__________________________________ _____________________
Signature of Person Obtaining Consent Date

__________________________________ _____________________
Printed Name of Person Obtaining Consent Role in the Research Study
Research Study Assent Form
Study Title: Teen Suicide: Experiences in the Emergency Departing following a suicide attempt

Researchers:
Principle Investigator: Roxanne Vandermause PhD, Assistant Professor College of Nursing 509-324-7281
Co-Investigator: Carrie Holliday, PhD Student, College of Nursing, 509-570-8205

24 hour phone number: First call for help 509-838-4428

My name is Carrie Holliday. I am from Washington State University. I and the other people listed at the top of this form are inviting you to take part in a research study.

Your parent(s) know we are talking with you about the study, but it is up to you to decide if you want to be in the study. This form will tell you about the study to help you decide whether or not you want to take part in it.

Why is this study being done?
The purpose of the study is to help us learn about the experience of teens that have visited the emergency department after a suicide attempt.
You are being asked to take part because you were identified as having visited the emergency department for that reason. You cannot take part in this study if you do not speak English, are under 15 years of age or do not want your voice recorded during the interview.

What am I being asked to do?
If you decide to be in the study, we will ask you to participate in an interview where you will be asked to share your story about your emergency department visit.
☐ You will be asked to participate in 2 interviews approximately one week apart
☐ Carrie will ask you questions about what happened to you at the emergency department and what you thought about it and how it made you feel.
☐ Each interview will last no more than 60 minutes, but you are free to end the interview at any time
☐ Each interview will be recorded at the time of the interview
☐ Once again, you may end the interview at any time
☐ You do not have to answer any questions that you do not want to answer
☐ An example of some of the questions that will be asked will be: Tell me what it was like to visit the Emergency Department. What happened before your emergency department visit? How did you feel when that happened?

What are the benefits to me for taking part in the study?
Taking part in this research study may not help you in any way, but it might help us learn how to help kids that go to the emergency department after an attempt to hurt themselves.
If you take part in this study, you might find that just talking about your experience makes you feel better.

Are there any risks to me if I am in this study?
The potential risks of taking part in this study are:
There will be no physical discomfort or distress if you participate in this study, however you may experience emotional discomfort after talking about your thoughts and feelings surrounding your experience.

☐ We have to report any information that is given to us about the abuse of a child or if you are experiencing current thoughts of harming yourself. This information will be reported to the health care provider taking care of you (for example your nurse, counselor or psychiatrist). The information will also be reported to your parent. If you do report current thoughts about hurting yourself and the interviewer feels you are in danger of hurting yourself at the time of the interview, the interview will be stopped and your counselor and parent will be immediately called. The interviewer will stay with you until your counselor or parent comes to get you. Your counselor or parent will identify a plan to ensure your safety.

If you do not have a counselor, a list of counselors will be provided at each session.

The interviewer’s phone number is provided if you choose to ask questions about the study prior to or after the interview.

Will my information be kept private?
The information for this study will be kept private and confidential to the extent allowed by federal and state law. Under rare circumstances the information from the interview may be reviewed by WSU officials.

☐ Each person that participates in the study will be given another name by the interviewer so that you can remain anonymous.

☐ The interview will be recorded. Before each interview we will ask your permission to record the interview.

☐ The person that writes up the interview from the recording will be required to remove any identifying information, such as names of people, your parents name, the names of any friends, places such as schools, hospitals and town.

☐ We are required by law to report any potential of suicide, homicide or abuse of a child. (e.g., potential suicide or homicide, child abuse).

☐ The consent to be interview, the interview recording and paper copy of the interview will be kept in a locked cabinet in a locked office at Washington State University’s College of Nursing room 406 in a password protected computer.

☐ The following people have access to the audio recordings and typed anonymous interviews:
  o All researchers and research staff
  o Institutional Review Board (IRB)

When we tell other people or write articles about what we learned in the study, we won’t include your name or that of anyone else who took part in the study.

The voice recordings for this study will be destroyed immediately after transcription is completed and verified. Anonymous paper copies which will be kept indefinitely for teaching purposes.

Are there any costs or payments for being in this study?
There will be no costs to you for taking part in this study.

You will receive $20 for taking part in the interviews. The money will be given to you prior to the interviews.

What are my rights as a research study volunteer?
Your participation in this research study is completely voluntary. You do not have to be a part of this study if you don’t want to. There will be no penalty to you if you choose not to take part and no one will be upset or angry at you. You may choose not to answer any questions you don’t want to answer, and you can change your mind and not be in the study at any time.

**Who can I talk to if I have questions?**
If you have questions at any time, you can ask the researchers and you can talk to your parent about the study. We will give you a copy of this form to keep. If you want to ask us questions about the study, call or email

*Carrie Holliday 509-570-8205, cholliday@wsu.edu*

The Washington State University Institutional Review Board has reviewed this study to make sure that the rights and safety of people who take part in the study are protected. If you have questions about your rights in the study, or you are unhappy about something that happens to you in the study, you can contact them at (509) 335-3668 or irb@wsu.edu.

**What does my signature on this consent form mean?**
Your signature on this form means that:
- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has answered your questions and concerns
- You believe you understand the research study and the potential benefits and risks that are involved.

**Statement of Consent**
I give my voluntary consent to take part in this study. I will be given a copy of this consent document for my records.
I understand that my voice will be recorded____ (initials).

__________________________________ _____________________
Signature of Participant Date

________________________
Printed Name of Participant

**Statement of Person Obtaining Informed Consent**
I have carefully explained to the person taking part in the study what he or she can expect. I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation. I also certify that he or she:
- Speaks the language used to explain this research
- Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her
- Does not have any problems that could make it hard to understand what it means to take part in this research.

__________________________________ __________________________
Signature of Person Obtaining Consent Date

________________________
Printed Name of Person Obtaining Consent Role in the Research Study
Research Study Parent Permission Form

Study Title: Teen Suicide: Experiences in the Emergency Departing following a suicide attempt

Researchers:
Principle Investigator: Roxanne Vandermause, PhD, RN, College of Nursing, 509-324-7281
Co-Investigator: Carrie Holliday, PhD Student, College of Nursing, 509-570-8205
24 hour phone number: First Call for Help 509-838-4428

You are being asked to allow your child to take part in a research study carried out by Roxanne Vandermause and Carrie Holliday. Please read this form carefully, taking as much time as you need. Ask the researcher to explain anything you don’t understand.

This study has been approved for human subjects to take part by the Washington State University Institutional Review Board. You may refuse to give permission, or you may withdraw your permission for your child to be in the study, for any reason. Your child will also be asked if he or she would like to take part in this study. Even if you give your permission, your child can decide not to be in the study or to leave the study at any time.

What is this research study about?
This research study is being done to understand how best to help teens that have attempted suicide. Our interest is to improve the care provided to teens in the Emergency Department. We are first interested in hearing about your child’s emergency department experience.
We are asking your permission for your child to be in the study because a health care provider has identified your teen as having visited the emergency department for a suicide attempt within the past 6 months.
Taking part in the study will take about a total of 2 hours, approximately one hour one week apart.

Your child cannot take part in this study if he/she does not speak English or is less than 15 years old or prefers not to have their voice recorded on a digital recorder.

What will my child be asked to do if he or she is in this research study?
If your child takes part in the study, he or she will be asked to
☐ Sign an assent form to agree to be in the study.
☐ Meet with the researcher at a location chosen by your child (the college of nursing can be used for the interview if desired)
☐ There will be two interviews, approximately one week apart, lasting approximately one hour each
☐ During the interview your child will be asked about their emergency department experience, including what they thought about the experience, what led up to the emergency department visit and how it made them feel.
☐ The child may refuse to answer any question at any time during the interview.
☐ The interview will be recorded using a digital voice recorder
If your child is expressing current thoughts to harm him or herself, you will be immediately notified. Your child’s counselor or psychiatrist will also be notified. The researcher will stay with the child until a parent is available and a safety plan has been identified.

Are there any benefits to my child if he or she is in this research study?

There is no direct benefit to your child from being in this study. However, your child may experience positive emotional reactions after sharing their story.

If your child takes part in this study, it may help other suicidal teens in the future.

Are there any risks to my child if he or she is in this research study?

The potential risks to your child from taking part in this study are:

- A possibility of psychological discomfort after talking about their experience
- A possibility of a loss of confidentiality if your child shares information about the abuse of a child or information about current suicidal thoughts
- A possibility of distress or discomfort due to answering sensitive questions

The precautions that are being taken to minimize your child’s risks, such as emotional disturbance are:

- The interviews are being done by a trained mental health nurse practitioner
- The interview will be stopped at any time if your child becomes emotionally upset and asks to stop the interview
- A list of counselors will be given to you and your child after the interviews if your child does not have a counselor
- Your child will be urged to make regular visits with their counselor to follow up on any emotional reactions that may come up after the interviews are over.

Will information about my child be kept private?

The information for this study will be kept private and confidential to the extent allowed by federal and state law.

- The interviews are coded and a key of the code is kept separately in a locked cabinet. Only the researcher has access to the code.
- All identifying information will be removed from the interview by the transcriptionist, including people’s names and names of places.
- The interview will be in a private setting with just the interviewer and your child present in the room. Your child’s privacy will be maintained throughout the study.
- All information will be kept confidential unless: your child discusses thoughts of harming him or herself or thoughts of hurting others as well as any information about child abuse, in that case the interviewer will need to contact appropriate persons such as child protective services.
- The audio recordings, de-identified transcripts and consent will be kept in a locked office, in a locked cabinet, in a password protected computer in room 406 at Washington State University’s College of Nursing.
- Those people that have access to the audio recordings will be the principle investigator, the co-investigator, the transcriptionist and the Institutional Review Board. The people that have access to the de-identified transcripts will be members of the research team which may include other doctoral students.
- Excerpts from the transcript may be used in publication and for teaching purposes but your child’s name will not be used
- Audio recordings will be made of your child, and this is required to be in the study.
Information will not be shared with your child’s health care provider unless your child shares current thoughts of harming themselves at which time you will be notified along with your child’s mental health provider/counselor. The audio recordings made of your child will be destroyed immediately after transcription is completed and verified. De-identified anonymous transcripts will be kept indefinitely for educational purposes.

Are there any costs or payments for your child being in this research study?
There will be no costs to you or your child for taking part in this study. Your child will receive __$20___ for taking part in this study and will be given the amount prior to the first interview.

If your child receives payment for taking part in this study, you may be asked to provide your home address or your child’s social security number.

What are my child’s rights as a research study volunteer?
Your child’s participation in this study is completely voluntary. Your child may choose not to take part in this study, choose not to answer specific questions, or leave the study at any time. There will be no penalty or loss of benefits to which you or your child are entitled if you choose not to give your permission for your child to take part or your child withdraws from the study.

Who can I talk to if I have questions?
If you have questions about this study or the information in this form, please contact the researcher Carrie Holliday, cholliday@wsu.edu, 509-570-8205. If you have questions about your rights or your child’s rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3005.

What does my signature on this consent form mean?
Your signature on this form means that:
☐ You understand the information given to you in this form
☐ You have been able to ask the researcher questions and state any concerns
☐ The researcher has responded to your questions and concerns
☐ You believe you understand the research study and the potential benefits and risks that are involved for your child.
☐ You understand that even if you give your permission, your child may choose not to take part in the study.

Statement of Consent
I give my voluntary permission for my child to take part in this study. I will be given a copy of this consent document for my records.
I understand that my child will be audio recorded ____ (initials)

__________________________________________  ________________________
Signature of Parent Date

__________________________________________
Printed Name of Parent

Statement of Person Obtaining Informed Consent
I have carefully explained to the parent of the child being asked to take part in the study what will happen to their child.
I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of his or her child’s participation.

I also certify that he or she:

☐ Speaks the language used to explain this research

☐ Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her

☐ Does not have any problems that could make it hard to understand what it means for his or her child to take part in this research.

________________________________________________________________________
Signature of Person Obtaining Consent Date

________________________________________________________________________
Printed Name of Person Obtaining Consent Person’s Role in Research study