Revising the Escape Theory of Suicide: An Examination of Avoidance and Suicide Ideation

Maureen Alsop, M.S., Ed.S.

Dissertation

James Cook University

Department of Psychology

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"...the snow falling into the dark water
part upon rock, part in the dry weeds
and part into the water where it
vanishes- it's form no longer what it was..."

William Carlos Williams

Abstract

A two phase investigation was undertaken to examine and develop a comprehensive understanding of a potential indicator of suicide, *Fear of Negative Evaluation*, and support and expand Baumeister's (1990) escape theory of suicide as one possible model for the events leading to suicidal behaviour.

This investigation addressed the questions: 1) what is the relationship between fear of negative evaluation, depression, hopelessness, and coping (specifically avoidant-oriented coping) in participants demonstrating suicidal thoughts, and do these factors support a revised, interactional escape theory? and 2) how do the factors of fear of negative evaluation and depression interact along the pathways identified through a revised escape theory, and can these factors be identified through the experiences of those

who have had incidents of suicidal ideation and/or engaged in deliberate self-harm?

Two separate studies involved a combination of face to face interviews and the use of psychometric instruments as the methodologies for examining: coping styles, causal explanations for life events, the presence of self-aversive thoughts, depression, fear of negative evaluation, and hopelessness for those at risk of suicide. Risk of suicide, for the purpose of this study, was defined as the self reported presence or demonstration of thoughts of suicide. The target populations for this two phase study were 1) participants who had been identified as demonstrating thoughts of suicide and /or depression, and 2) participants who self reported an incident of deliberate self-harm.

Phase 1 involved a purposive sample of 132 participants who were identified by local community health and counselling services to be experiencing symptoms of depression. Participants completed a series of questionnaires measuring the following factors: fear of negative evaluation, depression, hopelessness, suicidal ideation, and coping styles. Participant responses were separated with the qualifying criteria of the presence of suicidal ideation. A path analysis of these results from 121 participants was

conducted. The analyses of these results identified a significant relationship between fear of negative evaluation, and maladaptive coping. However limited support for fear of negative evaluation as a direct relationship to suicidal ideation prevailed.

Phase 2 involved a qualitative approach to interpreting the dynamics of phase 1 results. Phase 2 consisted of 27 interviews with participants who had engaged in suicidal behaviour, specifically deliberate self-harm. The interview framework mirrored Baumeister's theoretical framework with an additional focus on participant's perceptions of others during the events leading to an incident of deliberate self-harm. Results of phase 2 were discussed in relation to Baumeister's framework. Negative life events emerged as a significant factor, specifically a history of sexual abuse. Considerations for intervention, prevention and treatment approaches related to suicide were reviewed in specific reference to the results of this investigation. This included the applications for the identification, intervention, and the prevention of suicide. Results supported a focus on feminist issues related to suicide research, the role of social supports for intervention and treatment, and the relevance of developing a framework for participants to conceptualise suicidal experiences. Through an increased understanding of how suicidal participants attribute life events,

cope with stress, and develop a state of self-awareness and self-aversion, clinicians would be in a better position to effectively intervene.

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Chapter One: Prevalence of Suicide

1.1 Introduction

Epidemiological data on suicide has been crucial to understanding the scope, prevalence and trends in suicide. In order to understand the causes of suicide and to develop strategies to prevent suicide, it has been critical to consider the full ramification of the social, psychological and medical angles of suicidal behaviour. From a historical perspective, documented cases of suicide have been steadily rising though considerable fluctuations in the rate of suicide have occurred over time (ABS 2000a). Causes for the rise in suicide rates have varied. The oscillation in the rates of suicide have related to sociologically and psychological influences including cultural, environmental, interpersonal, or political factors. The means, or method, for committing suicide has had an impact on suicide rates over time. The reporting of suicide as a cause of death has become more concise, and within western cultures, has become less stigmatised by the taboos related to suicide of

time past. Increasing rates of suicide however, cannot solely be explained by the mere improvement and precision in identifying causes of deaths, or by examining psychological or sociological trends. Multi-factor explanations for increased rates of suicide must be considered, paralleling the multifaceted explanations for individual acts of suicide.

1.2 World wide Prevalence

The phenomenon of Suicide has been found throughout recorded history. The World Health Organisation (1999) reported the following data regarding suicide:

- Estimations for deaths due to suicide for the year 2000 were one million people world wide
- Ten to twenty million people were estimated to have engaged in deliberate self-harm worldwide
- Over the last 45 years, suicide rates have increase by 60% world wide
- Suicide rates in the elderly (particularly men) have traditionally been the highest risk group, but young people currently represent the highest risk group for suicide in one third of all countries

- Rates of suicide have indicated that more people die from suicide than from all the armed conflicts around the world and, in several countries, more individuals die from suicide than from traffic accidents
- Suicide has been identified as one of the three leading causes of death among individuals aged 15-44 (both males and females)

The problem of suicide, particularly youth suicide, has increased markedly in a number of western countries including the United States (CDC, 1999), the United Kingdom (Prichard, 1995), and Australia (ABS, 2000b).

Youths and adolescents aged 15 to 24 years have been especially at risk, as have individuals aged over 65 (CDC, 1999, ABS, 2000b). In the United States increases in youth suicide have risen from 300% since the 1950's and 200% since the 1970s. Current data indicates higher rates of suicide in 22-44 age group in Australian populations (ABS, 2000a)

The coding of a death as suicide has become relatively uniform in developed countries. Most members of the World Health Organisation have used the standardised ninth revision of the International Classification of

Disease (ICD-9) to code mortality data (Moscicki, 1997). These systematic recording methods have allowed for international comparisons in suicide rates (Hassan, 1995).

1.3 Australia

In a review of 1998 data, suicide rates in Australia averaged 14.1 per 100,000 (ABS, 2000a). Additional data related to suicide indicated the following (ABS,2000b):

- (2%) two- percent of all deaths in Australia were attributed to suicide
- (80%) eighty percent (2,150 out of 2,683) of these deaths were men
- (20%) twenty percent of these (533 out of 2,683) were women.

Though there has been an increased rate of youth suicide world wide, in 1997 Australia and New Zealand had one of the highest rates of suicide among young people in the developed world in (Camilleri, 1997). However, more recently, these rates of suicide dropped for the 15-24 year

old age group, reducing from 19 deaths per 100,000 in 1997 to 17 per 100,000 in 1998, accounting for a total of 24% of all deaths for this age group (ABS, 2000a). Male suicide death rates were reflected in the trends for total population suicide rates (ABS, 2000b). Table 1 presented rates of suicide per 100,000 in Australia from 1979, 1990, and 1998. The rate of suicide in men has been demonstrated to be at a steadily higher rate than completed suicides in women.

Table 1
Suicide Rates Australia by Gender 1979, 1990 and 1998

Suicide rates per 100,000 population in Australia 1979, 1990 and 1998 by sex and age

	Men			Women		
Age	1979	1990	1998	1979	1990	1998
15-19	12.7	17.8	17.2	3.6	5.0	5.5
20-24	23.7	36.5	35.9	7.9	3.9	7.1
25-29	22.6	32.8	42.6	7.9	5.9	7.6
30-34	23.3	25.3	39.4	6.9	8.1	7.5
35-39	21.4	26.1	36.6	8.6	5.3	10.3
40-44	25.5	24.8	29.5	9.8	6.5	8.3
45-49	29.0	20.9	25.5	11.2	7.1	5.1
50-54	25.1	22.1	24.9	14.2	6.5	6.8
55-59	23.7	26.7	19.7	11.8	6.7	7.0
60-64	22.9	22.8	20.3	13.2	5.7	6.2
65-69	20.5	25.2	26.0	9.8	7.7	5.7
70-74	26.1	27.5	17.1	12.0	8.1	6.4
75+	19.8	32.1	25.6	4.8	8.4	6.6

Note. From: Australian Bureau of Statistics, Suicide in Australia Cat. No. 3309.0 (2000).

Out of the five states and territories in Australia, data for men and women has demonstrated that rates in Queensland and Tasmania have been consistently higher than other states for individuals aged 15 years or more. The Australian Institute of Suicide Research and Prevention reported that the Queensland rate of completed suicides for young men was 29.2 per 100 000 and women 6.4 per 100 000 (AISRAP, 1997).

In an attempt to develop a local picture of suicide rates in the Cairns (far north Queensland region), Reser and Storck (1997) established a registration system to identify incidents of suicidal behaviours in the region. Preliminary findings of a three-month data collection of a small sample (n = 60) indicated that the most commonly occurring incidents were: suicide ideation (36.7%), cuts or slashes (21.7%), and overdoses (16.7%).

1.4 Suicide Ideation

Schotte and Clum (1982) have demonstrated a relationship between the frequency of suicide ideation and the likelihood of engaging in deliberate self-harm. Suicidal ideation has been thought to precede suicidal

contemplation eventually leading to threats, attempts or completion. In a study investigating suicidal ideation among Australian University students, suicide ideation and incidents of deliberate self-harm were higher than predicted. Sixty-two percent (62%) of university students reported suicide ideation (Schweitzer, Klayich, and McLean, 1995). Suicidal ideation has been identified to logically precede a suicidal threat, suicidal attempt, or completed suicide (Beck, Kovacs, and Weissman, 1979). Lennings (1994) suggested that suicide ideation might be more prevalent than depression.

Beck et. al. (1979) defined individuals with suicidal ideation as individuals who currently had plans or wishes to commit suicide but had not made any recent overt suicide attempts or incidents of deliberate self-harm. Pfeffer (1990) stated that suicidal behaviour include both the idea of self-destruction, and actual acts. O'Carroll, Berman, Maris, Moscicki, Tanney, and Silverman, (1996) in a review of current terminology and definitions of suicidal behaviours recommended a standard definition of suicide ideation to mean: "any self reported thoughts of engaging in suicide related behaviour" (p.239). For the purpose of this study, the definition of suicide ideation adhered to this definition. Under this definition, evidence, based on self-reported measures, required that individuals had thoughts or desires of engaging in suicide or self-injurious behaviours.

1.5 Deliberate Self-harm

Although there may be an overlap between groups, follow up studies have suggested that those who have completed suicide and those who have engaged in deliberate self-harm, represent different populations (Fawcett, 1987; Barraclough and Hughes 1987). However, several studies suggested that youths who engaged in acts of deliberate self-harm of high lethality did share many characteristics with those who completed suicide (Slap, Vorters, Chaudhuri, and Centor, 1989). The study of nonfatal suicide behaviour has been hampered by investigators failure to use clear operational definitions when collecting data or reporting clinical outcomes (Moscicki, 1997). Intention, motivation and affect in cases of deliberate self-harm has been difficult to distinguish (Pritchard, 1995). Little information has been available about the extent of suicidal thoughts, deliberate self-harm, and other self-destructive behaviours (Rafael, Donald, Lucke, Windsor, Pratt, and Wooding, 1996). O'Carroll's et. al. (1996) definition of suicide related behaviours as "potentially self-injurious behaviour for which there is explicit or implicit evidence ...that the person intended at some level to kill himself/herself" (p.239) was the definition of deliberate self-harm applied to this research. Researchers have referred to

the terms deliberate self-harm, parasuicide, or suicide attempts, though definitions of these behaviours may have vary based on their applications. For the purpose of this study, the term deliberate self-harm was applied to describe these terms as defined.

The incidence and actual rates of deliberate self-harm have not been accurately identified (Baume, 1996). It has been estimated that sixty (60%) of individuals who deliberately self-harm never present for medical attention (Martin, Clarke, and Pearce, 1993; Smith and Crawford, 1986). Blumenthal (1988) reported that individuals who engaged in deliberate self-harm tended to be younger and more often women and the incidents tended to be more impulsive and ambivalent. Whereas those who completed suicide were most often males, older, and used more lethal methods for self-destruction (Blumenthal, 1988).

It has been estimated that for each completed adolescent suicide, there have been between 50-120 incidents of deliberate self-harm (Pearce and Martin, 1994; Smith and Crawford, 1986; Garland and Zigler, 1993). Kosky (1987) further identified gender differences in rates of deliberate self-harm indicating that there were between 30 and 50 incidents of deliberate self-harm for every completed male suicide, and between 150

and 300 incidents of deliberate self-harm for every completed female suicide. Although males have been identified to complete suicide approximately three to four times as often as females, research has reported that females engage in deliberate self-harm at least three times more often than males (Garland and Zigler, 1993). Researchers have reported that between six percent (6%) and thirteen percent (13%) of adolescents have reported that they engaged in an incident of deliberate self-harm at least once in their lives (Meehan, Lamb, Saltzman, and O'Carroll, 1992; Schaffer, Garland, Vieland, Underwood, and Busner 1991).

Hawton and Fagg (1988) found that the highest risk for eventual suicide was during the first 3 years and especially the first 6 months, following an incident of deliberate self-harm. Deliberate self-harm has been associated with far higher levels of mortality, not just from suicide, but also from other forms of death including accidents and undetermined causes (Barraclough and Hughes, 1987; Hawton and Fagg, 1988). An incident of deliberate self-harm has been cited to be a critical risk factor for completed suicide. The relationship between suicide and deliberate self-harm has been identified as significant because a history of deliberate self-harm has been one of the most powerful predictors of suicide (Blumenthal, 1988). In studies of risk in different psychiatric patient populations, a history of

deliberate self-harm was the best predictor of eventual suicide, with those who engaged in repeated incidents of deliberate self-harm at the greatest risk (Hawton, Arensman, and Townsend, 1997). About one percent of the persons who engaged in deliberate self-harm eventually killed themselves, but about thirty percent demonstrated subsequent incidents of deliberate self-harm. The risk of suicide in the first year following an incident of deliberate self-harm was approximately one percent. Eventual suicide rates have been estimated to be as high as thirteen (13%) for individuals who have engaged in an incident of deliberate self-harm (Cantor, 1994). Hawton et. al. (1997) reported that 40 -50% of people who died by suicide had previous incidents of deliberate self-harm. Those who engaged in deliberate self-harm had a 50% risk of suicide compared with the general population (Cantor, 1994).

1.6 Continuum of Suicide

An individual who completed the act of suicide could not provide information or insight to define, explain or measure the effect of their behaviour prior to their death. Therefore, though the distinction has been drawn between these behaviours, that is, an act of deliberate self-harm and

the act of completed suicide, for the purpose of this investigation, these behaviours have been considered, as Lennings (1994) argued, a continuum of suicidal behaviours that do relate to one another. Deliberate self-harm and completed suicide may be distinguished from one another based on a range of factors including intention, ambivalence, level of risk, and choice of means. However, these factors can never truly be fully assessed in individuals who have completed the act of suicide without intensive, longitudinal studies. As Kay Jamison (1999) stated in her book, Night Falls Fast: Understanding suicide:

> The line between suicidal thoughts and action is not as clear as it might seem. A potentially deadly impulse may be interrupted before it is ever acted upon, or an attempt with mild intent and danger of death may be carried out in full expectation of discovery and survival. ... ambivalence saturates the suicidal act. Some wish to escape, but only for a while. ... Many who attempt suicide later deny or minimize it once the acute crisis or pain is in the past (p.39).

Psychological autopsies have been successful in distinguishing between cases of suicide and cases of accidental death. However,

distinguishing between a completed suicide and an act of deliberate self-harm that resulted in a completed suicide has not be scientifically proven nor identified to date. In expanding our understanding of suicide, it has been important to recognise the difference between the various levels of suicidality, however it would be biased to isolate acts of suicidal behaviour from one another. There has been great merit for research that differentiates these concepts, and such research has been crucial in defining and understanding these continuums. Referencing levels of progressive pain or isolation in relation to the prevention of suicide has been of paramount importance. It has been critical to determine what forces interact to propel an individual contemplating taking their own life to making plans to do so. For in understanding the continuums between suicidal ideation, contemplation, deliberate self-harm and completed acts of suicide we can begin to understand what would prevent an individual from completing the act of suicide.

1.7 Summary

The epidemiology of suicide has provided a reference for gauging the

status of mental health within a given population. However, the causes related to suicide rates have not been interpreted through simplistic explanations. In fact, such rates have mirrored a myriad of variables and in themselves, provided a superficial portrait of suicidal behaviours. For every completed suicide ten to twenty incidents of deliberate self-harm have occurred world wide. In seeking to understand the phenomenon of suicide, we must seek to understand all components of the phenomenon. Epidemiological data has been a critical component of suicide research that has delivered an overview of the problem of suicide that has had immediate and historic applications, and has provided a foundation of knowledge to work from. This investigation pursued an understanding of suicidal behaviour from an individualised, rather than societal or community based level. For this reason factors that influence suicide have required consideration from a wide spectrum of internal variables. In order to develop effective strategies to prevent suicide, research related to suicide has required a broad coverage of perspectives, in order to uncover the multitude of factors that influence both the individual mind, and the collective population.

Chapter Two: Understanding Suicide

2.1 Introduction

Suicide has been identified as a complex human behaviour and the final common pathway for many human problems (Fawcett, Scheftner, Clark, Hedeker, Gibbons, and Coryell, 1987). The self-destructive act of suicide has reflected many motivational determinants: personal and interpersonal, biological, familial, and cultural (Blumenthal, 1988). Suicide has been determined to be a behavioural outcome reached through several different behavioural pathways and contingencies. It has been a process in which social, psychological, neurobiological, and cultural variables have contributed to produce the end result. These contributing factors have carried unequal weights and no single one has been demonstrated to be necessary or sufficient to cause suicide (Baume, 1996). No single set of individual clinical features observed at a single point in time has been a good predictor (Fawcett, et. al. 1987). However, a number of risk factors,

correlations, cognitive patterns and indicators that may lead to suicidal behaviours have been explored in recent times. Suicide research has drawn a number of conclusions that have been useful for identifying those at risk. Psychiatric illness, personality traits, cognitive factors, behaviours, life events, social characteristics, genetics, and a number of other factors associated with suicide and deliberate self-harm have been important for researchers to consider in understanding suicidal behaviour.

2.2 Profile of Suicide Risk

There have been a number of significant factors that clinicians have relied on in order to identify individuals who may be at risk of suicide. Though researchers have identified as many as twenty-eight different risk factors (Poland, 1992) in adolescence, and youths, the usual clues of suicide behaviour have included the following: loss of significant other (e.g.: recent relationship break-up, disturbed family relationships such as a separation from a parent at an early age), recent suicide of a peer or family member, legal difficulties, unwanted pregnancy, family stress, recent and/or frequent changes in school, difficulties in relationships, depression and withdrawal, abuse of drugs or alcohol, physical illness, unemployment, disorientation and isolation, rigid thinking, and prevailing feelings of

hopelessness (Camilleri, 1997; Hahn, 1992). Depression, a previous attempt, angry rebellious behaviour, gun availability, and impulsive and reckless behaviour have also been factors frequently involved in many completed youth suicides (Poland, 1992).

A number of danger signs have been identified that increase the immediate risk of suicide. These signals have included: direct or indirect suicide threats, preoccupation with death, or changes in behaviour (Camilleri, 1997). Behavioural indicators related to suicide risk have frequently included: making final arrangements, marked changes in personality or behaviour, making a will or giving possessions away, increased risk taking, heavy use of alcohol or drugs, (Hahn, 1992), helplessness, or hopelessness (Beck, Steer, Kovacs and Garrison, 1985). Specific behavioural changes have been cited in relation to characteristics of severe depression. These behaviours have included: social withdrawal, isolation, loss of involvement in interests and activities, lethargy, exhaustion, extreme anxiousness, unexplained headaches, dizziness, nausea, exaggerated fears of disease, loss of self-esteem, decreased work or academic performance, frequent lateness, unexplained absences, abrupt changes in appearances, sudden weight changes, inability to concentrate or think rationally, crying easily, sleeplessness or sleepiness, irritability or

anger, moodiness, and uncommunicativeness (Blumenthal, 1988).

However, these risk factors have not been prescriptive for all incidents of suicide. Each adolescent or young adult confronted with significant indicators for risk have not necessarily been suicidal (Fawcett, et. al, 1987). Blumenthal (1990) identified factors that clinicians must consider when assessing a young person's risk for suicide. A modified summary of these factors have been outlined and adapted to include risk factors applicable in assessing adult's risk of suicide, thus providing a comprehensive (though not all inclusive) summary of risk factors for suicide assessment across the life span. Any of the factors listed may be present in the individual's life and not indicate any serious suicidal tendency; however, the combination of several of these signs has been cited to increase the severity of risk (Magill, 1993). These risk factors have been critical in the assessment of suicidal risk for there has not been a simple test or technique that has been applicable in identifying an individual's level of suicide risk. The aim of clinician's assessment has been to determine the individuals' current level of severity so that the appropriate course of intervention could be determined. The following risk factors related to suicide have been categorized across the following dimensions including presenting symptoms, psychiatric illness, personality factors, family

history, and psychosocial history (Blumenthal, 1990; DeSpelder and Strickland, 1996; Jacobs, Brewer, and Klien-Benheim, 1999; Moscicki, 1999; APA, 1994). Features within differentiated categories may overlap. These factors have been determined to be an important component in the prevention of suicide. Presenting Symptoms of suicide risk include:

- Hopelessness
- Self-reproach, feelings of failure and worthlessness
- A sense of a lack of control over one's life
- Low self-esteem and poor self-image
- Devaluing of emotional expression
- Depressed mood
- Agitation and restlessness
- Difficulties with sleep/sleep disturbance or insomnia
- Weight loss, slowed speech, fatigue
- Increased social isolation, withdrawal, or loss of interest in usual activities

Clinical considerations related to psychiatric illness have included the following range of risk factors:

- Previous Incident of Deliberate Self-harm (suicide attempt)
- Affective disorder

- Schizophrenia
- Alcohol and/or substance abuse
- Borderline or antisocial personality disorder
- Conduct disorder (particularly early stages of incarceration for young males).

Personality factors associated with higher suicide risk have been identified to include:

- Impulsiveness, aggressiveness, and hostility
- Cognitive rigidity and negativity
- Excessive perfectionism

A family history of suicide and/or family history of affective disorder and/or alcoholism have also been identified for consideration when determining the level of an individual's risk for suicide.

An individual's psychosocial history that has included the following events/features has been identified to increase suicide risk for some individuals:

- Recent loss, separation, bereavement
- Family chaos, lack of confidence, poor social supports

- Unemployed, recent job change or loss
- Running away from home
- Unwanted pregnancy
- Multiple life stresses (move, early loss, break-up of important relationship, school problems, threat of disciplinary crisis)
- Victim of physical, sexual or emotional abuse
- Chronic medical illness
- Excessive drinking or substance abuse
- Exposure to suicide
- Access to means
- Easy access to drugs or alcohol

Additionally, there have been specific factors relevant to suicide inquiry when identifying levels of risk. These factors have included:

- Presence of suicide intent
- Identification of a plan to commit suicide
- Identified means for committing plans
- Access to means

It has been a challenge for researchers to identify what differentiates

those who engage in deliberate self-harm or completed suicide and those who do not. For each risk factor pertaining to suicide and deliberate self-harm has been explored to reveal significant inter-factorial relationships. Research into suicide and deliberate self-harm has revealed further information relating the following risk factors: psychiatric disorders, alcohol and substance abuse, family indicators, cognitive factors, social environmental factors, other interpersonal, social and individual or predisposing risk factors. Risk factors of suicide include a multitude of indicators. The complexity in understanding the range of factors can be summarized as follows:

- There is not one single risk factor which determines or predicts suicidal behaviour
- Within any individual case history leading to suicide, various combinations of risk factors may be pertinent, and some risk factors may be absent. It is also possible that for any individual, factors which might be considered a risk factor other individuals, might function as a triggering events (i.e.: experience of trauma).
- Demographic variables do exist as an additional scope for examining at risk populations, however this is not the

primary target of this investigation.

- Predisposing risk factors such as a psychiatric disorder may be differentiated from more imminent or immediate signs of suicide (i.e.: suicidal intent, suicidal plans)
- The complexity of differentiating risk factors exists at various levels including family indicators, personality traits, individual vulnerabilities, and various triggering or precipitating factors including specific psycho-social histories (i.e.: excessive drug/alcohol use, recent losses, abuse, previous incident of self harm etc.). The compilation of these factors may increases risk of suicide in vulnerable individuals.

This study focuses on the exploration of critical, known risk factors and presenting symptoms associated with suicide including depression and hopelessness.

2.2.1 Psychiatric disorders.

Depression, alcoholism, conduct disorders, schizophrenia, personality

disorders, and a range of comorbid psychiatric disorders have been identified as risk factors of suicide and suicidal behaviour. Virtually all individuals across the age span with psychiatric diagnoses have been cited to be at a substantially higher risk for both attempting and completing suicide than the population at large (Low, 1990). People with mental disorders have ten times greater risk of suicide than the general population, but the degree of risk has depended on the nature and severity of the disorder (Healy, 1997; Wilson, 1991). Mental and addictive disorders have been held as key risk factors for suicide and suicidal behaviour. More than ninety percent of completed suicides in all age groups were associated with mental or addictive disorders (Healy, 1997; Moscicki, 1997); less than ten percent of people who killed themselves had no documented psychiatric illness (Shaffi, 1985; Barraclough, 1974). Substantial evidence from psychological autopsy studies of adult and adolescent suicides has revealed that most people who commit suicide were suffering from a major psychiatric illness at the time of their death, although only a small percentage were being treated (Shaffi, 1985). Evidence drawn from prospective studies of cohorts of youthful psychiatric patients and from retrospective studies of unselected samples of youthful suicide victims indicated that psychiatrically disordered young people may run a risk for suicide about two-hundred or more times the rate of their counterparts in

the general population (Low, 1990).

In adult populations, individuals who have engaged in nonfatal incidents of deliberate self-harm have been reported to more likely have personality disorders, chemical dependence, and situational disorders. Those who actually kill themselves have shown a predominance of major affective disorders, alcoholism, and schizophrenia. Substance abuse, depression, and behavioural disorders such as antisocial personality and conduct disorders have been found in much larger proportions in adolescent suicides than in older suicides (Moscicki, 1997). The co-occurrence of one or more of these illnesses with certain personality disorders, including antisocial or borderline personalities, has indicated an increase in suicidal risk. However, there have been limitations in predicting suicide based on these demographic variables. These factors often yielded many false positives. That is, many people have demonstrated a number of these risk factors, but have not proceeded to kill themselves (Low, 1990).

In adolescent populations, research studies have documented that 63-95% of suicide victims may suffer from psychiatric illness (Brent, et. al, 1988; Shaffi, 1985; Barraclough, Bunch, Nelson, and Sainsbury, 1974). Brent, Perper, Goldstien, Kolko, Allan, Alman, and Zelenak, (1988) also

found that one third of their sample had received some mental health treatment, but only 7% were under active treatment at the time of their death. The psychiatric conditions that have been empirically linked to suicide among young patient groups include 1) prior inpatient hospitalisation, 2) previous incident of deliberate self-harm (Shaffi, Carrigan, Whittinghill, and Derrick, 1985), 3) affective illness (unipolar and bipolar depression), 4) psychosis or schizophrenia, and 5) alcoholism and drug addiction (Low, 1990). Shaffer, Garland, Gould, Fisher, and Trautman (1988) reported results from a controlled study of adolescents' aged 15 to 19. Risk factors identified through this study were gender, being male, with a prior incident of deliberate self-harm, major depression, and substance abuse. Shaffer's et.al (1988) study also revealed the presence of conduct disorders in a large number of adolescent suicide victims often complicated by depression, substance abuse and previous suicidal behaviour. In a detailed study of patients admitted to a regional poisoning treatment centre, between 1968 and 1985, Hawton, Fagg, Platt, and Hawkins (1993) demonstrated the accumulative impact of psychiatric and stress-related factors, which were associated with deliberate self-harm in young adults. Their results indicated that people who engaged in deliberate self-harm, and who eventually died, were almost five times as likely to have had a previous hospital admission for mental illness, were likely to

have had long-standing difficulties as reflected in their previous incidents of self-harm, were of a lower socio-economic status, and had a diagnosis of personality disorder. No single factor necessarily led to suicide, but all these features were reported to be interactive in a manner unique to each individual. Major depressive disorder, dysthymia, disruptive disorders including attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, schizophrenia and developmental disorders have correlated highly with suicidal tendencies (Pfeffer, 1997).

2.2.2 Affective disorders.

Garland and Zigler (1993) identified that the most prevalent psychiatric disorders among competed adolescent suicides were affective disorders, conduct disorder or antisocial personality disorder and substance abuse. Affective disorders followed by alcoholism have been cited as the strongest observed risk factors for individuals who engaged in deliberate self-harm, and have been frequently been associated with suicide in adults (Barraclough, 1974; Winokur and Black, 1987; Moscicki, 1997). Depression has been consistently noted as a major correlate of suicide (Lennings, 1994). Anxiety, depression, and aggression have been most associated with youth suicidal behaviour (Pfeffer, 1997). Barraclough et. al.

(1974), in a study of one hundred completed suicides, recorded that 64% were diagnosed with a depressive illness uncomplicated by other serious physical or mental disorders. Suicidal thoughts and plans have also been common symptoms of major depression (Blumenthal, 1990).

Other symptoms of depression have included the persistence and clustering of several other complaints for longer than a 2-week period, including depressed mood, difficulty concentrating, appetite changes, sleep disturbances, psychomotor agitation or retardation, loss of interest or pleasure in usual activities, loss of energy and fatigue, feelings of worthlessness, and self-reproach, or excessive or inappropriate guilt (APA, 1994). In young people, additional symptoms have been cited to include vague somatic complaints, school problems, low self-esteem, irritability, and aggressive behaviours (Blumenthal, 1990). Symptoms of depression have been linked closely to problematic self-esteem and, in this way, have increased the risk for suicidal ideation and deliberate self-harm by increasing the risk for hopelessness. Deficits in self-esteem have also had effects on individuals' social relationships, and enhanced the risk for suicidal ideation or deliberate self-harm as social relationships tended to be problematic for such individuals (Pfeffer, 1997).

People who have suffered from bipolar disorder, mania, or hypomania have been considered to be at particularly high risk for suicide and suicidal behaviour (Brent, et. al., 1988; Avery and Winokur, 1978), as have those who have had a mixed cycling between depression and mania, and have been considered to be particularly vulnerable at the time of the switch (Fawcett, et. al., 1987). Brent et. al. (1988) reported that one-fifth of suicide victims had a diagnosis of bipolar disorder in his study of high risk, suicidal psychiatric inpatients. Though depression has been highly correlated to suicide, not all suicides have been linked to depression (Fawcett, et. al., 1987).

2.2.3 Anxiety disorders.

Anxiety has been identified as an important risk factor for suicidal adults. Fawcett, et. al. (1987) found that anxiety symptoms were highly correlated to completed suicide within one year of assessment. Weissman, Klerman, Markowitz, and Ouellette (1989) found that 20% of patients with panic disorders and 12% of patients with panic attacks had made suicide attempts. However, Hornig and McNally (1995) reanalysed the data from Wiessman's study and concluded that comorbid conditions and not panic disorder increased the risk for incidents of deliberate self-harm. Social

anxiety disorder has been shown to be the primary disorder in 70.9% of people with coexisting depression, 76.7% of people with coexisting drug abuse, and 85% of people with coexisting alcohol abuse. Data has indicated that the potential for suicide rises dramatically in-patients with social anxiety disorder with coexisting conditions (OCD and ADFV, 1996).

In a study of state and trait anxiety in adolescents who had engaged in an incident of deliberate self-harm, Ohring, Apter, Ratzoni, Weizman, Tyano, and Plutchick (1996), found that trait anxiety was significantly higher for those who had engaged in deliberate self-harm in comparison with those who did not. Schaffer (1988) identified a very different minority of adolescent suicide victims who had not exhibited any behaviour or school problems. These young people experienced pathological anxiety and were seen as perfectionistic and rigid; they appeared to be particularly vulnerable at times of change or dislocation.

Adolescents with eating disorders have constituted another risk group because they too have demonstrated self-destructive behaviours (Garland and Zigler, 1993). Affective disorders with a comorbidity, bipolar disorder, and lack of continued treatment, have been reported by Brent et. al. (1988) as specific risk factors for completed youth suicide.

2.2.4 Schizophrenia.

Schizophrenia has afflicted one percent of the population and carried with it a high incidence of suicide (Blumenthal, 1988). Sumich, Andrews, and Hunt (1995) reported that up to 50% of individuals with schizophrenia were clinically depressed during the first six months after the acute episode. The risk of suicide was particularly high during this period. Ten to fifteen percent of individuals with schizophrenia have ended their life by suicide (Ray, 1982). The risk of suicide has been considered to be particularly high in the first five years following diagnosis of schizophrenia. The risk of suicide has been considered greater for those who feel hopelessness, despair, fear mental disintegration, have had previous incidents of deliberate self-harm, have had a chronic relapsing course to their illness, and who have not been compliant with treatment (Virkkunen, 1976; Drake, 1985). Incidence of non-psychotic depression and the co-occurrence of alcohol and drug abuse have been identified to further contribute to suicidal risk (Drake, 1985). For individuals with schizophrenia, suicide has often been related to depression but may also have occurred in the absence of depression sometimes in response to delusional beliefs (Sumich et. al.,

1995).

2.2.5 Personality disorders.

A number of mental disorders have been cited as being highly correlated to suicide and suicidal behaviour. These disorders have included mood disorders, anxiety disorders, conduct disorders, and personality disorders.

Tyrer, Coid, Simmonds, Joseph, and Marriott, (1987) reported that individuals presenting with personality disorders, particularly with borderline and avoidant traits were among those who had frequently engaged in incidents of deliberate self-harm. Antisocial and borderline personality disorders were particularly associated with suicidal behaviour in adults; conduct disorders (Pfeffer, 1997), and borderline personality disorders were associated with youth suicide (Blumenthal, 1990). Lester (1990) indicated that personality disorders existed in a patterned way and were often present in people who have had a long-standing history of a lack of engaging with other people and of self-disruptive behaviour. These behaviours often damaged both themselves and others, and were associated with suicidal behaviour and suicide (Pritchard, 1995). Those most prone to

violent behaviour were those with a severe illness such as mania or acute schizophrenia, as well as deeply ingrained maladaptive, patterns of behaving (a disordered personality) (Tyrer, et. al., 1997). This combination of mental illness and disordered personality had been also associated with more self-harm and death by suicide (Friedman, 1983). In youths, the co-occurrence of depression with conduct disorder, anti-social personality or borderline personality disorder and substance abuse had represented an extremely lethal combination of factors. Furthermore, though individuals with borderline personality disorder often engaged in self-destructive behaviour, without lethal intent, at least 5-10% eventually committed suicide (Blumenthal, 1990).

2.3 Alcohol

Substance and alcohol abuse have played an important role in incidents of deliberate self-harm and suicide in adolescence (Greenhill and Waslick, 1997). Alcohol and substance abuse have represented major risk factors for all ages in both alcoholic and non-alcoholic populations (Barraclough, 1974). Drug and alcohol abuse has been considered a significant risk factor for suicidal behaviour as it has effected both affective, cognitive, social, familial, and behavioural functioning and acted

as immediate precipitants to suicide due to decreased inhibitions (Shaffer, 1988). Substance abuse and depression have been found to be associated with suicide more often than any other disorder (Rich, Fowler, Fogarty, and Young, 1988). Studies have indicated that alcohol was associated with anywhere from 25-60% of suicides (Brent, et. al., 1988; Shaffi, 1986; Winokur and Black, 1987).

The relationship of suicide and substance abuse in young people has been significant (Blumenthal, 1990). In a case-control psychological autopsy study, of 120 of 170 consecutive suicides of individuals aged under 20 years old, all but one of the individuals who completed suicide and had a history of substance or alcohol abuse, were male. A previous incident of deliberate self-harm, a diagnosis of mood disorder and substance or alcohol abuse significantly increased the risk for suicide (Schaffer, Gould, Fisher, Trautman, Moreu, Kleinman, and Flory, 1996). In over one- third of youthful suicide victims, substance abuse has been diagnosed, both alone and in combination with affective disorder (Shaffi, et. al. 1988; Friedman, 1985). Researchers have estimated that 60-70% of adolescent and youth suicide victims have suffered from alcohol or substance abuse problems (Brent et. al., 1988; Murphy, 1988).

Blumenthal (1990) reported that alcohol and drug abuse could be a complication of other psychiatric disorders including affective and anxiety disorders, schizophrenia and certain personality disorders. It has been estimated that 12-55% of alcoholics have an additional psychiatric diagnosis (Rich, et. al., 1988). Additionally, it has been reported that substance abuse exacerbates the course of psychiatric illnesses and may predispose to depressive symptomology. Many young psychiatrically ill persons have been reported to engage in alcohol and other drugs to self medicate. Alcohol has also been reported to increase the potential for other methods of suicide such as drug overdose. Friedman (1985) also reported that many adolescents and young adult victims of single motorcar accidents, thought to be suicides, had been drinking. Additionally, chronic alcohol abuse has been reported to contribute to the disruption of social relationships that increases social isolation and increases the risk of suicide (Rich et. al., 1988; Shaffi, et. al. 1985).

2.4 Family Indicators

Family factors are highly correlated with adolescent suicide (Magill, 1993). There has been a long-standing division between ideas of nature and nurture in the causation of mental illness. Through the years there has been

a growing recognition of the interaction between genetic predisposition and the environment. There has also been a growing appreciation of the biochemical changes related to eventual suicides (Pritchard, 1990). Family histories positive for suicide and for depression have frequently been found among suicidal patients of all ages (Low, 1990). A family history of aggression, substance abuse, and parent-child conflict has been associated with deliberate self-harm in adolescents (Greenhill and Waslick, 1997). Environmental and familial factors thought to be contributory to adolescent and youth suicides have included: interfamilial and extrafamilial exposure to suicidal behaviour, a family history of affective disorder and suicide, and the availability of handguns in the home (Brent et. al., 1988). A history of suicidal behaviour has been found in first-degree relatives of adolescent suicide victims compared with relatives of controls (Brent, Moritz, Bridge, Perper, and Canobbio, 1996). Youths whose parents and other family members who have engaged in suicidal acts have had higher rates of deliberate self-harm (Rotheram-Borus, Walker, and Ferns, 1996). Suicide and the psychiatric disorders commonly associated with it, such as affective disturbances, schizophrenia, antisocial behaviour, and alcoholism, have been found to run in families and have appeared subject to genetic transmission. Although environmental and learning factors have also been likely to be operative in adolescent suicide, twin and adoption studies of

suicide have suggested the operation of a genetic factor for suicide susceptibility that is independent of, or an additive to, the genetic transmission of other psychiatric disorders (Roy, Segal, Centerwall, and Robinette, 1991).

Family discord has been found to be associated with suicidal behaviour in young people. Poor relationships with parents (Camilleri and Storck, 1997), a lack of family cohesion and poor family behavioural control have been reported as important external stressors precipitating suicidal behaviour in adolescents (Pfeffer, 1997). A majority of adolescents who deliberately self-harm come from families in which home harmony has been lacking. It has been common that a high degree of conflict between the adolescent and his or her parents and a complete breakdown of family communications has been a precipitating factor for many youth suicides (Magill, 1993). A psychological autopsy study of 120 of 170 consecutive suicide victims younger than 20 years of age found that there was a significant independent impact of such psychosocial factors as school problems, a family history of suicidal behaviour, poor parent-child communication with both parents, and stressful life events (Gould, Fisher, Parides, Flory, and Shaffer, 1996). Gould et. al. (1996) also found that suicide victims were significantly more likely to come from a non- intact

family of origin, had significantly less frequent and less satisfying communication with their mothers, had mothers with a history of mood disorders, and a father with a history of trouble with the police.

Families of suicidal adolescents have been characterised as chronically disorganised, chaotic, and unstable with a higher prevalence of family break- up, violence, and suicidal tendencies. The experience of physical or sexual abuse in their family has also been reported as a serious risk factor for suicidal behaviour in adolescents (Wagner, 1997; Green, 1978).

In studies of suicidal children and adolescents, youths have responded to severe family discord by feeling expendable to the family. This has been proposed to develop out of blame being placed on the child with high levels of hostility, rejection, disapproval, and withdrawal of support being directed toward the youth (Asarnaw, 1987). Magill (1993) reported that studies of suicidal adolescents have found a lack of family cohesion. Many suicidal youths have felt unloved, unwanted, and alienated from their family. Additionally, the stressful life event of parental loss due to separation, divorce, or death has also been significant correlates to youth suicide behaviours (Pfeffer, 1997).

2.5 Cognitive Features

Though a number of developmental, sociological, and environmental factors have had an impact on an individual's risk of suicide, ultimately, the act of killing oneself has been considered by Lennings (1994) as a decision mediated through cognitive processes. Studies which have investigated the cognitive characteristics of suicidal individuals have identified that suicidal individuals demonstrated greater cognitive rigidity (Schotte and Clum, 1982), more dichotomous thinking, less effective problem solving (Schotte et. al, 1992), and more negative attitudes toward self and life, and more positive attitudes toward suicide than non suicidal individuals (Ellis and Ratliff, 1986). Though a number of variables have been identified, hopelessness, poor coping or problem solving skills, stressful life events, contagion effects, social withdrawal, and personality factor are among the features which have continually emerged out of the literature which explore the cognitive and social processes occurring for suicidal individuals.

2.5.1 Hopelessness.

Hopelessness has often been associated with suicidal behaviour (Garland and Zigler, 1991). Hopelessness has been demonstrated by the individual's belief that his or her situation will never improve. Hopelessness, as a cognitive process has also included the individual's belief that his or her current feelings would never change (Magill, 1993). Numerous research studies have demonstrated that hopelessness related more strongly to suicidal intent than depression (Blumenthal, 1990). After examining 2,174 outpatient clinic records over a 10-year period, Beck et. al (1985), found that out of the 10 individuals who eventually committed suicide, 90% of these patients scored 10 or above on the hopelessness indicator of the Beck depression scale.

The role of hopelessness in relation to suicide and suicidal ideation has been documented in a number of studies. Beck defined hopelessness as a cognitive variable that underlies suicidal behaviour. Some researchers have suggested that depression, characterised by increased levels of hopelessness, may be a subtype of depression (Lennings 1994). Hopelessness has been found to mediate the relationship between depression and suicide for individuals demonstrating incidents of deliberate self-harm for all age groups, as well acted as a predictor of suicide completion among adults demonstrating suicidal ideation (Beck, et. al.

1985). Case control studies have shown higher rates of hopelessness in inpatients (Spirito, Overholser, and Hart, 1991) and in female outpatients who engaged in incidents of deliberate self-harm (Marks and Haller, 1977).

2.5.2 Coping.

A number of studies have demonstrated cognitive differences between suicidal and non-suicidal persons, even when depression or the degree of psychopathology has been controlled. Suicidal individuals have tended to demonstrate factors such as dysfunctional attitudes, dichotomous thinking, rigidity, and the inability to generate or act on alternative solutions. These factors have been related to the general category of poor problem solving abilities (Weishaar and Beck, 1990). Deficits in interpersonal problem-solving skills, such as generating fewer alternative solutions to problems and seeking social support less often have often been associated with suicidal behaviour (Rotheram-Borus, et. al., 1990; Garland and Zigler, 1993). Studies have identified that suicidal risk has been associated with irrational thinking, poor problem solving, (Bonner and Rich 1987; Rainieri, Steer, Laurence, Rissmiller, Piper, and Beck, 1987), dysfunctional attitudes (Ellis and Ratliff, 1986), and dichotomous thinking (Lester, 1992). Research has indicated that individuals with suicidal ideation demonstrated

worse problem solving skills, including less knowledge of how to solve their problems and handle emotions, and were more cognitively rigid than non-suicidal students (Bonner and Rich 1987).

Thomssen and Moller (1988) found that individuals who engaged in deliberate self-harm used problem focused ways of coping less often and used emotion oriented, wishful thinking, self-blame, and denial/avoidance strategies to cope more often. Cole (1989) suggested that a failure to believe in one's own self-efficacy and ability to cope might be more critical than the factor of hopelessness. Asarnow, Carlson, and Guthrie (1987) found that suicidal children failed to spontaneously generate cognitive mediation strategies to regulate their affective and behavioural responses to stressful events. The presence of dysfunctional assumptions (Deal and Williams, 1988), the absence of positive reasons for living (Linehan, Goodstien, Nielsen, and Chiles, 1983), dichotomous thinking, and the limited ability to generate solutions to interpersonal problems have been cognitive variables cited to affect suicidal behaviour (Wiesshar and Beck, 1990).

2.6 Life Events

Systematic clinical studies of suicides have found psychosocial stressors in virtually every case (Rich, et. al., 1988; Chynoweth, Tonge, and Armstong, 1980). Individuals who were reported to be experiencing an excess of stressful recent life events were reported to be at a higher risk for suicide than those who experienced fewer stressful life events (Low, 1990). Interpersonal losses and conflicts, family disruptions, medical illness, moving, legal problems, and economic problems have been found to be the most common stressors among those demonstrating suicidal behaviour (Murphy, 1988; Rich, et. al, 1988; Moscicki, 1997).

Further evidence has suggested that suicide victims have experienced more recent interpersonal conflict, stress of all kinds, more interpersonal loss or conflict, death or loss of significant others, more critical events (especially humiliating events and acute psychiatric episodes), in the week or year prior to their suicide (Rich, et. al., 1988; Litman, 1989). Younger victims of suicide also tended to have experienced more legal troubles, economic stress, and unemployment, (Lester, 1992). Stressful life events have included such incidents as: the birth of a sibling, parental death, parental hospitalisation, separation, divorce, remarriage, the death of a grandparent, spouse, significant other, or other profound interpersonal loss or rejection, loss of employment, being jailed, or being diagnosed with a

terminal illness. Some investigators have suggested that the accumulation of recent life stressors, rather than the specific nature of these stressors, may increase the likelihood of suicide (Brent, Perper, Moritz, Baugher, Roth, Balach, and Schweers, 1993; Lesage, 1994). Research has indicated that compared to normal controls, those who engaged in an incident of deliberate harm experienced more severely stressful life events in the three weeks prior to their attempt (Farmer and Creed 1989). The most important problems facing these individuals were more often interpersonal (Linehan, Chiles, Egan, Devine, and Laffaw 1986). Stressful events, particularly in the areas of personal relationships, general well-being and problems with authority have been identified as significant stressors for those who engaged in incidents of deliberate self-harm (Welz, 1988).

However, Low (1990) argued that life stress has not, by itself, been important enough to serve as a predictor of suicide. Stressful life events have been an inevitable part of the life cycle. Dietzfelbinger, Kurz, Torhorst, and Moller, (1988) suggested that it has not been so much the social environmental variables (e.g.: life events or social support) that have been responsible but rather the manner in which an individual having a particular personality reacts to these variables.

2.7 Suicide Clusters

The impact of a negative life event of a suicide has also been identified as a trigger that may lead to additional incidents of suicide in communities. As with other negative life events, the impact of a suicide on a community may result in copy-cat acts or additional suicidal incidents. However, as with most factors pertaining to suicide this contagious effect has not been readily predicted. Suicidal behaviour has often appeared to have an epidemic or contagious nature (Hawton, 1986). A suicide cluster has been defined by O'Carroll, et. al. (1988) as "a group of suicides or suicide attempts or both, that occur closer together in time and space than would normally be expected in a given community" (p.1). Evidence has suggested that the exposure to the suicidal behaviour of others has led to suicidal behaviour in vulnerable individuals (Davidson, Rosenberg, Mercy, Franklin, and Simmons, 1989; Wagner, 1997) Many youth oriented suicide prevention programs and school policies have highlighted specific procedures for managing post-suicidal incidents (Brock, 2001).

2.8 Relationships and Social Indicators

Modern psychology has attempted to describe the connection between

life events, and the development of individual personality. Coping strategies and different mediating factors have been seen as essential in the individual's reaction to his life events. Social supports and various types of coping behaviours have frequently acted as a buffer to stressful events (Moller, et. al., 1988). Factors such as social withdrawal and a history of fewer adolescent friendships have pointed to possible interpersonal deficits associated with suicide (Fawcett, et. al, 1987). Wade (1987) found that adolescent girls who had attempted suicide demonstrated greater separation-anxiety. Boys have been reported to be at greater risk for suicide completion following a romantic break-up than girls. Data from psychological autopsies has indicated that adolescent male suicide victims had developed an excessively dependent romantic relationship, making them subject to overwhelming stress when their girlfriends left (Gould et. al, 1996). Suicidal adolescents have been described as having insecure or disorganised attachment styles, which were associated with cognitive distortions and impairments in interpersonal relations especially under stressful conditions (Pfeffer, 1997). Research studies have found that individuals who had attempted suicide were less well socially integrated (in their community, their work, and their family/friends) and had less available attachments than the general population (Bille-Brahe, 1988). Young adults or adolescents who were subjected to drifting with no

connection to either school or work were reported by Gould et. al.(1996) to have an increased risk for completing suicide.

2.9 Personality Traits

Personality has played an important role among the psychological risk factors predisposing suicidality (Dietzfelbinger, Kurz, Torhorst, and Moller, 1988). In addition to the characteristics of poor problem solving, depression, helplessness, and hopelessness, personality traits that have been suggested as being particularly relevant to suicide include: self degradation, intropunitiveness, belief in external locus of control, neuroticisim, alienation, low self-esteem, and a propensity for risk taking. Research studies of young people who committed suicide pointed to specific personality traits including the tendency to be withdrawn, perfectionistic, impulsive, or aloof (Holden, 1986; Schaffer, 1974; Dean, Range, and Goggin, 1996)

Adolescent males who deliberately self-harm have been found to be more anxious, restless, perfectionist, and fearful. Adolescent females who deliberately self-harm were reported to be more dependent, isolated and self reportedly unstable than non-suicidal adolescent females (Marks and

Haller, 1977). Additional personality traits that have been associated with adolescent suicide include: heightened anxiety, hostility, interpersonal sensitivity and obsessive compulsiveness (Tishler and McKenry, 1988). These traits although associated with suicidal behaviour have been poor predictors independently, because they may be associated with other psychotic disorders (Low, 1990). Impulsivity has been perceived as a major correlate in adolescent deliberate self-harm and suicide ideation (Withers and Kaplan, 1987; Klierman, 1987). Impulsivity has been reported to play a role in weakening the restraints in a suicide prone adolescent (Lennings, 1994).

2.10 Summary

Understanding the increasing rates of suicide within our culture has required an understanding of the multi-layered, multi-factored scope of the problem. Suicide, deliberate self-harm and suicidal ideation have occurred across all echelons of society and existed in every culture. Research has identified prominent risk factors associated with suicide. There have been numerous acknowledged factors associated with completed suicide. A number of these critical factors have included: mental and addictive disorders, especially mood disorders, gender (male), previous incidents of

deliberate self-harm, access to means, and cumulative risk factors. These factors have been among the key features that many clinicians sight in determining the level of an individual's risk of suicide. However, these factors alone have not been foolproof in the identification of risk nor in the prevention of suicide. This study focuses on the risk factors of suicide as a means of exploring the presence of underlying cognitive schemas, or interpersonal anxieties.

However, the plethora of at risk behaviours that may be considered when identifying a suicidal individual has been so all encompassing that the task of addressing suicidality can become lost. Increasing public consciousness on the issue of suicide has provided limited measurable influence in the prevention of suicide. The dynamics involved in preventing suicide have been highly complex. As the field of suicidology grows it has become increasingly important to develop theoretical frameworks that can be examined and developed over time.

Many suicide prevention programs have tended to approach suicide prevention from a community-wide framework. From this orientation, risk factors have expanded to include a broader range of behaviours, negative life events and indicators that refer to suicide risk. Approaching suicide risk

and prevention from a comprehensive approach has been a central focus of suicide prevention programs. Ultimately, there has not existed one single factor or one clearly and widely identifiable indicator of suicide risk. In some complicated cases of maladaptive psychosocial behaviour, the risk factors related to suicide have become blurred by the immediacy of more pervasive psychiatric disorders such as substance abuse or personality disorder (Alsop, Harris, Powell-Davis, Battye, and Gerhardt, 2000). Multiple factors have contributed to suicidal outcomes. The factors relevant to the proposed research included an overview of indicators related to psychiatric disorders. Additionally relevant factors included depression, coping, negative life events, hopelessness and associated cognitive features.

Chapter Three: Developing a Model of Suicide Ideation

3.1 Introduction

A number of theories have been developed in order to understand the complex problem of suicide. Theories of suicide have traditionally followed three models: 1) epidemiological, 2) individual differences, and 3) environmental. Though theoretical models have contributed meaningful information, the overall findings have provided limited use in the prediction of suicide (Bonner and Rich, 1987). However, Leenaars (1996) argued that theory is the foundation of science and is required in order to understand any human behaviour. The pathway that leads to suicide has been identified as multifaceted, and because the continuum of suicide (e.g.: suicidal thoughts, to deliberate self-harm, to completed suicides) has been demarcated by complexity, it is likely that no singular theory can explain suicidal behaviour. No single theory can provide an answer to all suicidal behaviours. However, theories of suicide have been worth exploring as models for the further investigation and understanding of

suicide and suicidal behaviour. The model on which this research is based is Baumeister's escape theory of suicide.

Current interest in youth suicide warrants specific research and intervention and prevention strategies that effectively target young people. The purpose of this investigation is to explore one theoretical framework as it relates to a suicidal population. Though research has identified specific factors that impact suicidal behaviours in youths, the current model, as proposed in the following chapter, encompasses a broad age span. The purpose for targeting a wider bandwidth of individuals assists in verifying the fundamental premise that a revised model of Baumeister's theory may be warranted. The theoretical framework under investigation involves several universal risk factors to suicide. A broad base application of currently accepted risk factors of suicide was necessary in establishing a frame of reference for Baumeister's escape theory.

3.2 The Escape Theory of Suicide

Baumeister (1990) proposed one model of suicide based on the concept of escape, or flight. The theory that Baumeister proposed, relevant to this research, argued that suicide is an escape from the self. The theory was built on the concept that the individual is escaping from meaningful self-awareness and implications about the self. The individual would seek to escape negative emotion, eventually by escaping from the feeling entirely. Baumeister's (1990) escape theory had six main steps. First, the individual experiences a stressful life event in which the current outcomes or circumstances fall far below the individual's standards. This failure of standards would be produced either by unrealistically high expectations or by recent problems or setbacks or both. Second, the individual would make internal attributions and blame the disappointing outcomes on him/herself. This would create negative implications about the self. Third, an aversive state of high self-awareness would develop from comparing the self with relevant standards. This aversive state of high self-awareness would also be connected with self-blame for recent disappointments. The individual would be acutely aware of him/herself as inadequate, incompetent, unworthy, and guilty. Fourth, negative affect would arise from the

unfavourable comparison of self with standards. Fifth, the person would respond to this unhappy state by trying to escape from meaningful thought into a relatively numb state of cognitive deconstruction. Baumeister further theorised that this form of escape would not be fully successful, and so the individual would desire an increasingly stronger means of terminating these negative thoughts and feelings. Six, the consequences of this deconstructed mental state would include a reduction of inhibitions that may contribute to an increased willingness to attempt suicide. Suicide would emerge as an escalation of the person's wish to escape from meaningful awareness of current life problems and their implications about the self.

Baumeister's (1990) escape theory of suicide has been previously examined (Dean and Range, 1999, Dean et. al. 1996). Baumeister has produced a plethora of social psychology research which addresses self regulation (Baumeister, Muraven, and Tice, 2000), interpersonal aspects of guilt (Baumeister, Stillwell, and Heatherton, 2001), self defeating behaviour (Twenge, Catanese, and Baumeister, 2002), repressive coping, (Boden and Baumeister, 1997) social exclusion (Twenge, Catanese, and Baumeister, 2003; Baumeister, and Leary, 2000), and concepts of the social self (Baumeister and Vohs, 2004; Baumeister and Twenge, 2003; Baumeister, 1999). However, the primary target of this research involves

Baumeisters (1990) escape theory as the basis of exploration. Twenge, Catenes and Baumeister (2002) identified that self-defeating behaviour can occur out of social exclusion. Baumeister further presents research on self-regulation (Baumeister and Vohs, 2004, Baumeister and Vohs, 2003), willpower (Baumeister and Vohs, 2003) and addresses the internal processes occurring in relation to self-concept and behaviour. Baumeister's critical studies include other theoretical aspects and an additional model of suicide (Vohs and Baumeister, 2000). Vohs and Baumeister (2000) propose a combination of the escape theory of suicide with a resource model of self-regulation that offers explanation of the processes occurring which reduce self-regulation or inhibition. Vohs and Baumeister (2000) stated, "when people attempt to escape from the self, internal efforts may focus on trying to alter their emotional states or reduce the high awareness of personal failures and inadequacies". These processes of self-regulation offer an exploration of the model of the escape theory and address the state of ego depletion in which self-regulation becomes increasingly passive.

This investigation explores one theoretical framework as a means of expanding an unidentified variable of fear of negative evaluation as it relates to one model of the process of suicidal ideation. For this reason, Baumeister's Escape theory is targeted scaffold for this research.

Theories of self-regulation, ego depletion and were not of primary focus for the aim of this investigation.

3.3 Interactional Model

Two recent studies, Dean and Range (1999) and Dean et. al (1996), provide support for an interactional model of suicide and offer support for the Escape theory of suicide. Dean et. al. (1996) examined an aspect of the escape theory in relation to the development of suicidal ideation and concepts of perfectionism. They posed that this model was not linear, but interactional. A review of the escape theory, based on Baumeister's theoretical principals, was examined as a component of this research. A revised, interactional model includes the investigation of attributions for events, coping style, self-awareness, self-aversion, depression, and hopelessness. The pathway that would lead to suicidal ideation or suicidal behaviour would involve a number of features, and would include aspects relevant to the escape theory of suicide. In a study of outpatients vulnerable to suicidal thoughts, Dean and Range (1999) concluded that the Escape theory of suicide offered a strong overall Goodness of Fit index, resulting from the expected relations between depression, hopelessness,

reasons for living and suicidal ideation.

The proposal for this investigation is only one possible model of an interactional process. First, the individual would experience a negative or stressful life event. This factor is not directly included in phase 1 of the investigation but becomes more meaningful in the discussion of results from phase 2. Research has clearly documented that stressful life events are associated with the risk of suicide and suicidal behaviours, establishing this factor in phase 1 of the investigation would not contribute to answering the proposed hypothesis. Second, the individual would cope with these events through an avoidant or maladaptive style of coping. Third, the individual would attribute self-blame for a failure to cope with these events, including the events themselves. This would require the individual to be aware of his/her behaviours and coping abilities. Fourth, as an extension of this avoidant coping style, the individual would fear engagement with others (who may also be a source of conflict or stress) and generally would avoid other possible avenues of support. This would increase isolation and further alienate the individual. Fifth, self- blame would build into a self-aversion, which would lead to a sense of hopelessness, and possibly to depression. Six, suicide would become a viable option of escape from oneself, and would follow the pattern of avoidant coping. Though this model has been

presented in linear terms, the interactive processes involved in the development of self-aversion, fear of negative judgement/interactions with others and the continually avoidant pattern of coping, would interact and build up to a final attempt to escape.

In order for this theory to be possible, it would require that the individual would typically cope through an avoidant style of coping. Several research studies have demonstrated a relationship between an avoidant style of coping and deliberate self-harm (Josepho and Plutchik, 1994; Thomssen and Moller, 1988). Shneidman (1980) proposed that suicide is the outcome of intolerable psychological or mental pain, perturbation and press which he labelled as psychache. In order to reduce this internal psychache, Shneidman suggested that individuals release their tension or further escape from him/ her self by deliberately engaging in self-harm. In this context, self-aversion would build and may manifest as a source of stress, anxiety, depression, or psychache.

This theory suggested that individuals respond to stress by demonstrating a maladaptive and/or avoidant style of coping. They would attribute these poor coping responses to themselves, blame themselves for negative events, and develop negative state of self-aversion (depression).

The combination of an avoidant style of coping and fear of others contributes to further isolation.

3.3.1 Behavioural continuums of escape/ suicide

Lennings (1994) emphasised that the concept of escape can be generalised to behaviours other than suicide or behaviours that are frequently associated with suicide such as addiction, and risk taking behaviours. A number of investigators have suggested that suicidal behaviours should be conceptualised as a continuum of suicidal ideation, contemplation, threats, attempts, and completions in which suicidal ideation is viewed as a precedent to suicide contemplation (planning, preparation, etc.), which then leads to threats and attempts which ultimately proceed to suicide completions (Rickelman and Houfek, 1995; Beck, et. al., 1985; Ritter, 1990)

Boudewyn (1995) stated that chronic self-destructive behaviour is the tendency to engage in behaviours that result in negative consequences for oneself, as well as the tendency to avoid engaging in behaviours that lead to positive consequences for oneself. Escape behaviours may occur as a consequence of a failure to cope appropriately and effectively with stress

(Lennings, 1994). Such behaviours would represent a way out. In this context, suicide would be linked on a continuum with other escape behaviours.

3.3.2 Coping style.

The relationship between suicide and avoidance has been important for a variety of reasons. Evidence of avoidance has been present in a variety of contexts for individuals demonstrating suicidal behaviours. Individuals who have engaged in deliberate self-harm, for example, appeared to avoid problems they were struggling with (Josepho and Plutchick, 1994). Research has suggested that suicidal individuals also tended to avoid medical treatment (Martin, et.al., 1993; Smith and Crawford, 1986). Suicidal individuals may be struggling with continuing avoidance issues, which manifest as an internal struggle between their desire to live and their desire to die. This struggle may mean more than an internal struggle between life and death, but if extended, would parallel the conflicts and aspects of pain, from which they were attempting to escape. In this context, suicidal thoughts would emerge as an ambivalent option of escape from the aspects of the psychological pain and social supports from which the

individual had attempted to avoid. This emotional or psychological struggle may start earlier, at the stage of contemplation and, as a patterned response, would occur at other suicidal continuums such as an incident of self-harm or even a completed suicide. By identifying the factors that cause or contribute to psychological pain, or distress, interventions could be developed to respond to the issue of avoidance and suicidal behaviours on a continuum.

Stress, anxiety and coping are enduring aspects of everyday life. An individual's coping strategies (or style) would play a major role in an individual's physical and psychological well being when he or she is confronted with negative or stressful life events (Endler and Parker, 1990a). Originally, coping was conceptualised as an unconscious process. Freud theorised that individuals responded to stress through various defence mechanisms. In more recent research coping has been conceptualised as a response to external stressful or negative events. These responses were usually conscious strategies or styles on the part of the individual (Endler and Parker, 1990a). Coping has always involved some kind of change or adjustment in the transaction between people and their environment. The elements to be modified would be either external factors within a given situation or intraindividual factors such as cognition and emotion. In the

first case, coping strategies would aim for changes in the real world by such means as direct action, support seeking and/or task oriented behaviour. In the second case, coping strategies would imply either cognitive changes such as minimisation, restructuring, and efforts to restore self-esteem or to focus directly on the negative emotions with the aim of eliminating or reducing (at least temporarily) the impact of these negative emotions without changes to address the given situation (Gutscher, 1988; Taylor, 1983). Some individuals would be likely to demonstrate particular coping styles or patterns in responding to different stressful situations (Endler and Parker, 1990b).

A number of studies have investigated styles of coping in relation to suicide and suicidal behaviours. Josepho and Plutchik (1994) found a significant and positive relationship between suicide risk and suppression and reported that the more an individual utilises avoidance manoeuvres as a means of coping with stress, the higher their risk of suicidal behaviour. In their study, suppression, as a coping response, was described as the avoidance of the person or problem that the individual perceives as the source of the situation. This dimension of coping stemmed from the emotion of fear and the behavioural response of escape, reflects a style of dealing with stress primarily through avoidance. Examples of this coping

method included: " I try to avoid unpleasant situations," " I avoid funerals" and "I take tranquillisers when I feel nervous". Thomssen and Moller's (1988) findings supported the existence of self-blame and avoidant/denial coping strategies in relation to deliberate self-harm. However, the links between an avoidant style of coping, self-awareness, and suicidal behaviours have not been fully explored. When an individual both blames him/her self, is aware of his/her actions, reactions and negativity, and tends to avoid stressful or negative situations (as a coping response), it would be logical that the individual would also desire to avoid oneself (a cause of further pain).

Based on the revised model of the escape theory, maladaptive coping is considered to include styles of coping that relied on poor problem solving, irrational thinking, self-blame, difficulty handling emotions, and avoidant coping strategies.

3.3.3 The role of attribution.

Attributions have been considered as attitudes, beliefs, and appraisals that people use to explain world events and particularly, the events that happen to them personally (Rickelman and Houfek, 1995). Ellis and Ratliff (1986) concluded that individuals were upset more by their own interpretation and appraisal of stressful events than by the events themselves. Attribution theory has been the premise of learned helplessness and primarily a reformulation of the learned helplessness (Abramson and Sackeim, 1978) model of depression. Research has revealed inconsistent support for this model (Gladstone and Kaslow, 1995). However, Sweeny, Anderson, and Bailey (1986) conducted a metanalysis on the relationship between attributional style and depression in adults and concluded that

> internal, stable, global, attributions for negative events and /or external, unstable, specific attributions for positive events are significantly associated with depression, and that the relationship between depressive symptoms and attributions for negative events was stronger for depressive symptoms and attributions for positive events, and that the relationship between attributions and depression was not effected by a variety of potentially mediating variables (p.976).

Gladstone and Kaslow (1995) found consistent results in their review of literature on attribution style and depression in adolescents and children. Researchers who attempted to demonstrate a link between causal explanations for events and depression worked from the premise that: individuals who have an explanatory style of internal, stable, and global causes for bad events tended to become depressed when bad events occurred (Peterson and Seligman, 1984).

According to attribution theory, in response to negative events individuals blamed themselves for the negative event (internal), viewed the cause of the event as consistent over time (stable) and generalisable across situations (global) (Gladstone and Kaslow, 1995). An overall attributional style of more internal, stable, global causes for negative events and external, stable, specific attributions for positive events was associated with increased levels of depressive symptoms. The direction of causality has been challenged, suggesting depression causes negative internal global, stable cognitions rather than the reverse (Cochran and Hammen, 1985). However, Priester and Clum (1992) investigated the interaction of attributional style and stress and concluded that attributional style preceded depressive symptoms, hopelessness, and suicide ideation. Bruss (1988) studied characteristics of hopelessness in depressed patients and found that

the most prevalent, defining characteristic was sighing and saying "I can't", which may have evidenced a negative cognitive schema and a sense of incompetence related to global, stable, and internal attributions.

For the purpose of this research, the proposed model hypothesises that individuals who contemplate suicide would tend to avoid tasks perceived as difficult, and this tendency may manifest as an avoidant or other maladaptive style of coping. For the purposes of this investigation, the role of attribution is relevant in determining the level of blame individuals place on themselves for negative or stressful life events, and their ability to cope with these events. Attributions are a critical link in the interactive chain of events that this model proposes. In relation to the proposed model of suicide, the attribution theory would imply that suicidal individuals believe that their unhappiness is due to global internal (rather than external) factors, and the internal factors could be stable or unstable (situational). The critical component of attribution will be how the individual perceives: recent negative events, their response to these events, and whether they attach blame to themselves for either of the events themselves or their response to the events. Internal attributions for negative events will be a component of phase 2 of this investigation as related to the proposed model. Attributions for self-blame, would appear to be the step which may

lead to a state of self-aversion, shame, self-hate, or depression.

3.3.4 Self-aversion.

The escape theory of suicide emphasised a recent state of negative attitude toward the self rather than chronic low self-esteem (Baumeister, 1990). If, as the hypothesis suggested, individuals tend to attribute negative events to themselves, blame themselves for their inability to cope with these events as well as blaming themselves for the actual events, then it would be likely that individuals may, as Lester (1997) has highlighted, also develop a sense of shame as a component of a state of self-aversion. The role of shame in relation to this model is critical in that, as an emotional state, shame may be reflected in a number of the dependent variables to be examined. Those variables would include: self-blame, self-aversion, avoidant coping, and a fear of negative evaluation by others. Lester (1997) highlighted that shame may manifest within the self as a whole and would generate a desire to hide, disappear, die, or escape the interpersonal situation in question (Tangney, 1991). Furthermore, this sense of self-shame would lead the individual to conclude that he or she is no good, inadequate and unworthy. These terms were similar to those used to describe self-aversion.

Negative views of the self, being self-hate, shame or feelings of worthlessness, in the context of this research are a likely component of what could be more broadly termed self-aversion. In relation to the escape theory of suicide, and the model proposed, Lester also emphasised that escape from others (as well as self) was more convincing since shame is a socially determined emotion. The revised model of the escape theory draws connections between patterns of avoidance, self-blame, self-aversion and fear of negative evaluation by others. This connection was further supported by the concept of shame. Shame proneness and the externalisation for causes of blame, as well as anger, arousal, and hostility, have previously been linked (Tangney, Wagner, and Gramzow, 1992). In the case of suicidal behaviours, and the model being examined the hypothesis indicated that shame and internalisation of cause (self-blame) would be linked. Lester (1998) identified that shame was more strongly associated with suicidality than guilt. In this study, Lester differentiated shame from guilt as shame involved the "inability to face other people" or to hide one's actions; whereas guilt, involved internal negative, emotional awareness, but was less prone to secrecy from others. Though suicidologists have suggested a link between shame and suicide, it has been unclear what the role of self-blame, suicidal behaviours and shame play in

relation to one another.

Gilbert, Pehl and Allan (1994) stated that shame was not one affect but was related to a variety of emotions and cognitions such as fear of negative evaluation, feelings of helplessness, anger at others, anger at self, inferiority and self-consciousness. The experience of shame has been one of acute self-awareness in relation to social others (Mokros, 1995) and involved the self's negative evaluation not of a specific behaviour, but of the entire self (Tangney, 1991). Shame has invoked the experience of an objectified self, and the experience of a split self away from this objectified self, within the context of social expectations as voiced by others. Feelings of shame in the continuum of shame to pride, would lead to a dysfunctional state in which the individual experiences separation, distance and "no sense of social place" (Mokros, 1995). Shame would be a global, painful, devastating experience. The negative affect that has accompanied shame involves a sense of shrinking, being small, and by a sense of worthlessness and powerlessness. Research on the concept of fear of negative evaluation, which is investigated in this study, matches shame (Gilbert, et. al., 1994).

Gilbert suggested that the definition of the fear of negative evaluation could be paraphrased as shame proneness. Findings suggested that people

who fear the negative evaluation of others were both aware of social rank/status issues and operated selectively within them, and were inhibited from challenging those seen as superior or more powerful (Friend and Gilbert, 1973; Gilbert et. al., 1994). States of self-aversion, shame or deep humiliation may have a number of sociological and biological influences. Biological and sociological models suggested that emotions may have a physiological basis which would be shaped over time, and that a range of sociological factors, such as long standing social isolation or situations perceived as hopeless in which escape is blocked would potentially influence individual states of depression and suicidal behaviours (de Cantanzaro, 1991; Gilbert, 1992).

For the purposes of this study, the existence of a state of shame or self-aversion will be critical to document. However, the depth, range, and full description of these negative emotions (e.g.: measuring the emotion of shame) would be not necessary to distinguish. The critical component, for the purpose of this research, will be the existence of a cognitive state of negative self-awareness.

Negative views of the self may manifest as an intermediary step between self-blame and self-aversion. This study will explore self-aversion

as a state based on recent or automatic thoughts the individual experienced the in relation to suicidal ideation. Mills, Dunham, and Alpert (1988), demonstrated those youths at high risk for suicide, developed a cognitive framework that confirmed specific attitudes toward the self and the environment. Research has documented that suicidal individuals tended to demonstrate low self-esteem, feelings of worthlessness, and had more interpersonal difficulties (Bonner and Rich, 1987; Blumenthal, 1988). Most young people who committed suicide were those who had difficulty finding a secure role in society. These individuals experienced a deeply humiliated state of being and often have no one to turn to (Mokros, 1995). Suicidal ideation and behaviour may be viewed as an attempt to cope with a perceived psychological loss that results in a deterioration of the sense of self-integrity and self-cohesiveness. Suicidal ideation and behaviours would act as an effort to communicate the sense of loss and lack of self-cohesion, and these suicidal behaviours would act as a defence against being overwhelmed by unwanted emotions (Shreve and Kunkel, 1991). This research will attempt to demonstrate that self-aversion,
as manifested by negative cognitions about the self, would be one component of an internal pattern or process of an escape/avoidance interaction.

3.3.5 Fear of negative evaluation.

It has been within the context of social bonds that individuals have experienced the self, through the actions and reactions of others (including self as other) to the self (Mokros, 1995). Dean and Range (1996) have documented the relationship between suicidal ideation and socially prescribed perfectionism which involved an individual's perception that he or she needed to attain standards and expectations that were imposed by significant others. However, few studies have identified the relationship between fear of negative evaluation and suicide. Fear of negative evaluation has been more frequently reported in women (Gilbert, et. al., 1994) as are incidents of deliberate self-harm. Fear of negative evaluation has been associated with a number of psychological features such as socially prescribed perfectionism (Flett, Hewitt, and DeRosa, 1996), and social anxiety (Monfries and Kafer, 1994; Leary, 1983). The fear of negative evaluation was defined by Watson and Friend (1969) as: "apprehension about others evaluations, distress over their negative evaluations, avoidance of evaluative situations and the expectation that others would evaluate oneself negatively" (p.449). Gilbert et. al. (1994) suggested that the definition of fear of negative evaluation could be paraphrased for the definition of shame proneness.

Davidson, Feldman, and Osborn (1984) found that individuals demonstrating high fear of negative evaluation and high levels of irrational thinking tended to perceive stressful situations as more stressful and anxiety provoking than individuals with lower levels of fear of negative evaluation and low levels of irrational thinking. The fear of negative evaluation has been an indicator relevant to diagnosing social anxiety disorders such as social phobias (Jefferys, 1996). Social phobia, for example, has recently been called the third most common psychiatric disorder followed by depression and alcohol (Jefferys, 1996; Kessler, McGonagle, Shanyang, Nelson, Hughes, Eshleman, Wiltchen, and Kendler, 1994). The role of fear of negative evaluation may be a critical link that underlies features of suicidal behaviours. Fear of negative evaluation may be a more critical indicator of suicidal ideation than socially prescribed perfectionism because it has more tangible implications for diagnosis and treatment, and measures an individual's level of fear, or perhaps fear of failure, rather than simply the need to meet high expectations or to perform.

Abramson and Sackiem (1977) theorised that in relation to depression, individuals may blame themselves for things that they believe they neither caused nor controlled. So may suicidal individuals with high

levels of fear of negative evaluation, experience a state of paradox in which they would demonstrate an approach- avoidance tendency of avoiding disapproval but also seeking approval (Friend and Watson, 1969). Schneier, Johnson, Horning, and Liebowitz (1992) reported that incidents of deliberate self-harm and the experience of wanting to commit suicide has been common for individuals experiencing social phobia. High fear of negative evaluation was a critical indicator in the identification and treatment for social phobia, and fear of negative evaluation was a critical indicator of shame (Gilbert, et. al., 1994) which may also been associated to suicidal ideation (Lester, 1997). People who were highly fearful of negative evaluation would attempt to avoid potentially threatening social comparisons to a greater degree (Friend and Gilbert, 1973). Individuals who demonstrated a fear of negative evaluation would also follow an avoidant style of coping. People who were highly concerned about being perceived and evaluated negatively would be more likely to behave in ways that would avoid the possibility of unfavourable evaluations (Leary, 1983).

Critical to the proposed interactional model of escape, would be that fear of negative evaluation would further expand and explain suicidal individual's tendency toward isolation in context of self-blame, avoidant style of coping and would expand Baumeister's (1991) model from an

escape from the self to include an escape from others. The concept of fear of negative evaluation would also support Baumeister's (1991) original escape theory and Dean's et. al. (1996) findings in that the individual may indeed possess high expectations. However these expectations alone would not create internal psychache. It would be the fear attached to potential negative evaluation within the context of an interactive model that would lead to suicidal behaviours. The presence of high levels of fear of negative evaluation in suicidal individuals would also explain commonly identified behaviours of isolation and withdrawal not only as potential symptoms of depression, but in the context of a state of self-aversion and a pattern of avoidant coping.

3.4 Summary

The social role of a suicidal individual has been a focus of contemplation since the early development of the study of suicide, or suicidology. The field of psychology has perseverated on the internal world of the suicidal mind. In considering the prevention of suicide, both community oriented and individually targeted prevention methods have been applied. By transposing Baumeister's escape theory of suicide into an interactional model of suicide, which would incorporate the context of an

individuals' role within a sense of social awareness (which may include irrational social fears or perception of one's role in society), we would bridge our psychological understanding of suicide with s wider sociological construct.

However, one theory would not be likely to offer an adequate interpretation for all acts of suicide or suicidal behaviours. Exploring the escape theory, through empirical research, would provide the opportunity of to draw conclusions and to refine our understanding of suicidal behaviour.

The multidisciplinary field of suicidology will only grow through clearly defined and measured research outcomes. Such research must be grounded by theory. Theory provides a structure, a framework and a basis from which research becomes a natural by-product. If the aim of preventing suicide is to be achieved, we must have a foundation of knowledge to work from and to be guided by. Baumeister's Escape Theory of Suicide, has largely focused on the internalisation that would occur and escalate in suicide, and the reduction of inhibitions regarding suicide as an option. One component that was overlooked in this process was the individual's perceptions of others, which if highly negative,

would become an inhibiting factor towards help-seeking behaviours, or may further the level of negative internalisation which occurs. Fear of negative evaluation may be a key, yet unexplored component of suicidal thinking which further alienates the individual from others.

3.4.1 Aims.

This research utilises Baumeister's Escape Theory as the major tenant from which to explore and expand our psychological understanding of suicide. The two fundamental aims of the research are to:

1) Examine whether fear of negative evaluation is a predictor of suicide, and whether fear of negative evaluation increases as suicidal ideation increases, as do other established predictors of suicide specifically depression and hopelessness.

2) Examine maladaptive coping, specifically an avoidant style of coping, and how it contributes to levels of fear of negative evaluation, in a revised interactional model of Baumeister's escape theory of suicide.

3) In relation to these primary aims, a secondary aim is: to examine the premise of Baumeister's escape theory of suicide from a linear process to an interactional model of suicide that includes a social rather than solely internal approach to the understanding of suicide.

3.4.2 Hypotheses.

The general hypotheses underlying the aim of this research relates directly to current literature knowledge and to Baumeister's escapes theory of suicide. This hypothesis states that Baumeister's escape theory can be expanded to include internal cognition's that relate not only to the self but to a sense of fear of negative evaluation or shame proneness (the self as he/she relates to others). Additionally, the fear of negative evaluation and avoidant styles of coping increase as depression and hopelessness increase for individuals who are contemplating suicide.

The specific hypotheses formulated in relation to the identified aims are:

1) that fear of negative evaluation, as an indicator of suicide risk, will increase as suicide ideation increases
2) Avoidant coping patterns will increase in relation to the factor of

fear of negative evaluation for individuals demonstrating suicidal ideation.

A simplified model of this theoretical pathway is presented in figure 1.

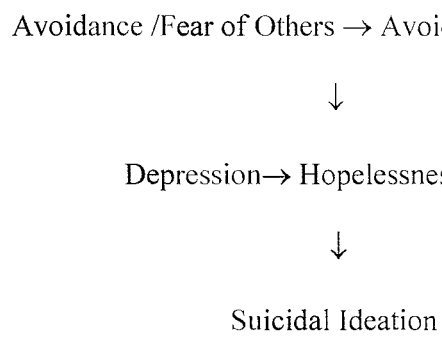


Figure 1 Revised escape theory: theoretical pathways

The factors of fear of negative evaluation, coping, depression, and hopelessness were presented in a relatively linear manner, but these factors are hypothesised to involve an overlapping or interactive effect.

Chapter Four: Method, Phase 1

4.1 Introduction

Broadly, phase 1 of this study involved data collection of participants identified with depressive symptoms across a sampling obtained through community support services. This approach was appropriate for the purpose of the study that involved eliciting (self reported) measures of depression, hopelessness, coping, suicide ideation, and fear of negative evaluation. Measures were administered individually rather than through mass or random sampling to ensure direct results from target or at risk populations. Data was collected over a nine-month period commencing in October 1998 and completed in July 1999. One hundred thirty-two individuals participated in this investigation. Of these, 121 participant results were used in the analysis of results. Eleven participant results were not included in the analysis. Of these

eleven results, seven did not meet the established criteria of obtaining a score of 10 or greater on the Beck Depression Inventory, nor did they express any suicidal ideation. Two of these eleven results were not included as the methodology for obtaining the results were not consistent or standardised, and two of the participant results were unable to be used as the participants did not complete the psychological scales.

The design of this study required a factor analysis and a path analysis of five factors within one group. Data collection was based on the information obtained from a total of five psychometric scales. Criterion for participant inclusion for the study required participants aged 18 or over who demonstrated suicidal ideation.

The experimenter, or researcher, was blind to participant criterion during the administration of the scales as criterion was based on the results obtained from instruments and was not analysed until participants' results were collected in entirety. The independent variables (criterion) were measured using the Beck Scale for Suicide Ideation (BSS) and the Beck Depression Inventory (BDI). The BSS was normed on a psychiatric in-patient population and was piloted on 10 participants to ensure that was an effective measure for the targeted population of this investigation.

4.2 Participants

Participants included 61 women, and 60 men (Appendix A, Figure 6). The majority of participants were Caucasian; ages ranging from adolescent classification to over 60 years of age (the youngest participant's actual age was 18 years, the oldest participant was aged 71 years) refer to Appendix A, Figure 7 and Figure 8. The level of education for participants is presented in Appendix A, Figure 9. The majority of participants did not complete high school and the majority of participants were unemployed at the time of the investigation (Appendix A, Figure 10). Though educational status and employment status were not considered confounding factors relevant to the focus of the investigation.

The participants for this study were selected from key agents in the Townsville- Thuringowa area. The population of the Townsville-Thuringowa area was approximately 123,575 (ABS, 1996). The participant sample accounted for roughly .1% of the total community population. Participants were identified through a broad cross-section of various community support groups, health services or community agencies as

follows: hospital (n=21), Employee Assistance Program (n=13), Privately Practicing Health Professional (n=8), Disability Support Service(n=2), Community based Mental Health Education/Support Service (n=15), Women's Health Centre (n=7), Support Groups (n=6), Higher Education Counselling Service (n=1), Correctional Services (n=20), Alcohol and Drug Services (n=8), Community Shelter (n=7), Community Mental Health Services (n=10) (refer to Appendix A, Figure 11).

From the 21 patients that were identified through the hospital, 2 participants were identified through the social work department of the Women's Hospital (primarily post-natal depression support), 12 were identified through the Townsville General Hospital Psychiatric Unit, and were identified through the hospital consultation liaison, and outpatient clinic.

Through the process of participant selection and assessment, data reflected a cohort of participants who demonstrated thoughts of suicide or suicidal ideation (as measured by the results obtained from the Beck Suicide Scale, which was a self report measure that identified the presence of suicidal thoughts, wishes, and plans). This group also demonstrated mild to moderate levels of depression (as measured by the Beck Depression

Inventory, with a recommended cut off score of 10). Cut off scores for the Beck Scale for Suicide Ideation (BSS) had not been established. Any positive response on the BSS has been considered as a possible indicator of the presence of suicidal thoughts, attitudes, or intentions, and as scores increased, the presence of suicidal thoughts has been assumed to increase. The Beck Scale for Suicide Ideation, the Beck Depression Inventory, and the Beck Hopelessness Scale were designed to be used in conjunction for the purpose of assisting clinicians in the assessment of suicidal risk. For the purpose of this investigation, the results obtained from the Beck Scale for Suicide Ideation was the primary screening instrument for determining the presence of suicidal thoughts or the wish to die. It was important to determine whether the factors that were being measured were unique to suicidal populations. The results were analysed in relation to this criterion variable, as indicated by the presence of suicidal ideation on the Beck Scale for Suicide Ideation.

Out of the 121 participants, 54 reported that they had never previously had an incident of deliberate self-harm or attempted suicide (based on the self-report measure of the SSI) 64 out of 121 participants reported that they had previously had an incident of deliberate self-harm (attempted suicide,

as stated on the rating scale). These scores were further distributed to identify whether the participant engaged in deliberate self-harm (stated as attempted suicide on protocol) "once", or "two or more times" and the level of intention of the suicide attempt (the wish to die). Scores ranged from 0 to 4 on this section of the scale. A total of 64 participants indicated that they had had a previous incident of deliberate self-harm. Eleven out of 64 (17%) participants who had previously had an incident of deliberate self-harm obtained a score of 1 indicating one previous incident of self-harm with a low level of intent/wish to die, 19 out of 64 (30%) obtained a score of 2, 14 out of 64 (22%) obtained a score of 3, and 20 out of 64 (31%) obtained a score of 4, indicating a higher level of suicidal intent/risk related to previous incident of deliberate self-harm (suicide attempt).

Though epidemiological data indicated that youths aged between 15-25 were a high risk group for suicide in Australia, the age cut off for this study was 18 years and over. Adolescent populations may not have demonstrated the same level of social, psychological and emotional development as a young adult population. As the purpose of this investigation was to examine additional risk factors related to a pathway that leads to suicidal thinking, it was justified to include a wide range of participants who varied in age, ethnicity and gender. Participants with an

identified intellectual disability, severe brain injury or of non-English speaking were not encountered as participants for this study.

4.3 Instrumentation

Table 2 indicates a listing of psychological tests used in this study, factors each test measures, dimensions of these measures, number of items, and time required for administration. Tests were administered in a random rather than in a particular order.

Table 2

Variables and tools of measurement

Factor Measured	Assessment Tool	Dimensions	No. of items	Time
Hopelessness	Beck Hopelessness Inventory (BHI)	N/A	20	10 min
Depression	Beck Depression Inventory (BHI)	N/A	21	10 min
Suicide Ideation/ Suicide thoughts/ intentions	Beck Scale for Suicide Ideation (BSS)	a) active suicidal desire b) preparation c) passive suicidal desire	21	10 min
Fear of Negative	Brief Version of the Fear of	N/A	12	5 min

Evaluation	Negative Evaluation Scale (FNES)			
Coping Style	Coping Inventory for Stressful Situations (CISS)	1) Task Oriented Coping 2) Emotion Oriented Coping 3)Avoidance Oriented Coping a) distraction b) social diversion	48	10 min

Refer to Appendix B for a review of unpublished measures/questionnaires

4.3.1 Beck Hopelessness Scale (BHS).

Hopelessness was measured using the Beck Hopelessness Scale that measures a participant's expectations for their short and long range future. The BHS (Beck et. al. 1974) was a self-report measure that contained 20 true- false items. The true false items measured the degree to which a participant's cognitive schemas were dominated by negative expectations about the future. The statements assess the extent of self-perceived negative attitudes about the future including loss of motivation, and expectations. Scoring was calculated following procedures outlined in the manual, and achieved by assigning weightings of 1 to each negative question. The higher the score the greater the degree of negativism or hopelessness was reported.

The BHS has been demonstrated to be internally consistent as demonstrated by a coefficient alpha (KR-20) of .93 reliability (Beck, et. al., 1974). The BHS has demonstrated a moderate correlation with clinical ratings of hopelessness. Beck et. al. (1974) reported that clinical ratings of hopelessness of two samples demonstrated a Pearson product-moment

correlation between .62 to .74 with an interrater reliability of .86.

Test retest reliability of the BHS demonstrated a Pearson product-moment correlation of 69 and, 62 in a one-week and six-week test retest of two sample populations.

The internal consistency of the 20 items of BHS has been demonstrated across seven clinical samples with a Kuder-Richardon (KR-20) reliability rating between .92 (suicide ideators) to .65 (college students) (Beck and Steer, 1988).

4.3.2 Beck Depression Inventory (BDI).

The BDI was a self-report measure that consisted of 21 items that participants' rated on a scale of 0 to 3 on intensity. Scores were obtained by taking the score for each item and adding the total number of points for all items. The BDI has a maximum total score of 63. Scores ranged from 0 to 9 indicating normal range, scores between 10 to 18 would have indicated mild to moderate depression, scores ranging from 19 to 29 indicated moderate to severe depression, and scores of 30 to 63 indicated extremely severe depression. The BDI has been widely used tool for estimating the

overall severity of depression. The BDI also included questions identifying suicide ideation and hopelessness. The BDI was used to assess participant's level of depression.

In studies of test retest reliability, on nine studies of non psychiatric patients, the BDI demonstrated test retest correlations ranging from .60 to .90, and a test retest reliability of .90 over a two week interval with undergraduate populations (Beck and Steer, 1987; Beck and Steer, 1984).

The BDI correlated highly with psychiatrists rating of depression for the age group that this study targeted. The Pearson product- moment correlation coefficient between psychiatric diagnosis and BDI measures was .77 (Bumberry, et. al., 1978). BDI scores have been shown to be highly reliable and valid indicators of severity of depression for mild and moderate levels of depression seen in non-clinical outpatient samples. The Second edition of the Beck Depression Inventory, developed in 1996, was not utilised during this investigation. The original version of the scale was available, and no objections were raised as to the use of this tool for research purposes at the time of the data collection. Data was collected for research use only.

4.3.3 Beck scale for Suicide Ideation (BSS).

The Beck Scale for Suicide Ideation (BSS) was a 21 item self report measure designed to assess and quantify suicidal thinking. Items were graded in intensity from 0 to 2. The BSS produced a suicidality score ranging from 0-42. The BSS has produced high correlations with clinical ratings of suicide risk.

The internal reliability of the BSS yielded a reliability coefficient of .89, and an interrater reliability of .83 (Beck, et. al., 1979). The BSS also measured three factors: 1) Active Suicidal Desire, 2) Preparation, and 3) Passive Suicidal Desire. The BSS was partly designed as a research instrument that could be used to discriminate between groups who differed in levels of suicide intent.

4.3.4 Brief Version of Fear of Negative Evaluation (FNE) Scale.

The Brief Version of the Fear of Negative Evaluation Scale was

developed by Leary (1983) and was based on the Fear of Negative Evaluation Scale (Watson and Friend, 1969). Though Heimberg, Hope, Bruch, and Monroe (1988) determined that the Fear of Negative Evaluation Questionnaire does not adequately screen social phobia, the scope of this investigation did not aim at determining nor identifying underlying social phobia, but to isolate the variable of fear of negative evaluation as a separate construct. Watson and Friend's (1969) original Fear of Negative Evaluation Scale has been the most commonly used scale to determine the degree to which people experience apprehension at the prospect of being evaluated negatively including the level of dread, or anxiety related to perceptions of other's opinions or judgements. The Brief Version of the FNE Scale was a 12 item scale assessing anxiety and distress over others evaluation of oneself. The questions use a 5 point likert scale from 1 to 5. The higher the score, the higher the level of fear of negative evaluation was represented. Lower scores indicated no fear of negative evaluation. The brief version of the Fear of Negative Evaluation Scale was highly correlated (.96) to the original 30 item scale of Fear of Negative Evaluation (Watson and Friend, 1969). The internal reliability of the Brief FNE Scale was found to be quite high (Cronbach's alpha = .90). This compared positively with an obtained reliability coefficient of .92 for the original FNE scale. Watson and Friend (1969) reported a coefficient of .94. For the

brief version, the 4-week test -retest reliability coefficient was .75 that compared favourably to the original, longer scale in which Watson and Friend (1969) reported a test -retest coefficient of .68. A sample of the Brief Fear of Negative Evaluation Scale was presented in Appendix B.

4.3.5 Coping Inventory for Stressful Situations (CISS).

The Coping Inventory for Stressful Situations was a 48-item inventory that identified and measured individual coping styles in response to stress. The adult form was used for this study. It was a self-report measure that took 10 minutes to complete. It was appropriate for use with a wide range of respondents including adolescents, adults, and psychiatric in-patients. It was developed as a consequence of extending the interactional model of anxiety to include coping variables that produced an interactional model of stress, anxiety and coping (Endler and Parker, 1990b). Coping, as assessed by this instrument, has been conceptualised as a stylistic variable with potential for patterns of coping styles to change as a function of the situational context. The CISS measured three major coping styles: 1) Emotion- Oriented Coping, 2) Task- Oriented Coping, and 3) Avoidance Oriented Coping. The Avoidance- Oriented Coping scale provided two sub scales: distraction and social diversion. Raw scores were utilised for the

results on these scales as they represented a more diverse level of responses. High scores on any of these coping dimensions indicated coping skills that relied on these responses to stress. For the purpose of exploring maladaptive styles of coping for this investigation, the dimensions of emotion-focused coping and avoidant coping were utilised. Task focused coping was not included in the model as it represented a more adaptive approach to coping and would not be a likely predictor of depression. Additionally, the two subscales that constituted avoidant- oriented coping were not included as two separate analysis as the responses produced a similar cluster of scores. CISS was appropriate for normal and clinical populations who had a reading level of grade eight or higher. Normative data for CISS has been derived for adults, college students, adolescents, and clinical populations.

Coefficient alpha was a test of the internal consistency of a scale's items, or the extent to which all items were measuring the same construct. Overall, the alpha coefficients across normative groups were satisfactory. On the Task Scale the alphas ranged from .87 for adult female to .91 for male psychiatric patients. The Emotion scale alpha ranged from .82 for male psychiatric patients to .90 for adult males. On the Avoidance scale, the alphas range from .76 for female psychiatric patients to .85 for

undergraduate males. The alphas for the two-avoidant subscales were also satisfactory. The Distraction subscale alpha ranged from .69 for female psychiatric patients to .79 for female undergraduates. The alphas for the Social Diversion subscale ranged from .74 for adult males to .80 for female psychiatric patients.

Test retest reliabilities, measuring the stability of the CISS scales over time, were conducted over a six-week period. Test retest reliabilities were moderate to satisfactory. Subscale correlations ranged from .51 to .73 for male and female undergraduate student populations.

Validity of the multi-dimensionality of the Adult version of the CISS indicated a congruence coefficient, comparing each of the three factors, that was above .95.

4.4 Procedure

Key agents included community counselling and health services (n=5), tertiary counselling services (n=2), general practitioners (n=3), and privately practising mental health professionals (n=3). Participation from key agents was on a voluntary basis. Agencies were provided with the basic

aims and objectives of the research being conducted (Appendix C and Appendix D) and were asked to identify potential participants for this study. A brief checklist was provided to those services or professionals who had demonstrated an interest in participating or assisting in the identification of participants for this study. The checklist included 4-5 questions regarding the participant's background and criteria for participation in the study (Appendix D). If a participant met the criterion for participation, community agents asked the participant if they were interested in participating in the study and offered an Information to Participants statement and a brochure that provided participants with the aims and objectives of the study (Appendix E). After reading the information, if the participant was interested in being contacted as a potential participant in the study, they completed a consent form that allowed the researcher to contact them (Appendix E). They also identified the phone number and time of day they preferred to be contacted.

The researcher made phone calls to referring agents every second day on a routine, scheduled basis to establish whether there were consenting participants identified. Regular communication with referring agents was a critical component to participant involvement. The researcher made regular contact (every 2 days) with participating services. The purpose of regular

contact was 1) to identify participants, and 2) to obtain regular updates on participant consent. Service providers who identified willing participants collected consent forms. The researcher collected consent forms by face to face contact with referring agents. Service providers were also given stamped envelopes and in some cases, in which the researcher was unable to make face to face contact with the referring agent, consent forms were mailed back to the researcher.

In identifying participants, the researcher also approached community support groups, but first obtained consent to discuss the aims of the study with the group. The researcher provided an overview of the research to these groups through an informal presentation that included question and answers about the purpose of the study. Information, including brochures, consent for participation (refer to Appendix E) were left with support group leaders. This provided participants with the opportunity of meeting the researcher and asking questions about the research. Once consent was obtained from service providers, the researcher contacted participants within 3-4 days, and arranged to meet with participants.

Upon contacting participants the researcher indicated where the participant's name was received from, and informed participants of the

aims and objectives of the study, consistent with the information outlined on the Information for Participants handout. The researcher ensured that the participants understood that the referring agent was not involved in this study except in the identification of participants. Referring agents were not allowed access to personal information related to this study. Interested participants, were asked to make an appointment with the researcher at one of several agreed upon locations.

Locations for meeting with participants varied. Participants met with the researcher at convenient and comfortable locations that included referral agency offices (e.g.: Women's Centre, Drug and Alcohol Centre, Hospital, Mind Survivor Offices) and participant homes. The first preference for meeting with participants was at the site of the referring agency. Most service providers allowed for space and were supportive of the use of their facilities. Upon meeting with participants, they were once again verbally briefed on the purpose of the study and instructed to read the Information for Participants. The researcher reviewed the purpose of the study, responded to questions and obtained informed consent for participation. Once participant consent was obtained, (refer to Appendix F for Consent for Participation in Research Study) the researcher obtained demographic information, and administered the five psychometric scales. A

sample of questionnaires, including demographic information and the Brief Fear of Negative Evaluation Scale have been presented in Appendix B. Following the completion of the scales and data collection, a 10-15 minute period for debriefing with the researcher was allocated for each participant. Debriefing included an investigation of the participant's current emotional state, suicidal risk, and plans for follow up or continued care through the referring service provider. In the event that the participant did not have plans for future follow up care, they were provided with contact details of appropriate local counselling agencies or support services. The researcher confirmed follow up counselling appointments, with the original source of referral. Results of these interviews/ assessments were not used for diagnostic or treatment purposes, but strictly for the purpose of research.

The James Cook University Human Ethics Committee and the Human Ethics Committee of Townsville District Health Services (Townsville General Hospital, Queensland Health) approved the proposal for this investigation, including methodology, for both phase 1 and phase 2 of this study. Queensland Corrective Services Commission Research Committee also provided ethical approval for phase 1.

Referring agencies and those participants who participated in phase 1, who requested follow up information, received a brief summary of results from the initial analysis of findings, including information for counselling support (refer to Appendix G). These results were offered to participants and agents in the early stages of the research as an effort to offer communication and appreciation. Initial analysis at this stage was limited, therefore the information distributed was conservative in the conclusions offered.

4.5 Summary

Of the 132 participants who participated in this study, 121 participant's data was used for analysis and interpretation. The data from participants for phase 1 of this study consisted of the completion of five psychometric scales that measured: Fear of Negative Evaluation, Depression, Suicidal Ideation (and identified any previous incident of deliberate self-harm), Hopelessness and Coping. Participants completed these questionnaires through face to face, one on one, meetings with the researcher. These interviews included a period of debriefing and allowed for participant discussion/questions with the researcher. Of those who participated, and of those agencies involved in identifying participants, no negative effects were reported.

Chapter Five: Results, Phase 1

5.1 Introduction

A path analysis was the primary means of analysing the data. Additionally, a factor analysis was conducted on the results from Brief Version of Fear of Negative Evaluation Scale. Indicators of suicidality, depression, and fear of negative evaluation were based on the raw scores obtained on the Beck Scale for Suicidal Ideation, Beck Depression Inventory and Brief Version of the Fear of Negative Evaluation Scale.

5.2 Factor Analysis- Brief Version of Fear of Negative Evaluation Scale

The Brief Version of the Fear of Negative Evaluation Scale, used in this study, was the only instrument that was unpublished compared to the other psychological measures administered during this investigation. Therefore, a factor analysis was conducted on the results obtained from all

participant responses on this questionnaire to ensure that the scale adequately measured the fear of negative evaluation on a consistent basis across each question. As the Fear of Negative Evaluation Scale was composed of 12 questions, and has previously been tested for reliability, the purpose of conducting a factor analysis was primarily confirmatory. A factor analysis of question items also acted as an additional means of determining whether the items on the scale were similarly measuring the same construct, which indicated participant measures of fear of negative evaluation. Coakes and Steed (1999) reported that a factor analysis reduces data into a smaller measure, and can confirm or identify underlying factors With the sample size of 121 participants completing the 12-item questionnaire, there was an adequate sample size to conduct a factor analysis. Coakes and Steed (1999) recommend a minimum sample of 100 participants to conduct a factor analysis.

A principal component factor analysis was performed on the data set that included participant responses to each item on the Brief Fear of Negative Evaluation Scale. Any missing values were replaced with the mean of the participant's individual results. The Brief Fear of Negative Evaluation Scale consisted of twelve items that measured levels of fear of negative evaluation. These items were ranked on a five point Likert scale

response format. Items 2, 4, 7, and 10 were negatively worded and required reverse scoring when calculating results. Prior to conducting the factor analysis, these scores were reversed in order to ensure an accurate interpretation of results. Table 3 demonstrates the results of the correlation matrix.

Table 3

Correlation Matrix- Brief Version of Fear of Negative Evaluation Scale

	FNE1	FNE11	FNE12	FNE3	FNE5	FNE6	FNE8	FNE9	FNE10	FNE2	FNE4	FNE7
FNE1	1.000											
FNE11	.693	1.000										
FNE12	.341	.425	1.000									
FNE3	.670	.622	.324	1.000								
FNE5	.722	.725	.335	.670	1.000							
FNE6	.690	.674	.411	.606	.757	1.000						
FNE8	.636	.554	.313	.529	.652	.585	1.000					
FNE9	.694	.708	.395	.592	.642	.715	.727	1.000				
FNE10	.678	.691	.402	.585	.716	.637	.605	.643	1.000			
FNE2	.636	.604	.355	.640	.693	.624	.476	.612	.672	1.000		
FNE4	.713	.572	.338	.670	.698	.615	.614	.678	.708	.641	1.000	
FNE7	.693	.699	.387	.609	.747	.664	.527	.692	.737	.715	.712	1.000

The correlation matrix suggested that the scale was suitable for the

use of a factor analysis, all items obtained scores above 0.3.

Factor analysis results yielded a Kaiser Myer Olin (KMO) measure sampling adequacy greater than .6 at .93132, and a Bartlett test of sphericity = 1081.8352 (significant at < .05). Based on Kaiser's recommendation, this indicated that the questions on the Brief Version of the Fear of Negative Evaluation Scale represented a homogenous collection of variables that were suitable for factor analysis (Kaiser 1958; Kaiser, 1970; Guttman, 1954; Cronbach, 1951).

Measures of sampling adequacy of items on the Anti-image covariance matrix were presented in Table 4. Measures of Sampling Adequacy (MSA) were printed on the diagonal. Results for each question indicated measures of sampling adequacy were greater than .5 and considered suitable.

Table 4

Anti-image Correlation Matrix

	FNE1	FNE11	FNE12	FNE3	FNE5	FNE6	FNE8	FNE9	FNE10	F NE2	FNE4	FNE7
FNE1	.97023*											
FNE11	-.17162	.92070*										
FNE12	.05433	-.14818	.94980*									
FNE3	-.15111	-.16030	-.01564	.95693*								
FNE5	-.03792	-.26379	.12881	-.09595	.90514*							
FNE6	-.14137	-.00031	-.14978	-.04393	-.37414	.93824*						
FNE8	-.14130	.13238	-.04142	-.02580	-.32348	.08670	.88197*					
FNE9	-.03556	-.31208	-.00754	.02254	.29766	-.31321	-.48738	.88231*				
FNE10	-.04021	-.22275	-.08771	.08193	-.04508	-.02441	-.17598	.09440	.95147*			
FNE2	-.04412	.07410	-.04842	-.21178	-.16821	-.03255	.14570	-.11559	-.17536	.95586*		
FNE4	-.19880	.24265	-.01782	-.25011	-.12639	.06690	-.05171	-.18418	-.23657	-.01865	.93639*	
FNE7	-.07553	-.10844	-.04906	.05437	-.23167	.02295	.20415	-.20712	-.20400	-.20506	-.17978	.94539*

* Measures of Sampling Adequacy (MSA)

Extraction 1 for analysis 1, Principal Components Analysis (PC)

Following Kaiser's (1970) recommendation, using an Eigenvale value greater than 1, one factor was extracted. This factor accounted for 64.9% of the variance.

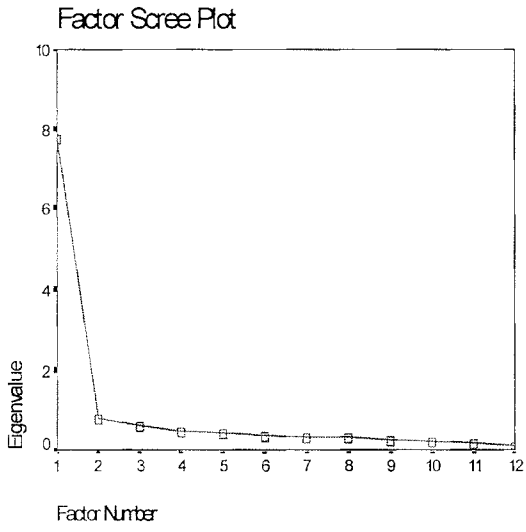


Figure 2 Scree Plot Brief Version Fear of Negative Evaluation Scale

Figure 2 demonstrated a scree plot illustrating the eigenvalues for each factor, and verified the dominance of a single factor out the 12 items on the Brief Version of the Fear of Negative Evaluation Scale.

The following component matrix table (Table 5) presented the strength of each question in relation to the factor of fear of negative evaluation.

Table 5

Component Matrix Table- Brief Fear of Negative Evaluation Scale

Question Number	Factor 1 Loading
5	.876
7	.856
1	.854
9	.844
10	.842
4	.832
6	.831
11	.830
2	.800
3	.783
8	.750
12	.491

The component matrix indicated that all items loaded on 1 factor. This indicated that the content of the questions that the scale was measuring was adequate. Only one factor was extracted, and therefore rotation was not necessary for this solution. This factor comprised all 12 items with factor loadings that ranged from .49 to .88.

The factor analysis confirmed the identification of one factor in the Brief Fear of Negative Evaluation Scale, and complimented the reliability, construction and definition of this measure. All 12 items in this scale represented a singular concept that was originally developed and defined by

Leary (1983), the creator of this scale, as fear of negative evaluation.

5.3 Path Analysis- Revised Model of the Escape Theory of Suicide

A path analysis was the chosen analysis model, which identified causal relationships between various predictors or variables. The revised, interactional model of the escape theory has been designed for analysis to explore causal pathways for each predictor. Again, this model offered only one interpretation or explanation for potential predictors of suicidal ideation. For this model, analysis involved a number of correlations, and a series of regressions including bi-variate regressions and multiple regressions.

5.3.1 Summary of model- revised escape theory of suicide.

The purpose of this investigation was to explore and expand Baumeister's escape theory of suicide. Baumeister presented the escape theory as a linear, primarily internal progression of negative interpretations of the self, which culminated in suicide as an escape from oneself. This

investigation explored a more interactional model of suicide that suggested that participant's perceptions towards other people also had a role in this process. The revised model acknowledged that negative or stressful life events, self-blame, an aversive state of self-awareness, negative self-evaluation were also part of the process; it proposed that maladaptive coping and fear of negative evaluation played a role in this process. As research suggested, diminished or maladaptive coping has been identified as a predictor of depression, and that there was a link between fear of negative evaluation and depression.

The revised model, as demonstrated below, indicated a triangulation between depression and hopelessness and suicidal ideation. Current research indicated that depression predicted suicidal ideation, and that depression predicted hopelessness. Hopelessness also predicted suicidal ideation. The role of fear of negative evaluation in relation to suicide or suicidal ideation has not been widely investigated. This proposed model suggested that there was a reciprocal relationship between maladaptive coping and a fear of negative evaluation, that is, that they influenced one another as negative cognitive processes. Ultimately, the purpose of this investigation was to explore the role of maladaptive coping and fear of negative evaluation as components of a revised model of Baumeister's

escape theory of suicide. Figure 3 illustrates the pathways of this model that were analysed.

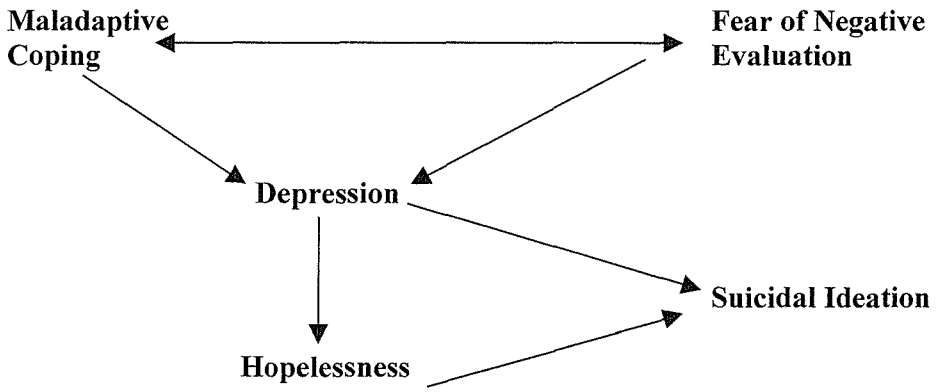


Figure 3 Pathways of the Revised Escape Theory of Suicide

The model was presented in three stages of analysis and interpreted sequentially beginning with 1) the relationship between maladaptive coping and fear of negative evaluation, 2) relationships between maladaptive coping and fear of negative evaluation and depression, and 3) finally, an analysis which involved established predictors of suicidal ideation, including depression and hopelessness. As measures relating to maladaptive coping involved the results from two separate subscales, results for each of these subscales were presented simultaneously at each stage of analysis. Diagrams for the results of each model are also presented for interpretation. Each of the predictor variables are outlined to describe what they measured and the direction of the scoring. The predictor

variables for this model included: maladaptive coping, fear of negative evaluation, depression, hopelessness, and suicidal ideation.

5.3.2 Maladaptive coping.

Steed (1998) presented a comprehensive exploration of the concept and application for measuring coping in research studies. He concluded that 1) situationally based coping scales were preferable in contrast to coping scales that attempted to measure coping dispositions; 2) the range of coping strategies could not be effectively measured in one single study, and 3) research needed to focus on qualitative strategies for examining coping. Though the aim of this investigation was to understand the context of avoidance (including avoidant coping strategies), in relation to suicidal ideation, the quantitative analysis of coping included all maladaptive coping. To support the understanding of the proposed theoretical framework, maladaptive coping, as a general concept, was explored in relation to the pathways identified. However, avoidant coping was a critical factor and was also reviewed as a separate factor.

5.4 Distribution of Means

The means, standard deviations and range for all of the variables used in the model were presented in Table 6.

Table 6.

Means, Standard Deviations and range (n=121) for variables in model 1.

Variable	**Mean**	**SD**	**Range**
Fear of Negative Evaluation	38.89	15.07	12.00-60.00
Emotion Oriented Coping	44.01	15.07	16.00-80.00
Avoidant Oriented Coping	42.08	12.7	16.00-78.00
Depression	26.30	13.18	0.00-59.00
Hopelessness	11.40	6.19	0.00-20.00
Suicidal Ideation	9.34	10.10	0.00-38.00

Correlations between all variables were calculated prior to the calculations involved in a path analysis for the model. Pearson's correlation results are presented in Table 7. These correlations represented all variables used in the model.

Table 7

Results of correlation's for all variables in model.

VARIABLE	Depression	Hopelessness	Suicidal Ideation	Coping (Emotion)	Coping (Avoidant)
FNE	0.235*	0.167	0.157	0.358**	-0.090
Depression	-	0.652**	0.646**	0.482**	-0.198**
Hopelessness	-	-	0.591**	0.334**	-0.286**
Suicidal Ideation	-	-	-	0.198*	-0.273**
Coping (Emotion)	-	-	-	-	0.099

* significant at 0.05 level (2-tailed)

** significant at 0.01 level (2-tailed)

The results from the series of Pearson's correlation coefficients indicated that there were positive, significant relationships between: fear of negative evaluation and depression, and fear of negative evaluation and emotion oriented coping, depression and hopelessness, depression and suicidal ideation, hopelessness and suicidal ideation, depression and emotion oriented coping, hopelessness and emotion oriented coping, and

also between emotion oriented coping and suicidal ideation. This indicated that as fear of negative evaluation increased, depression increased, as fear of negative evaluation increased, emotion oriented coping increased, as depression increased, hopelessness, suicidal ideation and emotion oriented coping increased.

Results also indicated a negative, significant relationship between avoidant coping and the following variables: depression, hopelessness, and suicidal ideation. As avoidant coping decreased, depression, hopelessness, and suicidal ideation decreased.

5.5 Path Analysis -Stage I.: Relationship between Fear of Negative Evaluation and Maladaptive Coping Styles

A Pearson's correlation coefficient r was used to ascertain if a relationship existed between fear of negative evaluation and maladaptive coping. To test the pathway between these variables, the results from both the Emotion-Oriented Coping subscale of the CISS, and the Avoidant Oriented Coping subscale were utilised. The model was presented with the separate findings obtained from these variables.

The correlation between fear of negative evaluation and emotion – oriented coping indicated that there was a strong, positive relationship between these factors ($r = .358$, $p<.01$). The results for the analysis of a relationship between fear of negative evaluation and avoidant coping indicated that there was a non-significant negative relationship between these variables ($r = -0.90$, $p = .331$).

5.6 Path Analysis - Stage II. Relationship between Fear of Negative Evaluation, Maladaptive Coping, and Depression

A multiple regression was conducted utilising raw scores from the Brief Fear of Negative Evaluation Scale, raw scores for emotion-focused coping (CISS subscale) in relation to raw scores obtained for depression. Results indicated a moderate relationship ($R= 0.482$). The total variance explained by these three variables was 23.7%. Individually, fear of negative evaluation explained 0.5% of the variance, and emotion oriented coping explained 23.2% of the variance. The overall relationship was significant at $F(2, 115)=17.844$, $p<.05$. The beta value of 0.457 was obtained for emotion oriented coping and was .071 for fear of negative evaluation in relation to depression. Fear of negative evaluation, accounted for less than

9% of the variance and a path value of less than .3 was not to be included in this model (Asher, 1983). The path results are presented below in Figure 4.

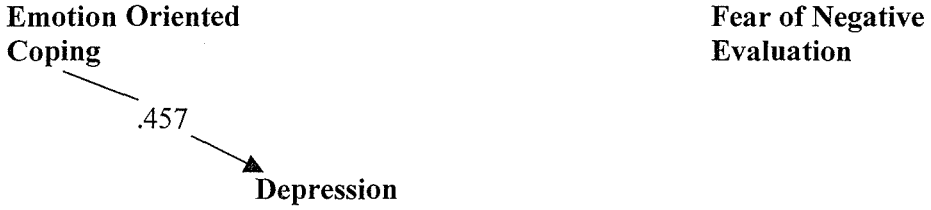


Figure 4 Path-analysis Results: Fear of Negative Evaluation, Emotion Oriented Coping and Depression

A multiple regression was conducted utilising raw scores from the Brief Fear of Negative Evaluation Scale, raw scores from the avoidant-focused coping (subscale results) in relation to raw scores obtained to measure depression. Results indicated that the strength of the relationship between these variables was low (R= 0.295). The total variance explained by these three variables was 8.7%. Individually, fear of negative evaluation explained 4.8% of the variance, and avoidant focused coping explained 3.9% of the variance. The overall relationship was not significant at F(2, 115)=5.461. A beta value of – 0.179 for avoidant-oriented coping and .219 for fear of negative evaluation were obtained in relation to depression. Both individually, and combined, avoidant coping and fear of negative evaluation, accounted for less than 9% of the variance. Each variable had a

path value of less than .3 and were deleted from this model.

When these three independent variables were analysed together, the factor of fear of negative evaluation was not a significant predictor of depression. However, emotion oriented coping was a significant predictor of depression.

5.7 Path Analysis-Stage III. Relationship between Depression and Hopelessness

A bivariate regression was conducted utilising the total scores obtained on the Beck Hopelessness Scale as the dependent variable and the results from the Beck Depression scale as the independent variable.

Examining the relationship between these variables, results indicated that the strength of the relationship between depression and hopelessness was strong (R= .652). Hopelessness accounted for 42.5% of the variance in relation to depression.

The regression analysis indicated that there was a strong, positive, significant relationship (R= 0.652, F (1, 116)=85.67 and <0.05) between hopelessness and depression. The beta value was 0.652. This beta value

was positive which suggested that, those who were high in hopelessness were also high in depression.

The beta value for emotion oriented coping was .283 and .550 for hopelessness. Both of the beta values were positive which suggested that those who were high in emotion oriented coping were also high in depression, and those who were high in hopelessness were also high in depression.

5.8 Path Analysis-Stage IV. Relationship between Depression, Hopelessness and Suicidal Ideation.

A hierarchical regression was used to analyse the relationship between depression, hopelessness and suicidal ideation. This multivariate regression utilizing depression, and hopelessness, in this order, as independent variables and suicidal ideation as a dependent variable was the second multiple regression conducted in the development of a path analysis of this model.

The results indicated a very strong relationship between these variables (R= 0.684). Together, these variables accounted for 46.8% of the

total variance. Depression accounted for 41.8% of the total variance. The variance for Hopelessness was 5% of the total variance. Depression and hopelessness were significant predictor variables in relation to suicidal ideation. These two variables were significant predictors of suicidal ideation.

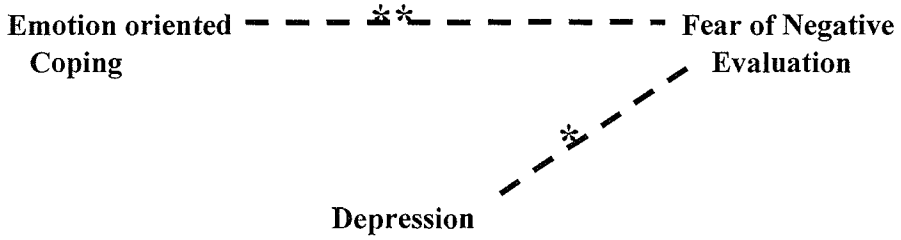
The beta value or path value, for depression was .454. The beta value for hopelessness was .300. When these two independent variables were analysed together, these results suggested that as depression and hopelessness increased, suicidal ideation increased. As hopelessness increased, suicidal ideation increased, and as depression increased, suicidal ideation increased.

5.9 Summary of Path Analysis

The final model presented both expected and unexpected results. The path analysis proposed in this investigation was developed based on the results of the analysis.

Correlations between fear of negative evaluation and depression and fear of negative evaluation and emotion oriented coping were identified.

These correlations are represented in the model outlined in figure 5 below.



Key

* significant correlation at 0.05 level
** significant correlation at 0.01 level

Figure 5 Fear of Negative Evaluation, Correlations

Figure 5 presents the correlation between fear of negative evaluation and depression and the correlation between fear of negative evaluation and emotion oriented coping as pathways. Fear of negative evaluation increased as depression increased. Fear of negative evaluation increased as emotion oriented coping increased.

However, fear of negative evaluation did not adequately fit into a theoretical indicator/predictor of suicidal ideation. Path analysis results reflected that there was not a direct relationship between fear of negative

evaluation and depression. Figure 6 presents the path analysis results of all variables.

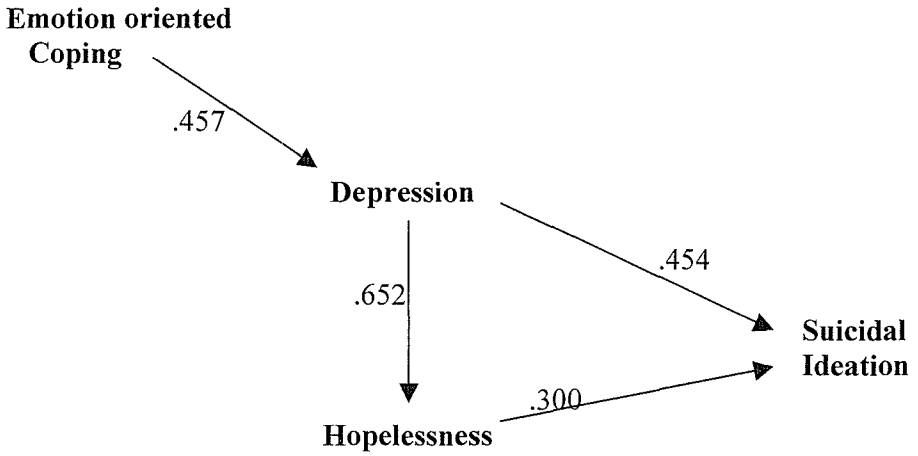


Figure 6 Path Analysis Results, All Variables

Emotion oriented coping increased as depression increased. As the original model proposed, as depression increased, hopelessness and suicidal ideation increased. As hopelessness increased, suicidal ideation increased. Figure 6 above represents the final path analysis model. Consideration of the role of fear of negative evaluation, relevant to this model is represented through the correlation between fear of negative evaluation and depression and fear of negative evaluation and emotion oriented coping, as presented in figure 5.

Chapter Six: Discussion, Phase 1

6.1 Introduction

Results from phase 1 of this study supported aspects of the original hypothesis, and also provided additional challenges to the understanding of suicide as proposed through Baumeister's revised escape theory. Path analysis results of phase 1 of this investigation did not mirror the originally proposed pathway. The role of fear of negative evaluation was not directly related to depression nor to hopelessness or suicidal ideation. However, a correlation between fear of negative evaluation and emotion-oriented coping was identified. This association offered a heightened understanding of fear of negative evaluation and provided additional insight regarding the role of fear of negative evaluation in relation to coping. Consideration of this relationship required a review of Baumeister's original theory and a reanalysis of the original hypothesis.

6.1 IntroDiscussion was presented in context to key areas of interest pertaining to phase 1 including a review of results related to the factor of fear of negative evaluation, maladaptive coping, and the interactional pathways elicited from data results. Limitations of phase 1 and implications of this study were also considered.

6.1.1 Fear of negative evaluation.

In reviewing the original aims and hypothesis of this investigation, fear of negative evaluation was considered to be a critical factor involved in the expansion of Baumeister's escape theory of suicide. In an effort to revise Baumeister's theory of suicide as an escape from the self to include an understanding that suicide may also be an escape from others, fear of negative evaluation and avoidant coping responses were critical determinants. Fear of negative evaluation did not increase in relation to suicide ideation, as did other established indicators of suicide such as hopelessness and depression. Therefore, contrary to the proposed hypothesis, fear of negative evaluation was not a reliable predictor of suicidal ideation. Though there was not a relationship between fear of negative evaluation and hopelessness, depression, or suicide, results did support a relationship between fear of negative evaluation and maladaptive coping. Whether this relationship was supported within the context

of a revised, interactional model of the escape theory may require additional research to consistently affirm this association as suicide specific. However, there was support for an interactional framework to understand and possibly predict suicidal behaviour. Events, emotions, interpretations and perceptions have not tended to occur in isolation. Suicidal acts have been evidenced to occur out of the culmination of behavioural, emotional, and cognitive mechanisms that have gone astray from rational and assuring responses. These interactions have been characterised by our best current predictor of suicide, hopelessness. Fear of negative evaluation may be a related factor along a chain of psychological states; however, it has not been demonstrated to characterise the experience of suicide, depression or hopelessness. In relation to suicide or suicidal ideation, fear of negative evaluation was not a predictor of suicide for a wide cross section of the population. Fear of negative evaluation has been a factor in the diagnosis of social phobia and may have contributed to irrational patterns of thought, which lead to suicidal thinking for some participants.

The most substantial finding in this study was the identification of the correlation between fear of negative evaluation and maladaptive coping, specifically emotion oriented coping. How these two factors interrelate was unexplored in phase 1 of this study. Possibly fear of negative evaluation either contributed to maladaptive coping, or was an associated feature of poor coping

responses. Fear of negative evaluation may also have evolved out of, or into, other emotional factors within the scope of an emotionally oriented coping framework. That is, all negative emotion may have become consumed and channelled into a state of poorly oriented emotional responses. However, fear of negative evaluation did not reach the same dynamic and did not correlate with depression as did emotion oriented coping, indicating that fear of negative evaluation was not as strong as other emotional indicators. Most likely, fear of negative evaluation has contributed to, but would not predict poor coping responses. As a central component of Baumeister's revised escape theory, fear of negative evaluation was not a direct contributor to suicidal thinking. Fear of negative evaluation was a peripheral factor that more clearly related to emotional indicators separate from the core features of suicide.

Fear of negative evaluation may have precluded emotion oriented coping, eventually escalating in depression, hopelessness and suicidal ideation. This may further explain the increased levels of social isolation that precede suicide. As an individual initially pulls away from others, isolates himself or herself and fears interactions with others, their coping responses may begin to lose a check with reality. Social interactions would offer a balanced perspective on the rationality of one's thought processes. Supportive interactions with others would begin to deteriorate, as individuals become increasingly suicidal. The results from phase

1 may actually have mirrored this effect of "coming undone". Initially an individual may fear his or her interactions with others due to extraneous circumstances and irrational internal interpretations of such events, this would build into emotionally maladaptive coping mechanisms.

6.1.2 Maladaptive coping.

In relation to a revised interactional model of Baumeister's escape theory, the role of maladaptive coping provided unpredicted, though not unexpected results. Avoidant oriented coping responses were not identified as a significant factor associated with suicide ideation in the revised model as had originally been hypothesised. Avoidance as a maladaptive coping strategy was not significant to any pathway factor. In fact, a negative correlation was identified between avoidant-oriented coping and the following factors: depression, hopelessness, and suicidal ideation. Avoidant coping responses reduced in relation to these variables and appeared to demonstrate the opposite of the predicted effect. Avoidant oriented coping did not contribute to fear of negative evaluation nor to suicidal thinking. Avoidant oriented coping responses decreased, rather than increased, as individuals became more depressed, hopeless or suicidal. Emotion oriented coping however appeared to correlate

with Fear of Negative Evaluation and increased as depression increased.

Moderating and mediating effects of stress, appraisal and coping have been cited by Baron and Kenny (1986) as critical to the analytic process, particularly when considering causal models. LaPore, Evans, and Schneider (1991) indicate that the buffering effects of social supports may not be sustained under various types of chronic stress. LaPore (1997) reported that "social environments can moderate, or alter, the impact of chronic stressors by mitigating, or exacerbating peoples response to them:" In numerous investigations, Baumeister has highlighted the impact of social exclusion and negative behavioural outcomes including increased aggression and self-defeating behaviours (Twenge, Baumeister, Tice, and Stucke, 2001; Twenge, Catanese, and Baumeister, 2002; Baumeister, Bratslavsky, Muraven, and Tice, 1998; Boden and Baumeister, 1997;). Additionally, self regulation and the impact on self-defeating behaviour, poor coping responses and repressive coping responses have a critical role in interpreting the results of this investigation. The impact of mediating and moderating stressors should be carefully considered in interpreting the results of this analysis. Environmental impacts and individual response to these cues were not the primary focus of this investigation. However, these factors are to be considered in interpreting the analysis of these results.

The role of coping in the context of the revised escape theory of suicide unfolded into a new dimension, one that required a reconsideration of Baumeister's original theory. Baumeister's escape theory of suicide had also been applied to the understanding of binge eating, as an escape from self (Heatherton and Baumeister, 1991). In viewing the escape theory of suicide from other angles, and attempting to understand maladaptive behaviours such as suicide and binge eating as an escape from self-aversion, the role of coping would become more predominant and more relevant. Conceptualising suicide as an escape, in a literal sense, escape would become a reaction or a method of coping as an independent action. However in the revised escape theory of suicide, the framework of escape was broken down into various components and was not a singular action such as in a fight or flight response. The results from phase 1 supported the escape theory model as a whole. Coping styles such as emotion oriented coping provided evidence that emotional regulation was a significant feature in understanding, predicting, and preventing suicide. Though avoidant coping responses were not significant in this study, the concept of avoidance should not be ruled out. The presence of highly emotional responses and coping patterns in relation to suicide suggested a blocking out of a range of responses and supported Baumeister's concept of numbing or constricted emotional and psychological functioning. This research supported existing evidence that emotional responses may facilitate suicidal thinking and

highlighted aspects of Baumeister's escape theory that had not been considered as a primary research focus.

6.1.3 Interactional model of suicide.

One of the aims of this investigation was to examine whether processes leading to suicidal behaviour may be interactional in nature rather than linear, as implicated in Baumeister's escape theory. Baumeister outlined a methodical step by step approach by which individuals turn toward self-destruction. However, these stages have not mimicked a spiralling staircase, rather the process toward suicide may be compared to a labyrinth or a maze in which the person faces increasing levels of turmoil, despondency and desperation. Phase 1 path analysis results supported a progressive framework converging in suicidal ideation. However, the links between these pathways could not be understood in full. What was clear was that these factors defined a model that may have explained the experience of suicidal ideation. Individual perceptions, as derived from internal dialogue, have the potential to be moulded over time based on continuous interpretation or re-interpretation. So too, have behaviours the potential to be influenced by thought. The path analysis results from phase 1 accounted for interactive effects between variables. Though data must be

analysed and accounted for in a linear fashion, because multiple factors, in association with one another, appeared to demonstrate a significant effect, it was likely that these factors influenced one another. Interpretations of cause effect relationships did not seem pertinent in relation to understanding suicidal ideation. What was significant was the identification of potential triggers that led from one dimension to the next. The diagnostic criterion for depression has included suicidal ideation and thus encompassed concepts of hopelessness and suicide. In fact, in analysing descriptions of suicide, based on the tools used, emotional responses related to coping may also have been identified. These factors, though they could be defined as separate constructs, seemed to interweave with one another. While the factors of depression, suicidal ideation and hopelessness have been well documented and integral to the measure's used (Beck, et. al. 1985), the examination of fear of negative evaluation and coping within this population offers further consideration to these interrelationships.

6.2 Limitations

The results of phase 1 left several questions unanswered. How did fear of negative evaluation and emotion oriented coping interact? Could avoidant coping have been identified better than through the measure

utilised? Or why did avoidant coping have the opposite result expected (decreased as suicidal ideation, and related variables increased)?

Steed (1998) in a review of coping scales drew several conclusions regarding the usefulness of measurements of coping in psychological research. These conclusions highlighted 1) inconsistencies between researchers empirical definitions of coping styles and the manner in which they subsequently applied these definitions and, 2) the general ineffectiveness of measuring coping through quantitative methods.

Though the scale used in this study was piloted on individuals, and carefully selected prior to this investigation, in reviewing individual items on the Coping Inventory for Stressful Situations (CISS), it became apparent that the scale did not adequately measure avoidant styles of coping as defined by the examiner. As Steed (1998) clearly identified, all-purpose coping scales have not tended to fully capture the complexity and range of coping responses that individuals engage. He further emphasised the flaws associated with the CISS and the differences in developing definitions of coping including avoidant coping. Steed identified that the avoidant coping strategies on the CISS were defined to include behaviours that may not have been considered as maladaptive e.g.: "go for a walk", "see a movie".

Though these reactions in the face of stress may have been characterised as avoidant, they did not necessarily capture the responses that reflected avoidance or inhibition toward others as sought through this current research. Additionally, Steed (1998) pointed out that one item on the avoidance subscale of the CISS included an item that stated "try to be with other people". This statement would be the exact opposite reaction than that expected from the theoretical framework proposed. Steed inferred that the difficulties with measurements of coping were also made problematic as definitions of coping styles varied from scale to scale. Steed (1998) concluded that cognitive rather than behavioural items provided a more accurate measurement of dysfunctional aspects of avoidant coping.

Prior research has supported the relationship between avoidant coping (defined as escapism) and depression (Conway and Terry, 1992). However, results have varied depending on the measures utilised. Endler and Parker's (1990a) investigation yielded a more modest, though significant, relationship between depression and avoidant coping. These results varied due to the measurements used in the research. Steed (1998) encouraged researchers to explore coping styles utilising qualitative methods. Phase 1 of this investigation yielded a limited understanding of the relationship between fear of negative evaluation and maladaptive coping. The role of

avoidant coping was diminished by the contradictory definition of avoidant coping as identified on the CISS and defined in the study. Therefore, further qualitative investigation is necessary to resolve these issues (refer to Chapter 7).

6.3 Implications for Suicide Prevention

The results of this research, as an exploration of a theoretical framework, contributed to the prevention of suicide by implicating therapeutic interventions which may be examined in future research, and offered additional substance for current applications of intervention practices. Suicide prevention strategies have required a holistic approach to identifying and treating individuals at risk of suicide. The follow up care for suicidal individuals would be prolonged as the influential factors between identified variables such as poor coping responses, hopelessness and depression (or other psychiatric disorders) were not linear in nature, and would require consistent assessment of a person's perceptions and levels of functioning.

Future research on a sub-population of individuals clinically diagnosed with social anxiety disorders or social phobias, may logically

yield more informative results regarding the impact of fear of negative evaluation. Therapeutic applications for individuals with social anxiety disorder would be very specific, and of course would be oriented towards the reduction of anxiety in social situations. As previously discussed, the study under review did not identify the presence of specific psychiatric disorders. Therapeutic interventions for the prevention of suicide were discussed broadly and were based directly on the results of this study. However, it should be acknowledged that specific treatment approaches would consider clinical diagnosis and applications for intervention would work in tandem with specified treatment approaches. Such treatment approaches would assumedly be targeted on an individualised basis to suit the specific needs of the person identified at risk.

Suicide prevention has been approached from three levels of prevention including: primary, secondary and tertiary. As the focus of phase 1 targeted participants who had already been identified as potentially at risk of suicide, intervention or prevention approaches reviewed as a result of these research outcomes were discussed in terms of secondary prevention strategies, or intervention strategies. Such strategies would be those prevention or intervention strategies that would not have a population focus, but would aim to target vulnerable individuals, typically those who

may already have been receiving some form of care. The secondary prevention of suicide would differ from tertiary prevention strategies, which would have a much narrower target group and would refer to follow-up treatment for individuals who may have already engaged in an incident of deliberate self-harm. There would be merit in considering primary prevention strategies in relation to this research as there may exist within the community at-risk individuals who have yet to be identified. However, to reflect the population targeted for this research who were identified by community and health service providers, and recognised as demonstrating symptoms of depression or thoughts of suicide, prevention strategies related to intervention would be applicable to the scope of this study. Baumeister indicated that the escape theory, if explored or researched from multiple angles, may aid in the development of effective interventions which may "break the link in the chain" along the identified pathways that lead to suicidal outcomes. A consideration of a range of compounding factors that lead to suicide has been an important component in addressing suicide prevention.

Critical to the foundation of quality care and suicide prevention at a secondary level has involved the clinical assessment of affective disorders or other psychiatric disorders. Accurate assessment of psychiatric disorders

has been required in order to determine the appropriateness and efficacy of available treatment approaches. Pharmaceutical and medical treatment may become an essential component for suicide prevention. However diagnosing psychiatric conditions and applying medical remedies have been considered as only one component of comprehensive quality care. Establishing rapport and developing a therapeutic alliance with an at risk individual would be the first essential ingredient in an effective intervention. Suicidal risk assessment, pharmacological interventions and the application of psychological therapeutic interventions would ensue. Though these approaches would work in conjunction.

The individual's denial, shame, or fear of divulging their intent may complicate the assessment of suicidal risk. These factors may be heightened as the individuals' level of suicidal intent increases. However, fundamental assessment of suicide risk has involved understanding demographic or clinical indicators (e.g.: male, presence of mood disorder, alcohol or schizophrenia), a recent loss or separation, previous incident of deliberate self-harm (including level of dangerousness), and a sense of pervading hopelessness. Core features involved in the detection of suicidality have included the identification and severity of suicidal intent, presence of a suicide plan, history of suicidal behaviour, physical emotional or cognitive

state, and coping potential. Each of these domains may also have been weighted by level of severity. Jacobs (1999) outlined a full range of comprehensive questions for each of these factors for the identification, assessment, and level of dangerousness or risk of suicide. The complexity of these factors would not be easily quantified, and would need to suit individual needs.

Presumably, prevention approaches at a secondary level, which would engage individuals already identified as at risk of suicide, would involve psychological applications for intervention. Gloauguen, Cottraux, and Cucherat (1999) in a review of the efficacy of cognitive behavioural therapy identified that cognitive behavioural therapy had a beneficial therapeutic effect for individuals with mild to moderate levels of depression. Their study suggested that cognitive behavioural therapy was equal in efficacy to anti-depressants and may be considered as the treatment of choice. In relation to the results of this research, therapeutic psychological interventions will be considered through the framework of the results of phase 1. Beyond establishing levels of risk assessment, critical to this study, strategies to intervene would relate to social support, coping, hopelessness and depression. Significant others, including friends and family would be critical in overcoming distress.

The factor of fear of negative evaluation as an earlier predecessor along the chain of internalised reactions leading to suicide, may actually have reflected a peak along a continuum in which the individual's focus has begun to dissolve into an internalising process. An individual, in response to his/her sense of self in relation to others, and in relation to his/her application of poor coping responses, would begin to internalise a sense of despondency or shame, which would then promote a sense of inhibition. In this context, fear of negative evaluation, though unhealthy at high levels, would represent the demarcation of the individual along a path toward isolation. To counter these effects, therapy would need to focus and build on positive aspects of the self. The at-risk individual would need to internalise a sense of self-worth, develop reasons for living, and understand that in times of need, engaging with others becomes more critical. If social supports were not present within the individual's life, a connection with natural community networks would need to be established. This would be a very critical feature of suicide prevention.

Results from phase 1 reflected a need for cognitive behavioural therapy applications that would focus on the promotion of individuals active engagement in solving problems or for task oriented coping

responses. Such coping behaviours would reflect the individuals' capacity to seek a wide range of options to identify the most adequate solution to problems. The promotion of healthy coping responses would also include engaging in or utilising assistance of others when help was offered/available, and flexibility in working in collaboration with such assistance (Aronoff, Stollak, and Sanford, 2000). Developing or potentially acquiring (thorough practice) the ability to respond to stressful situations or engage in coping styles which promote resiliency, would be a task which may not occur rapidly or without a great deal of work from the individual. As many of the thought patterns that precede behaviours may be automatic in nature or have been established as a reference point within the individual's schema of living. Therefore, the individual would need to reflect on and process their coping responses and develop techniques (cognitive behaviourally oriented) for overcoming ineffective coping responses. The relationship between cognition and behaviour has been complex in nature. These skills or changes would require effort and time to acquire or master.

Also critical to the scope of this study, would be the need for an individual to develop adequate coping strategies which would employ reflection on cognitive interpretations, and the need for individuals to learn

how to manage negative affect or highly emotionally charged responses to situations. This would have more practical application then re-formulating broad coping responses for all situations. Individuals would learn to identify triggers and check their perceptions and emotional and physiological radar in response to stressful events.

Ultimately, suicide, as Baechler (1979) implied, has resulted from some level of motive. The results of phase 1 suggested that suicidal thinking may evolve from an inability to cope and an inability to accurately perceive one's relationship with others as positive or helpful (thus represented by high levels of fear of negative evaluation correlation with high levels of emotion oriented coping) at times of intense stress. The solution to problems or negative events involved a disengagement from others (demonstrated by negative correlation of avoidant coping, which ultimately, as discusses in Limitations measured the opposite effect) and a narrowed focus. Ultimately, the motive or the consideration of suicide occurs out of a belief there exists no alternative (hopelessness) in the face of engulfing negativity (depression). Engaging individuals in recognising their vulnerability and providing alternative, effective means for managing personal setbacks eliminates the propulsion into depression, hopelessness, and suicidality.

6.4 Summary

In reviewing the results obtained from phase 1 of this investigation, emotional features that precluded the core aspects of suicide required a re-examination of the proposed hypothesis. Avoidant coping and fear of negative evaluation were proven not to be significant contributors to suicidal ideation and fundamentally played minor roles within Baumeister's revised escape theory. However, limitations regarding the effective measurement of avoidant coping should be noted. What did emerge was the significance of the emotional build-up that transpires in relation to suicidal ideation. This emotional effect however was not easily understood through this examination. Additionally, the triggers that existed between layers of poor emotional coping responses, depression, and hopelessness that led to suicidal thinking were not clearly defined. Baumeister's theory proposed a psychological numbing which would occur in relation to suicide. Emotion oriented coping, which arose as a significant feature in this study, would support the potential presence of a numbing or emotional immobility in relation to suicidal thinking. However, the grasp and hold of depression, and perhaps of highly charged emotional responses to situations, have been

much more widespread than completed suicide, for as the poet, Walt Whitman (1856) stated "it is not upon you alone the dark patches fall" (p.94). Suicidal ideation, a diagnostic symptom of depression, has had a wide reach. Considering the likelihood that many individuals if not all, experience at some stage of their life some level of loss or grief, and possibly symptoms of depression, would further heighten the relevance for examining risk factors and preventative strategies for building resilience for individuals susceptible to suicide. Not all individuals have experienced severe levels of depression or hopelessness, nor have they experienced triggers that would plummet their cognitive faculties into a darker level of suffering leading to suicide or suicidal thinking. A critical identification of the triggers that would propel a person to consider suicide would require further exploration. Phase 1 of this investigation has reinforced existing research findings that supported key factors of hopelessness and depression as predictors of suicidal ideation. These factors in study after study have predominated as the most salient features in suicide prediction.

Chapter Seven: Investigation- Phase 2

7.1 Introduction

The conclusion of phase 1 of this study did not support the role of fear of negative evaluation as an indicator or predictor of suicidal behaviour (suicidal ideation). Avoidant coping mechanisms were also not identified as significant indicators or risk factors related to suicidal ideation. Implications for this involved the lack of effective measures to examine avoidant coping, and the possibility that avoidant/maladaptive coping responses would have been a function of depression rather than a separate factor related to depression. However, phase 1 results provided evidence of a relationship between maladaptive (emotion-focused) coping and fear of negative evaluation in a population of individuals experiencing depression and suicidal ideation. The purpose of phase 2 of this study was to examine the relationship between fear of negative evaluation and maladaptive or emotion oriented coping, and to explore the potential presence of avoidant

coping as originally defined for this study. Phase 2 of this investigation involved a qualitative approach to understanding the psychological states that would occur prior to an incident of deliberate self-harm. The interpretations of these events were to be revealed by individuals who had experienced an incident of deliberate self-harm. Phase 2 of the investigation relied on individual's reflections on events within their own lives.

7.2 Reframing Research Interpretations

The components originally proposed in the revised escape theory were not significant. Redefining the framework to investigate aspects of the revised proposal of the escape theory was necessary in expanding current findings. It was essential to understand suicidal experiences through a theoretical framework, whether proven or disproved. Theories have provided a scope for examining accurate results and interpretation or expanding a body of knowledge.

The results presented in Chapter 5 alluded to a relationship between fear of negative evaluation and maladaptive, specifically emotion oriented coping strategies. In seeking to examine the presence of fear of negative evaluation, in relation to maladaptive coping in phase 2, it was important to

examine how fear of negative evaluation manifested. Phase 2 of this study assisted in answering the following questions:

- How does the correlation between fear of negative evaluation and maladaptive/ emotion oriented coping responses manifest?
- Could avoidant oriented coping factors be present in this model which may not have been clearly defined or identified in phase 1?

Baumeister's theory proposed that as an individual's view of him/her self increased in negativity, depression, anxiety and hopelessness escalated. Baumeister suggested that the presence of low self-esteem in suicidal individuals differed from low self-esteem in individuals who were not suicidal because "suicidal people may form negative views of the self that contrast sharply with their favourable perceptions of others" (p. 96). If Baumeister's hypothesis regarding self-esteem were accurate, it would be logical that self-comparisons in the presence of others would be avoided and/or would be the source of anxiety or fear (e.g.: leading to fear of negative evaluation).

Withdrawal, lethargy, and lack of motivation, have been identified as common symptoms of depression that may mirror avoidant behaviours. One premise for this research indicated that avoidant characteristics such as

an avoidant style of coping and fear of negative evaluation of others were features that were significant to suicidal populations. Though there was a significant level of comorbidity between suicidal behaviours and depression, depression, as described through the escape theory of suicide, was one dimension of a multifaceted, interactive model of suicide. Such a model reflects the inner dialogue, or cognitive processes of the individual's suicidal plight.

Phase 1 results offered a combination of interpretations that required additional consideration. Cole (1989) suggested that a failure to believe in one's own self-efficacy and ability to cope might be a more critical than the factor of hopelessness. Phase 1 results indicated a relationship between fear of negative evaluation and maladaptive coping offering support for the presence of distorted cognitive perceptions of others and/or the self. Alternatively, fear of negative evaluation and cognition's regarding others may have occurred in initial stages leading toward depression or suicidal behaviours, but as individuals became overwhelmed emotionally, their focus may have shifted solely to internal factors and the relevance of others began to dissolve. As Baumeister's theory suggests, depressive affect was overtaken by the "absence of emotion" leading to a state of cognitive deconstruction. Bonner and Rich (1987) indicated that individuals with

suicidal ideation demonstrated worse problem solving skills, including less knowledge of how to solve their problems and handle emotions, and were more cognitively rigid than non-suicidal cohorts. Phase 1 results demonstrated high levels of emotion oriented coping in a population of participants with high levels of depression, hopelessness and suicidal ideation. Thomssen and Moller (1988), in a study of individuals who had engaged in deliberate self-harm, identified that this group used problem focused ways of coping less often and used emotion oriented, wishful thinking, self-blame, and denial/avoidant methods of coping more often. Phase 1 results supported aspects of previous research, key elements, central to a revised escape theory these interpretations may be more clearly resolved through phase 2.

Phase 2 sought to expand these interpretations from phase 1 results with a greater level of personal insight to crystallise the interpretation from phase 1 results. The overlay of Baumeister's revised theory was to be explored in association with a more severe level of suicidal behaviour. Transposing a the model which resulted from phase 1, onto another population of suicidal participants who demonstrated higher levels of suicidal intent in the nature of their suicidal behaviour, offered a re-test or re-application of the explored framework. Data was presumed to yield

similar results. However, such data was also presumed to elicit an alternative course of understanding. As with phase 1, phase 2 sought to explore Baumeister's escape theory that proposed that suicidal behaviours develop out of an attempt to escape from a state of aversive self-awareness. In order to understand the dimensions previously identified and how these factors interact more comprehensively, additional research was employed. To investigate additional angles of phase 1, phase 2 focused on participants who have experienced an incident of deliberate self-harm, and adopted qualitative methods for data collection.

7.3 Deliberate Self-harm

In considering the replication of research of phase 1 in order to synthesise findings with more detail, it was important to understand the distinctive characteristics of participants targeted for involvement in phase 2. The focus of this investigation has been to seek a greater understanding of potential risk factors associated with suicide, including fear of negative evaluation and the implementation of avoidant coping strategies. These potential risk factors were examined within the framework of a revised escape theory (Baumeister, 1990). As this research evolved into a more in-

depth pursuit, participants who had experienced incidents of deliberate self-harm were conceived to be a group of people who would hold intrinsic knowledge essential to the scope of the proposed research. Information sought from participants provided a closer perspective to support research aims of examining elements of the proposed revised escape theory of suicide and interpreting phase 1 data more comprehensively. This consideration for targeting participants who have engaged in an act of deliberate self-harm, involved the premise that this cohort may demonstrate higher levels of salient features of suicide such as depression and hopelessness. Therefore additional factors associated with coping would also be identified at a higher rate in correlation to these factors. However, some researchers have argued that individuals who experience deliberate self-harm may be a distinctly different cohort than those who complete suicide.

In merging the results of phase 1 and phase 2 it was important to understand the variation between the selected cohorts from the outset. Though for the purpose of this research, suicidal behaviours were considered on a continuum, it was essential to understand the defining characteristics of participant populations in relation to current understandings of suicide. There were clear indicators, illustrated in a wide

range of research, which demonstrated that people who kill themselves were statistically distinct group from those individuals who were involved in other forms of apparently suicidal behaviour (Barraclough and Hughes 1987). Several studies suggested that individuals who engaged in episodes of deliberate self-harm of high lethality did share many characteristics with those who completed suicide (Slap, et. al., 1989). Although there may be an overlap between groups, follow- up studies suggested that those who committed suicide and those who engaged in deliberate self-harm, represent different populations (Fawcett, 1987). Research literature indicated that those who deliberately self-harm tended to be younger and more often women. Those who completed suicide were most often male, and used more lethal methods for self-destruction.

Pritchard (1995) emphasised that those who deliberately self-harm were at great risk of morbidity. He indicated that between 10 to 20% of all of those individuals who deliberately self-harm would die by their own hand within 2 to 3 years. Deliberate self-harm was clearly an important indicator of psychosocial distress and was clearly associated with eventual suicide. Deliberate self-harm, like mental illness carried a far higher risk of morbidity or mortality (Pritchard, 1995). Although a medically and psychiatrically serious incident of deliberate self-harm was probably the

single greatest risk factor for future completion, it was unclear whether the other risk factors for completed suicide were the same as those for engaged in deliberate self-harm (Slap, et. al., 1989). Research findings provided evidence for the delineation of two separate but overlapping groups of people who engaged in suicidal behaviour across the life cycle, those who engaged in an incident of deliberate self-harm and those who completed suicide (Blumenthal, 1990). This may have suggested that there was also enough evidence to distinguish between another overlapping group of people, those who contemplated suicide but did not take action, and those who took action, either by completing suicide or by engaging in an act of deliberate self-harm. Pritchard (1995) suggested that intention, motivation and affect in cases of deliberate self-harm were difficult to distinguish.

Though data regarding psychological autopsies of suicides and suicide notes have been our current closest link (Shneidman, 1996), researchers have been unable to precisely identify the mental status of those who completed suicide within those critically preceding moments. This has limited the investigation to the original quandary. As previously suggested in Chapter 1, the nature of suicide has made the delineation of intent extremely difficult if not impossible to quantify.

Lester (1983) pointed out that those individuals who completed suicide and individuals who experienced an incident of deliberate self-harm may have possessed different personality traits. Furthermore, that those individuals who engaged in repeated incidents of deliberate self-harm may have differed in personality from individuals who experienced one time incidents of deliberate self-harm. Those who engaged in repeated incidents of deliberate self-harm were often more disturbed and had a greater degree of psychiatric and substance abuse problems (Crumley 1990, Peterson and Bonger, 1990; Hawton, et. al. 1993). Table 8 outlines cited schematic differences between individuals who completed suicide and individuals who engaged in acts of deliberate self-harm.

Table 8

Differentiating Suicide from Deliberate Self-harm

Suicide	**Deliberate Self-harm**
Wishes to die	No decisions
More males	More females (2:1)
Unemployed	Unemployed and sickness
Living alone	Living alone and crowded
Psychiatric illness (over 80%)	Affective symptoms
Stress	Stress
Previous self-harm	Previous self-harm
Alcohol/ drugs	Alcohol/ drugs
More violent methods (e.g. firearms hanging)	Passive methods (e.g. overdose)

(Pritchard, 1995; Fremouw, dePerczel, and Ellis, 1990)

The factors listed in Table 8 were relevant for consideration. The aim of this research was to establish an understanding of suicidal behaviours through an interpretation of Baumeister's escape theory of suicide and explore the impact of maladaptive coping and fear of negative evaluation as relevant features within that theory. Ultimately, the overlap between

individuals who engaged in acts of deliberate self-harm and individuals who completed suicide was high. Each of the differentiating factors listed in Table 8 were relevant when interpreting data, considering the generalisability of research results, and developing strategies for the intervention and prevention of suicide. These factors related to personality disorders and other psychiatric conditions that needed to be considered in the scope of this investigation, but were not the primary focus or tool utilised in understanding the phenomenon of suicide through the selected theoretical framework of this research.

One of the essential elements of this study has been the consideration of suicide on a continuum wherein, the presence of relevant risk factors would be found in association with suicide across a range or spectrum of suicidal behaviours. Suicidal behaviours on this continuum have ranged from fleeting suicidal ideas, suicidal contemplation, planning, through to completing the act of suicide. The emotional or psychological struggle regarding an individual's wish to live and wish to die, would have started at the stage of contemplation and continued as a pattern through other suicidal continuums such as an incident of deliberate self-harm. Deliberate self-harm, or suicide related behaviour, has been defined for the purpose of this investigation as "potentially self injurious behaviour for which there is

explicit or implicit evidence either that a) the person intended at some level to kill himself/herself, or b) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end" (p.239) (O'Carroll's et. al. 1996). This definition was used based on O'Carroll's et. al. (1996) recommendation for the use of standard definitions. For the purpose of this investigation, the term deliberate self-harm was used to describe what some researchers refer to as suicide attempts. The term deliberate self-harm may be a more accurate descriptor of self-injurious behaviour since the intent to commit suicide may remain ambiguous.

7.4 Research Design: Rationale for Selected Phase 2 Methodology

In addressing the aims for phase 2 of the research study, qualitative methods were selected as the most effective means of eliciting desired information. Phase 1 of this investigation aimed to quantify the relationship between fear of negative evaluation and suicidal ideation. The second phase of this investigation sought to explore the revised Escape Theory of Suicide, and expand the results from phase 1 through a qualitative approach.

Phase 2 of this investigation involved a qualitative understanding of events, and a mapping of psychological states that would have occurred prior to an incident of deliberate self-harm. The interpretations of these events were to be revealed by survivors, or participants who had experienced an incident of deliberate self-harm in the past. Individual, personal reflections on these events supported the theory that was being investigated because it placed the participant outside of the "highly emotionally charged" incident in which other conflicts may have interfered with the clarity of the behavioural event itself. As the aim of this study was to explore issues of avoidance related to a "suicidal state of mind", the

retrospective understanding of an incident of deliberate self-harm and the distance between the incident and the present was highly important. This reflective, and distanced relationship to the incident supported the aim of the investigation, because it may have reduced the proposed levels of fear of negative evaluation, shame and avoidant behaviours that were being investigated.

Phase 2 qualitatively identifies Baumeister's theoretical stages, including participant's coping patterns, and participant's feelings and interactions towards others prior to their incident of deliberate self-harm. Bogdan and Bilken (1982) suggested that qualitative investigations were suitable for "exploring complexities and interrelationships of a situation" (p.165). The researcher acknowledged that this research design would not reflect the experience of all participants, would not explain the phenomenon of deliberate self-harm or suicidal ideation as a whole, and accepted the limitations of the obtained information. However, this methodology offered a greater level of detail, identified relevant themes, provided participants with a vehicle for expressing their perceptions of the events in their lives, and offered participants the opportunity to actively contribute to furthering the understanding and prevention of suicide. The results obtained from the qualitative interviews could be reviewed

independently and in reference to the results obtained from phase 1.

Qualitative research approaches have frequently been dismissed as unscientific. However, Robson (1993) indicated that there was greater merit in using qualitative approaches when considering the need to understand the relationship between theory and real world processes. Addressing our understanding of suicide through participant's needs, perceptions, encounters and lives, as represented by their own voices, contributed to the creation of theory that would be grounded in actual experience. Broadly, this has been referred to as grounded-theory (Grbich, 1999). Though there has existed a range of qualitative research methods, for the purpose of this research, the term qualitative methodologies was used broadly. The qualitative methodologies employed for phase 2 were implemented to address the complexities and to understand the interrelationships and dynamics of the research based factors under review. This type of research as Berg (1989) stated "refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things" (p.2). The selected methodology for phase 2 allows for a broader understanding of the suicidal experience by attending to individualistic details which may explain the preceding cognitions and behaviours that lead up to the act of deliberate self-harm.

The qualitative approach conceptualised for phase 2 data collection, was a design that empowered participant perspectives while maintaining an impartial, holistic interpretation of these perspectives collectively. As Campbell-Evans (1992) stated: "the essence of qualitative research is to explore and understand a situation, issue or question and to uncover the 'truth' of it" (p.27). The vehicle for this understanding in phase 2 occurred through individual interpretations of personal experiences. Herstien-Smith (1981) defined narrative as "consisting of someone telling someone else that something happened" (p.228). The personalised explanation of exclusive, unique, intimate details explained or verified the existence of factors that have been postulated to advance a revision of the proposed escape theory. Thus, these narratives facilitated a re-shaping of current interpretations of the presented theory and underlying hypothesis.

The methodology selected for phase 2 involved strategies that included a semi-structured interview designed to explore relevant issues, such as coping strategies, life events, and perceptions of self and others. These interviews yielded qualitative data containing features that were considered as case studies, for the information collected pertained to a broader understanding of participant's backgrounds in relation to the context of his/her particular situation. Data was interpreted through a

framework that sought to merge singular voices into a comprehensive yet broad interpretation of experiences based on a thematic analysis approach.

Ultimately the results of phase 2 data worked in tandem with the data, and results obtained in phase 1. Steckler, McLeroy, Goodman, and McCormick, (1992) supported the marriage of quantitative and qualitative research methods as a means of delivering balanced, and comprehensive data for interpretation. Sechrest and Sidani (1995) argued that the continued debate over qualitative and quantitative methods hinders the advancement of research in social science. They proposed that both methods complemented one another. Phase 2 results employed methods that complimented the methodology in phase 1. The uses of dual methods in research were complementary because error or biases were not derived from shared sources. As Reichardt and Cook (1979) stated "each method is based on different yet complimentary assumptions and each method has certain strengths that can be used to compensate for the limitations of the other" (p.115). Steckler, et. al. (1992) outlined various models or approaches for integrating methodologies.

Structurally, this investigation employed, as Steckler described, a study which "is predominantly quantitative [wherein] qualitative results are

used to help interpret and explain the quantitative findings" (p.6). However, analytically, results from both methodologies were presented in parallel. Results were analysed and presented separately, strengthening conclusions, instrumentally determining modifications, and identifying limitations of select methods. This modified triangulation of interpretation assisted in providing a succinct and valid explanation of outcomes. Results of phase 1 data and phase 2 data in combination, provided a fuller, more pointed interpretation.

7.5 Summary

Phase 1 results indicated that participants responded to stress by demonstrating an emotion-oriented style of coping, rather than an avoidant oriented style of coping. Phase 2 sought to examine the presence of avoidant coping responses as cited in other studies (Thomssen and Moller, 1998). Results from phase 1, in relation to Baumeister's theory suggested that suicidal participants responded to disappointments through maladaptive coping strategies and possessed a significant level of fear of negative evaluation by others that preceded or correlated with these coping responses. Phase 2 of this investigation compliments and expands the findings obtained in phase 1.

The two aims of phase 2 for this study include:

1) To examine the dynamics between fear of negative evaluation and maladaptive/emotion-oriented coping
2) To examine evidence of avoidant coping strategies which may not have been adequately measured in phase 1

Chapter Eight: Method- Phase 2

8.1 Introduction

The methodology for phase 2 of this study involved semi-structured face to face interviews with 27 participants who had previously engaged in an incident of deliberate self-harm. This population was targeted on the assumption that their experiences provided more explicit links between suicidal experiences and the theoretical framework under investigation. As the events being investigated have already occurred and the aim of phase 2 involved, as Grbich (1999) describes, "data that includes the perspectives, understandings and meanings constructed by people regarding the events and experiences of their lives" (p.89). Face to face interviews were selected as the preferred methodology to capture these perspectives. Qualitative methodologies allowed more depth to analysis that the quantitative measures in phase 1 did not provide. The results obtained from the qualitative interviews were analysed as a separate body of data. These results were then reviewed in association to the results obtained from phase

1. By conducting face to face, semi-structured interviews with participants who had experienced an incident of deliberate self-harm, the theoretical framework, and data collected from phase 1 was interpreted with a richer level of meaning.

8.2 Participants

Participants were identified through a cross-section of community agencies. The approach to identifying participants for phase 2 was similar in nature to that of phase 1. The criterion for participation in phase 2 was altered from phase 1 and the sole criteria for participation was a self-reported incident of deliberate self-harm. All of the participants who engaged in the face to face interviews for phase 2 were continuing to receive counselling or other community assistance. All of the participants involved in semi-structured interviews were identified through existing community support systems including community-based counselling service providers, typically non-government agencies (n=16), private practice therapists (n=2), and support groups (n=9).

Participants ranged in age from 18 to 77 years old. Participants described previous incidents of deliberate self-harm that occurred as long

ago as 24 years to as recent as a few weeks prior to the time of interviewing. Of the 27 participants, 11 participants were men and 16 were women. Participants with a diagnosed history of mental illness or chronic psychiatric disorders were considered for this investigation, though diagnosis was not relevant to the aim of this investigation, those who may have required an interpreter were not encountered. In some instances a considerable amount of time had elapsed between the instance of deliberate self-harm and the research interview, in one case, 24 years. Participant data was considered relevant for analysis and considered appropriate for inclusion in the analysis of results for phase 2. Results reflect perceptions and though subjective in nature, were relevant to the purpose of the study. One participant defined her difficulties, to the point of hospitalisation, with anorexia nervosa as an incident of deliberate self-harm. Anorexia frequently co-occurs with depressive disorder (APA, 1994) and though anorexia has not been empirically defined as a form of deliberate self-harm, for the purpose of this investigation, participant responses were considered relevant to the prescribed definition of deliberate self-harm and suitable for inclusion. The severity of anorexia for this participant was considered life threatening to the participant. This data was included as a valid and reliable personal account of an incident of deliberate self-harm.

8.3 Instrumentation

Instrumentation involved tape recorded, face to face interviews with participants who had experienced an incident of deliberate self-harm. Interviews were conducted over a 9-month period from August 1999 through May 2000. Interviews lasted in length from one quarter of an hour to two-hour duration; most interviews lasted approximately 1 hour. Semi-structured interviews followed a format which addressed the following content areas: number of previous suicide attempts (including age at the time of the attempt), level of the wish to die at the time of the attempt, negative life events, coping, self perceptions, insight into coping, perceptions of others, and possible prevention measures (refer to Appendix H). As the aims of the study involved the identification of the presence of fear of negative evaluation and to explore the relationship between coping and fear of negative evaluation, it was important to structure interview questions that would resolve these aims without leading the responses to the questions posed. Therefore, the semi-structured interview format in which specific questions related to coping and perceptions of others prior to an incident of deliberate self-harm were believed to be the least obtrusive option for eliciting the information. It is very difficult to assess possible bias in the interview situation relating to the concept of fear of negative

evaluation, therefore specific interview questions were adhered to which addressed the individual's perceptions toward others. For example the questions or statements: *How did you feel towards others? Describe your relationship with others at that time, How did your actions reflect your feelings toward people?* were appropriate in not leading participants to discuss fear or anxiety related to social interaction, but to state their view of others in their environment. Simple prompts such as *tell me more about this* or explain *what you mean* were the only prompts used by the examiner to elicit further description. Participant's self reported determination of their "wish to die" at the time of the incident of deliberate self-harm was adapted from the Beck Scale for Suicide Ideation (Beck, 1993). These questions were used as a gauge and confirmation of the appropriateness of participant inclusion for phase 2 and for assistance in ensuring appropriate level of debriefing required. Retest reliability was not considered to be a barrier to the use of these questions as the primary purpose of the data collection was of a qualitative nature. The number of participants involved in phase 2 would limit the applicability of quantitative data. Additionally, only very few participants were involved in both phase 1 and phase 2. The difference between participant age at the time of the suicide attempt and current age, as obtained from demographic data, was calculated and recorded in conjunction with interview notes and demographic data.

In order to reduce bias and to ensure thorough interpretation of results interviews were tape-recorded. Interviews with participants were tape recorded with a Sony voice-activated mini tape recorder. Two participants declined consent for the use of a tape recorder during the interview sessions. The interviews for these two participants were recorded through hand written notes taken by the researcher as close as possible to include the full dialogue of the interview. Transcripts were produced from these recordings.

8.4 Procedure

Phase 1 of this investigation established a relationship with a number of health professionals, agencies and support groups. These services had willingly identified over 100 participants for involvement in phase 1 of the investigation. Through phase 1 a number of other potential participants emerged who did not meet the criteria for phase 1 as they were no longer experiencing a depressive episode. There were a number of participants who were identified by health professionals within the community who had experienced an incident of deliberate self-harm, but whom were no longer suicidal. Participants were identified through community support groups

and agencies as described in phase 1. Referral sources were established in phase 1 of this study. These participant referral sources were maintained and modifications to participant criteria were made to include only those participants who had a history of an incident of deliberate self-harm.

Participation from key agents occurred on a voluntary basis. Agencies were provided with the basic aims and objectives of the research being conducted (Appendix C) and were asked to identify potential participants for this study. Despite the potential for selection bias, the practical limitations of the study dictated the option of utilizing participant volunteers identified through local support services. The researcher acknowledges that voluntary samples may involve selection bias. However, practical constraints for choosing identified participants including the importance of ensuring participant safety limited the range of options for participant section. Efforts were made to avoid the presence of selection bias by canvassing a wide range of service providers. However the presence of selection bias may be inherent in the population due to the nature of service provision and the inherent need to identify individuals with a unique history of self-harm. A brief checklist was provided to those services or professionals who had demonstrated an interest in participating or assisting in the identification of participants for this study. The checklist included questions regarding the participant's background and criteria for participation in the study

(Appendix D). Community agents asked the participants if they were interested in participating in a study being conducted by James Cook University, and were instructed to offer an Information to Participants statement and brochure which provided participants with the aims and objectives of the study (Appendix E and F). After reading the information, if the participant was interested in being contacted as a potential participant in the study, they completed a consent form that allowed the researcher to contact them (Appendix E). They also indicated the phone number and time of day they preferred to be contacted. The researcher made phone calls to referring agents on a routine, scheduled basis to establish whether there were any consenting participants. Contact details were obtained over the phone. The researcher collected consent forms from referral sources prior to making contact with participants. Participants were contacted within two days following their initial consent. When contacting participants the researcher introduced herself and indicated where the participant's name was received from, ensuring that the participant had read the Information for Participants and understood the scope of the study. The researcher reiterated the purpose of the research based on the Information for Participants. The researcher also ensured that the participants understood that the referring agent was not involved in this study except for the purpose of the identification of potential participants, and to provide continued care. Referring agents were not allowed access to personal information related to this study.

Participants made an appointment with the researcher at one of several agreed upon locations. Participants were offered several choices for interview locations. Choices included at the James Cook University (JCU) Psychology Department, or an office at Relationships Australia Counselling Centre. These locations provided participants with a range of options, and were on the main bus line. As participants were identified, locations and options for interviews expanded and varied. Interviews were conducted in a variety of locations and were dependent on several factors including transportation for participants, office space availability, referral source, and comfort level of participants. The majority of interviews were conducted on-site at community centres and community support group locations which included: St. Vincent De Paul Counselling Centre (n=13), Mind Survivors office (n=3), Women's Centre (n=4), and the Schizophrenia Fellowship (n=3). A number of the interviews were conducted at the participant's home (n=4).

Upon meeting with participants, they were verbally briefed on the purpose of the study and instructed to read the Information for Participants. The researcher obtained consent for participation, consent for tape recording the interview, demographic information, and engaged the

participant in a semi-structured, face to face interview. Participants were provided with both a written and verbal explanation of the aims and objectives of the study, and provided with a full explanation of what the study involved. Consent for participation was obtained from participants on two levels. Initial consent for contact by the researcher was obtained from referring agents in the community. Participants willing to participate in the study were also required to sign a statement of informed consent, giving the researcher permission to confidentially utilise their responses. Participants had the right to decline participation, withdraw from the study at any time, or refuse to answer any question. The letter of informed consent, and consent for initial contact was stored separately from questionnaire data, interview tapes, and interview notes.

The interview format contained several closed answer questions regarding the length of time which has passed following an incident of deliberate self-harm, number of incidents of deliberate self-harm, and the suicidal intent of these incidents. These questions were adapted from the Scale for Suicide Ideation (Beck,1993) (Appendix H). The interview format consisted of five fundamental questions addressing 1) precipitating events, 2) coping, 3) reactions toward self, 4) reaction towards others, and 5) factors for intervention/prevention. Questions asked during the interview

were listed in Appendix H. To ensure the appropriateness of the interview protocols, the interview questions were piloted on 2 participants. A need to modify the interview format or interview questions was not necessary. Participants responded to the scope and range of questions with clarity. Though the interview process was a reflective experience for participants, there was a potential that the interview may have created a certain level of psychological vulnerability. Therefore a debriefing period (20 minutes minimum) was allocated for each participant.

No harmful effects of participation in this research were envisaged as no treatments, manipulation of variables or deception occurred. The procedures used in the research were developed to ensure the confidentially, safety and appropriate support for each participant. The interview process in itself was not perceived to be a damaging or discomforting experience. However, the exploration of participants' eligibility for participation and the completion of the questionnaires had the potential of crystallising participants' awareness of current or previous emotional or psychological state of depression or suicidal risk. The main ethical issues for consideration in this proposal included: the identification and recruitment of participants, anonymity, confidentiality, sensitivity to

the potential distress of participants, and the need to provide appropriate safeguards. The safety of each participant was of high concern a plan for managing high-risk participants was established. The range of options included: directly contacting a support person or support services identified by the participant, directly contacting the local hospital, or directly contacting the intake assessment team at community mental health. Each participant was provided with contact details of local counselling agencies and, as relevant, follow up appointments with the original source of referral was confirmed. Debriefing also included an assessment of the participants' risk of suicide. All participants were debriefed and follow-up with existing support systems was identified. All participants participating in these interviews had identified issues for which they were continuing to receive assistance or counselling. The researcher was fully prepared to engage in securing immediate assistance for participants to ensure that their safety and follow up support was attained. No ill effects or crisis arose during the interview process, and no ill effects were reported to the researcher following the course of this study.

All participants' information was de-identified upon completion of the interview process. That is, their name, and identifying information was separated from their responses. The anonymity of participants was

protected from the initial contact point. Referring organisations did not have access to the raw data, nor did they receive feedback pertaining to the results of individual participants.

Confidentiality of participants was upheld throughout the course of the study. During the study and following its completion, data was secured in locked filing cabinet, to which only the chief investigator had access. Tape recorded interviews were also maintained in a locked filing cabinet.

Tapes were labelled numerically and were separated from participant consent information. Demographic data was recorded prior to tape recording the interview session through the completion of a brief survey (refer to Appendix B, Demographic Information), and labelled to correspond with interview tapes. These demographic surveys were administered orally by the researcher and were preceded by a brief script regarding the format of the interview session. Transcript materials maintained anonymity of participants, as participant's names were not identified verbally on the tape, nor were tape labels identified using participant names.

Tape recorded interviews were transcribed by the interviewer into verbatim accounts of the interview. An assistant was used in transcribing portions of select interview tapes and in transcribing whole interviews. The selected assistant was skilled in transcribing tapes of a sensitive nature, was experienced in working with confidential materials and had experience in working closely with psychologists, receiving high levels of recommendation. Assistance with transcribing interviews involved the training and supervision from the researcher in ensuring confidentiality and for outlining procedures for transcribing the interviews. Tape-recorded interviews were anonymous in nature due to the method involved in recording demographic data and labelling recorded tapes. Tapes and interviews did not identify participant names or demographic data. Participant names were only recorded on consent forms and were immediately separated from interview data. Demographic information and interview tapes were assigned numeric codes to protect participant identity. Interview transcripts, once transcribed in full, were again reviewed by the researcher. The researcher listened to the tapes in conjunction with reading transcripts in order to ensure the accuracy of recorded data.

It was envisaged that the participants who chose to be involved in these interviews were interested in sharing their experience. Based on the

response of the first stage of this investigation in which over 100 people completed five psychometric scales, and engaged in a debriefing session, most participants had expressed a sense of satisfaction for their involvement in this investigation. Phase 2 of this investigation allowed participants to express their experiences more openly and in their own terms. This sense of control over information may have provided participants with heightened sense of accomplishment for their involvement. As the researcher was also a registered psychologist, skilled in counselling, it was hoped that therapeutic effects might have resulted from the interview process. It was believed that the potential benefits to the participants and to the general body of knowledge outweighed the risks because a comprehensive understanding of the risk factors of suicide and suicidal behaviour are necessary as a foundation for effective interventions.

Chapter Nine: Results-Phase 2

9.1 Introduction

Results obtained from phase 2 offered a scope and depth of perspective that was not available from the traditional quantitative data results obtained in phase 1. Excerpts of narratives were used to highlight key reoccurring themes; elements of the suicidal experience emerged which transcend circumstantial differences. These experiences resonated directly from the voices of those who once felt the compelling grip of suicide. These experiences yielded to a language of their own. Together, in a full review of these narratives, there was a human element that both unfolded and dissolved. These reflections in combination, began to speak to larger universal insights regarding incidents of deliberate self-harm. However the people behind these words did not disappear. To the contrary, their words, their experiences moved beyond our daily utterances and placed themselves in a space of prosaic endurance. Ann Sexton (1966), who took her own life at the age of 45, in her poem "Wanting to Die", wrote: " suicides have a special language... have already betrayed the body...stillborn, they don't

always die..." (pp.1308-9). Incidents of deliberate self-harm, and preceding moments, reflected a kind of trauma. A trauma in which self-murder appeared a viable alternative to the psych-ache suffered. This trauma did not readily vanish. For Sexton, and perhaps others, suicidal gestures or incidents of deliberate self-harm were not always a singular circumstance. Sexton in her confessional poetry provided us with another glimpse into the suicidal mind through an artistic representation. The samples of narrative excerpts presented in the following chapter were simply that, a sample.

9.2 Analysis of Data

Data analysis consisted of several components. These components included frequency counts on aspects of the interviews that could be quantified, a categorical review of responses based on the structure of the interview, and the identification of themes based on interview text. Interview transcripts were elicited from the text. Coder reliability was taken between two independent coders and the researcher's coding across time, to check for potential bias and ensure validity of the coding framework. Analysis of transcripts occurred through a data driven format in which themes were identified and categorised in a manner that was not

bound strictly by the interview structure. The analysis of qualitative data, (e.g.: recorded interviews), was data driven. Data driven analyses occur where no preconceived coding categories are established and codes are created or driven, as they emerge in the data itself. Codes were thus identified through the interview scripts, categorically themed, and represented as a form of narrative to illustrate aspects of the investigation results. Each participant, for the purpose of analysis and presentation, was provided with a different name to protect anonymity and confidentiality. Allocating fictitious names to participant results was done to protect the confidentiality and anonymity of each participant, but also to maintain a human identity to each voice, rather than to apply a mechanical code number.

Demographic information and several other factors were quantified to provide a descriptive backdrop to enhance the understanding of this particular group of participants.

9.3 Findings

Findings were presented to include the results of frequency counts

and core thematic categories. Thematic categories included: life events, coping, depression, self-blame, self-loathing, hopelessness, feelings toward others and prevention. These factors ultimately represented the framework of the interview format. Participants were asked to rate the strength of their "wish to die" at the time of their incident of deliberate self-harm. Of the 27 total participants interviewed, 20 participants rated their wish to die as high at the time of their incident of deliberate self-harm, 2 participants indicated that their wish to die was of medium intensity, and 3 participants were not able to recall, or were unable to identify the level of intensity of their wish to die at the time of the incident.

As data was analysed, one area that emerged as substantial was the precipitating negative life events that lead to suicidal behaviour. Though this subset of results did not contribute to a new understanding of research related to suicidology, the results were relevant to the scope of investigation and were coded and tabulated. Most participants described a build-up of events that contributed to their incident of deliberate self-harm. Numerous negative life events, interpersonal and emotional distress were identified as precipitating factors prior to suicidal behaviour. These issues frequently overlapped with a point of crises in which participants identified ineffective means of coping with these negative events. Quantifying,

separating and categorising life events involved the use of multiple descriptors. For example a life-threatening situation may have also related to an incident of physical abuse. Thus life events were tabulated to include all appropriate descriptors. Additionally, the meaning or relevance of these events may not have been specifically articulated by the participant as contributing factors to the incident of deliberate self-harm, but were included in the participant's narrative of the events surrounding the incident. Critical life events may a role in increasing depressive symptoms or suicidal ideation in vulnerable individuals. However these events, for the purpose of this study, are not considered to be independent risk factors for suicidal behaviour. These factors act as a trigger for increasing suicidal risk or escalating exacerbating risk factors for suicide such as a sense of hopelessness, increased symptoms of depression or anxiety. These life events compound with perceptions, coping strategies and individual moderating factors to increase the risk of suicidal behaviour. Not every individual who experiences set backs or negative life events, will be at risk of suicide nor experience suicidal thoughts.

The range of life events participants identified included:

- Family problems (17 out of 27)
- A history of sexual abuse (10 out of 27),

- Loss (specifically defined as a death or separation from others) (9 out of 27)
- Relationship break-up (9 out of 27)
- Development of mental or physical illness (5 out of 27)
- General life stress (4 out of 27)
- History of trauma (accident, life threatening situation) (3 out of 27)
- Sexual identity issues (2 out of 27)
- A history of physical abuse (1 out of 27).

These events were difficult to quantify as many life events, as described in participant interviews, expounded to encompass multiple issues or led to additional relationship problems/ break-ups or other social or emotional deterioration. It was important to note that participants were identified through all "walks of life" and that neither men nor women were specifically targeted. The life events that contributed to the participant's incidents of deliberate self-harm were significant in establishing a framework for further analysis or interpretation of the content of these interviews as they related to Baumeister's Escape Theory. The first proposal to Baumeister's theory was that life events did not live up to participant's expectations. Clearly, evidence gained from the interviews

supported the first premise of Baumeister's theory, which has also been supported by research literature.

In conducting interviews that were reflective in nature, there were a number of issues to consider in regarding validity, reliability, and support for the interviewers. Results reflected the perceptions of unique, participant life experiences. Therefore, these narratives were subject to the interpretation of the participant who owned the experience, including any interpretation of events, lapse in memory, or modification to the actual experience. These factors may have shaped the outcome of interview data, but accurately recorded the voices of the people who have suffered and survived beyond their suffering. These accounts were considered to be valid and the integrity of a participant's narrative was not questioned.

9.3.1 Life events.

As the accumulation of past negative life events and current life stresses culminated, participants described the multi-layered effect of past and present experiences which led to a state of ineffective coping, depression and sent them to the brink of desperation.

"A lot of things. ...All of this goes back to childhood anyway, but at that time I was working a 90-100 hour a week, I was in a relationship with extreme domestic violence, and yeah, ...so it was surfacing issues. It's kind of like a week before I overdosed, you know things from the past you seem to shut out of your head, and because everything was so sort of spinning out of control it unblocked everything from the past and everything resurfaced that hadn't been dealt with...it was just way too much..." *Beatrice*

As the experience of sexual abuse was a common experience for a number of the participants, it was worth noting the unique and soul-shattering trauma, which led participants to a state of suicidality:

"I have had suicidal tendencies for the last two or three years probably. I felt like I just wanted to end it all...Mainly I had a drunken father and I was sexually abused by him. I was eight when he started and I ended up telling mum when I was eleven, I think. From then on he never treated me like a daughter basically and he was angry with me all the time. He called me a moll and a slut...I basically think I would have had the depression I would say, from when I was a little girl. All I can remember of Dad now is that he stole my childhood away from me by doing what he did. I remember being a happy kid right up until that time... I was very insecure. I didn't have any girlfriends because I was so insecure with myself and I had no self-esteem, I suppose. I just hung around on my own basically, only my boyfriend and his friends... I was all right when he was around. ... I was confused I suppose. At that age, with all those hormones and Dad

was telling me I was all these things, I didn't know whether I had instigated things. When you are younger you don't know." *Carla*

Many participants described the effect of negative life experiences and their difficulties coping with these experiences. As the events were described, the methods for coping with these experiences also surfaced.

[Describes parents divorce, and unwanted pregnancy]... "I was devastated... especially by the divorce...those incidents actually led up to my decision to try to end my life. It was a number of things.... At the same time I was raped and also prior to that I was abused by a family member...No matter what I did I wasn't good enough for anyone.... Probably knowing now that I was scared that they were going to get to the root of the problem. Probably trying to block out everything that happened, the rape, the pregnancy, the divorce...I don't want to get started on talking about the abuse because that went on from when I was about 12 to 17½ . ....I try to block it out... I wouldn't want my worst enemy to go through it. It was terrible....I thought it was all my fault... but I know it's not my fault..." *Rebecca*

As Rebecca and Carla described their life experiences, which both involved incidents of sexual abuse, there were several similarities, which were clearly illustrated from their descriptions. Among the similarities described was the self-blame that arose from their experiences and their

inability to piece together, or to confront, the events, which most profoundly affected their sense of self-worth.

9.3.2 Coping.

Participant's descriptions of coping were frequently interwoven with their descriptions of depression. Many participants described states of withdrawal.

> *"...You go into your own world, you're not part of society anymore, you leave it... and go into your own head and close the door..."* *Robin*

> *"I just kept to myself. Prior to that happening I was withdrawn, bitchy. Not angry but frustrated with everyone I came into contact with."* *Rebecca*

> *"Well, believe it or not, I pull my bible out and start reading and praying, and with friendship and support, and every time I fall I get a bit stronger. I am very strong now, I'm not going to do it ever again, I'm a tough bitch now."* *Carol*

> *"I was hopeless. I wouldn't go to the shop; I didn't want to eat. All I wanted to do was sleep. I didn't think at all. I was too self-centred and feeling sorry for myself and not wanting to live. I didn't really"* *Sally*

"[I was] Not at all. [able to cope] I was working three jobs, I remember that and I got really sick and rundown. I was very tired. I know that this last time I was so tired and exhausted I just wanted to go to sleep. I had a nervous breakdown about five or six years ago and that was the worst time, for three months then. But because I've have had depression for a long time I recognised it in time so I got help. It took a while, it took about nine months and I was bed-ridden for about nine months, pretty bad. I think that most people I have talked to who have basically had the same problems I had are feeling the same, mostly tired, you want to give up the fight. You think about torment all the time. I used to find I would climb like this and drop down and then I'd have to climb up again. It was just one thing after another. I just couldn't cope. I was dysfunctional. I didn't cook, I didn't wash, I did nothing, I slept 17-18 hours a day for about nine months" *Carla*

"I would just go to my room and stay there for the rest of the day" *Mick*

"I looked shocking...I looked shocking.. I wasn't eating, I mean I'm pregnant now, but I mean I dropped right down to about 38 kilos. I wasn't eating, I wasn't sleeping.. ...the same thoughts you always have it's just the aloneness and my support network, you think that nobody cares, and it's basically just the hopelessness you know, you think 'look at me I'm better off not here and everyone's better off without me'... I totally isolated myself in the end, I cut off all ties with friends and then I'd have days where I'd sit in a chair ...I'd get up at 7.30 in the morning and I'd still be like that at 8 at night...just frozen ...just too scared to move ...hold your breath... too scared to breathe, too scared to do anything...it was awful, really really awful ... It was just everything, I was even scared of going out the front door, I couldn't answer the phone I couldn't do anything..." *Beatrice*

These descriptions of coping provided vivid examples of maladaptive coping, including the presence of pervading cognitive distortions that were interwoven into accounts of depression, and hopelessness.

In addition to depression, others may not have easily identified the maladaptive coping responses some participants indicated that they were experiencing.

> *"I mightn't have shown it on the outside, it hurt on the inside"* *Jessica*

As in Rebecca's description (see previous quote under section on Life Events) in which she tried to block out her negative experiences, Jessica's description of masking her pain revealed the use of coping strategies which employed defense mechanisms which may not have been the most highly adaptive.

9.3.3 Depression.

Symptoms of depression were clearly identified through participant interviews. Symptoms of depression including poor sleeping patterns, poor eating habits, anhedonia, and withdrawal were described in association with coping responses. The following example illustrated this:

> *"I wasn't sleeping at all. I wasn't eating. I didn't eat for about five days, and I didn't sleep for seven days solid. I used to get in the car about 3 o'clock in the morning and leave the kids in bed and just drive the car. I thought it would make me go to sleep but it didn't, it just made me more awake. I felt really desperate.... A few days, probably a week. I know things aren't right. Its starts off slowly when I can't cope with just normal duties like washing clothes and the dishes, I just can't cope with it and I just want to lie in bed all day, I don't want to get out. It just slowly builds up till I say 'I've had enough of this' and just want to do it. "* *Carol*

In William Styron's (1990) book, Darkness Visible, he qualitatively described his experience with severe depression, suicidal contemplation and a suicidal gesture. He clearly identified that his experiences were unique to his life and situation, stating that generalising his plight was not the objective of his descriptive autobiographical text. However, many of Styron's comments were consistent with those obtained through the face to

face interviews including but not limited to 1) psychiatric/medical specialist interventions which provided limited therapeutic effect, 2) a sense of pervading hopelessness 3) the clearly identified presence of symptoms of depression including physiological changes (e.g.: sleeping, eating), withdrawal, and suicidal thinking and 4) the reliance on alcohol as a mechanism for coping, demonstrating maladaptive, internalising coping strategies. Styron claimed that:

> loss in all its manifestations is the touchstone of depression- in the progress of the disease and, most likely in it's origin.... [this] acute sense of loss connected with a knowledge of life slipping away at accelerated speed, acute fear of abandonment [and an] acute loss of self-esteem (p.56-57).

Styron's account of his own experiences echoed the experiences described by several participants. Many descriptive symptoms of depression were interwoven throughout participant's detailed accounts. Elements of depressive symptomology were identified in conjunction with descriptions of coping, precipitating events and other factors.

9.3.4 Self-blame.

In developing Baumeister's revised theory, the concept of self-blame was associated with a sense of shame and fear of negative evaluation. As proposed, self-blame derived from perceptions of negative life events, where the participant blamed him/herself for these experiences. This sense of self-blame encompassed a layered existence with the scope of the results obtained through interviews. Self-blame was associated not only with negative life events and fallen expectations, but was linked with symptoms of depression and hopelessness:

> *" The rape and the child abuse, I blamed myself for them. I definitely blamed myself for Mum and Dad's marriage break-up."* *Rebecca*

> *"That was the only time that I ever wanted to give up. I just sort of felt, well that I had made that many new starts. I just didn't want to help myself... I blamed myself for so many mistakes"* *Sally*

The above excerpts illustrated the presence of self-blame, and in Sally's description, Sally's level of self-blame contributed to her sense of hopelessness.

9.3.5 Self-loathing.

Baumeister's theoretical framework distinctively defined a sense of self-loathing as a stage that led to suicidal behaviour. Symptoms such as low self-esteem, a sense of worthlessness, and rumination on past failures were frequently associated with depression. In the revised model, proposed for this investigation, self-loathing was not targeted as a separate variable, but was acknowledged as a feature of depression. In phase 2, these symptoms were elicited through the interview process:

> *"I hated the world... I was so fed up. I'd go on a hate period. I'd have hate sessions with myself...I'd get in a real bad mood and I'd take it out on myself. ...it was just too much. I thought, 'This is it, I'll give up. No more. The kids will be fine without me; I'm no good as a mother anyway'. ...I was a lousy mother and they would be better off with my friend who is a good mother. That I am no good as a mother and they would be better off with someone else."* *Carol*

> *"I had very low self-esteem; I hated myself and said things that I hated myself. It's not as bad as it was, but still I had very negative feelings for a long time and I believe they stay with you for a long time".*
> *Rebecca*

> *"You don't want to be around anymore. You don't think you have any self-esteem, you don't have the right to... ... you don't want to live. It was a hopeless situation. It was like I had no self-esteem*

what so ever, no dignity .... I had been pretty much stripped of any dignity and I didn't have much self-esteem." *Jessica*

"I felt angry with myself for the stupidity and things I did in the past" *Mick*

"...my self-worth was just not there..." *George*

A lack of self-worth, self-esteem, and anger directed at oneself were themes that emerged through participant descriptions of their experiences. This sense of self-loathing or self-hate was also associated with a sense of hopelessness as both Jessica and Carol indicated.

9.3.6 Hopelessness.

Currently research on suicide has explicitly identified a sense of hopelessness as one of the most crucial predictors of suicide. Interview participants did not easily define nor overtly describe their experience of hopelessness, but did identify the presence of a sense of prevailing hopelessness, for example:

"I was kind of in despair. If you can describe despair, it was over-despair. There was no other

way out, there was no solution." *Ed*

The existence of a sense of hopelessness certainly prevailed through nearly all participant descriptions. However this state of hopelessness was frequently identified through, or associated with, more indirect descriptions of emotional states or struggles to cope. This included the belief that there were no other alternatives, a pervading sense of loss, descriptions of depressive symptomology, and a sense of overwhelming fatigue.

9.3.7 Feelings/reactions toward others.

Participant's reactions towards others and participant's reflection on others perceptions were explored and presented as follows. These feelings and views of others supported the presence of a sense of fear of negative evaluation, shame or general maladaptive social perceptions.

> *"I felt that I couldn't communicate with them... that I couldn't get across what I was feeling... no one would listen, or I didn't think that anyone would listen... I was afraid that they wouldn't...there was a 'snowball of events' where I fell to bits and out of control...when too much happens in your life that you can't handle... I thought that people couldn't help me.... I felt hopeless...everything was spiralling to the bottom....[I] Couldn't imagine that they would be*

able to help.. I told them, my friends... when I was calling them, ... I said I was going far away... Well I thought everybody hated me, nobody liked me at all, so what's the use of living. ...Well because I took those overdoses I thought nobody cared". *Carol*

"I became...withdrawn, totally anti-anyone and everything" *George*

" ... you go into your own world, you're not part of society anymore, you leave it... and go into your own head and close the door... " *Terry*

"I cared about other people but I couldn't deal with other people because I felt so intimidated by everybody...I felt so... I don't know what the word is...so below everybody, unworthy...I found it really hard just to have conversations with people and stuff because I'd go into a panic just trying to talk to somebody. I felt totally irrelevant...I felt like every time someone would look at me they'd be looking down at me, 'oh look at her' you know?...It was really no self-esteem at all... it's unworthy, you feel so irrelevant ... undeserving. ....that's what I've battled with ever since I can remember, the unworthiness...yeah unworthy to breathe the air on the earth... " *Beatrice*

"I felt that other people, the other tenants were ganging up on me. I just felt that everyone just had it in...that very paranoid type feeling...I was suffering from a lot of stress. ...I felt that eyes were on me... I wouldn't go out during the day because of a fear of people.... some people call it agoraphobic, but I call it a fear of people. When it came to mixing with people, I had a fear of people not being genuine" *Vera*

"The main thing I find that the people who do it or attempt to, other people don't understand how you are thinking, or how you would want to do that. Because they look at me and think I have got everything. On the outside you give people the impression that everything is all right, but underneath you are not. ...I used to hide it. ...People don't understand your way of thinking. You think you are a burden, I know that's the way I felt. I hear it a lot today, people just don't understand how your mental state is. Your thinking is totally different, the mental state you get into and unless you have been there you don't know what it's like." *Carla*

In these descriptions, participants articulated a complete loss of faith in others, and the belief that others would not understand their feelings or experiences. Trout (1980) reviewed the impact of social isolation and it's correlation to suicide. She postulated that social isolation and suicidal behaviours were inextricably linked. In this investigation, unravelling the occurrence of social isolation as a component of coping was clearly identified by numerous participants. However acts of isolation or social avoidance appeared to be reinforced by depressive states of self-loathing and depressive thinking patterns. For example:

"I shut myself away from a lot of people, especially my family... I didn't trust people. Certain people, I loved having around, but I couldn't tell them anything. For example, my mother, I couldn't tell her anything. I felt heartless, cold, I felt hurtful...I felt

really mean...I looked at people and sometimes I hated them, I was jealous of them, I thought 'why do they have everything'. I knew the situation and never thought I'd get out of it... and you'd look and think they were so happy ... I was annoyed at what are they doing right and I doing wrong...I was distant to people. People can pick up vibes...that 'hey, she just wants to be by herself'. Inside ... I just wanted my mother, I felt safe with mom ... when I looked at mom, I saw myself and would hate her ...hate her and feel safe. I almost wanted to be her... that's as close as you can get? You want to be alone I suppose. I could never cry in front of anyone"...

Rita

In Rita's description, she articulated her internal struggle for self-acceptance, and perhaps an underlying ambivalence toward suicide. Her description illustrated her longing for a sense of security, which conflicted with her self-comparison, negative self-evaluation, and ultimate isolation. Broadly, these interview examples demonstrated the presence of anxiety, poor social engagement, alienation and withdraw.

9.3.8 Prevention.

Participants responded to questions regarding what may have prevented or stopped them from engaging in an incident of deliberate self-harm. Many respondents immediately replied that interventions that would

have prevented them were very limited. For example, Terry described her state of mind following a relationship break up:

> *"I was in a rage. ... I wanted to stop the pain... wanted to make the pain stop... it's terrible when you get that way"... I feel embarrassed talking about it now... it all seemed silly now.*
>
> Interviewer: If there were anything that anyone could have said or done, what would have stopped you or helped you?
>
> *No... There was no support in the town ... there was nothing nothing nothing ... ... I felt that I was a bad person. You don't realise that you are destroying yourself... Now I think 'Why?' things were so intense then, so important....Pain was so strong... a spiral trip... and you can't get off it... it's like grief... it's a type of grief.. it's not as bad as grief... but it would rate with grief.. it's a kind of grief... If someone had been there.... You get something set in your mind.. it's a mindset and once you are into that mind set ... that grief... nothing can stop you .... Nothing... nothing."* *Terry*

Upon further reflection, also identified in Terry's description, when she stated: *"if someone had been there,"* participants expressed the need for someone to listen to them with genuine concern.

> *"To talk about it without actually bringing all the emotions and reliving the experiences all over again. You can relive the experiences all over again without it actually happening. ...Well it's hard at that age... because you're a teenager because you think that no one will understand what you are going through. I thought he was a so-called friend. I got drunk one night and he just took advantage of me. I walked*

about 20 kilometres home. I got body odour, I scrubbed it till I was red raw, it just makes you feel so dirty and so worthless." *Rebecca*

"Probably (talking to)... Mum"... [the participant had described the events which lead to her suicide attempt which included a fight with boyfriend and her abusive father not allowing her to speak to her mother]" *Carla*

"Well I find that if I have company, friends come around... seems to make me feel better because I have somebody there to talk to. The loneliness gets to me too." *Carol*

"Somebody to really sit there and believe what I was saying...I was screaming out for help so loud you wouldn't believe ...yeah and not to say 'take these pills and go. Fine you'll be alright'... it's like, 'please listen to me!'. I even begged them once to put me into hospital so I could have a rest 'cause I was going to do something drastic... 'no that hospital's full, you'll be fine'...it's like they just don't hear what you're saying...it's like they have this category of people, so you're in this category and so you get treated just like that...and I had issues that I really needed to deal with...Yes. Like I said it's been a battle, I don't have the support network. That is the biggest thing, the support network. It's just not there." *Betty*

"If someone would have asked me what was going wrong... I just wanted to die. No one asked me why I was suicidal, why I was taking the tablets... I was going through a stage when I went to a lot of Doctors. None of them really bothered to sit me down and ask me what was wrong...I was paranoid to tell any doctors ...it frightened me." *Lucy*

These responses provided a noteworthy juxtaposition to earlier descriptions of how participants felt towards others e.g.: isolated, mistrusting and misunderstood. This contradiction between feelings and desires has been the ubiquitous challenge of suicide prevention. The prevention of suicide, from the perspective of an outside force, has required two layers of intervention 1) the weaning away of an individual's state of self against self and 2) the wedging in of therapeutic interventions for individuals who are in a state of conflict regarding their faith in others.

As in Rebecca's description, many (10 out of 27) of the participants who were interviewed described the emotional difficulties related to coping with sexual abuse. These efforts to overcome these abuses paralleled and eventually collided with suicidal thinking; most participants described layers of events that contributed to the final act of suicide attempt:

> *"We had a lot of family strife at that time... I had been sexually abused by my grandfather and we were getting to grips with it....I felt dirty about myself...I wasn't really angry with my family. It was my body...I was trying to get to grips with being sexually abused and also having guilty feelings about talking about it with my sister...I had all these mixed up feelings about everything. I felt dirty...I felt really depressed at home... I never had any freedom. Then I started taking some pills... I didn't want anyone to know basically. My friends were a bit concerned. Although they had stopped hanging around with me...I just*

couldn't talk. I felt dirty, disgusted and all the rest of it....I felt so angry...When I was angry I couldn't control my temper and I would punch walls and I would scream and yell because there was nothing else I could do because no one would listen to me... No one would help me....It was just a whole range of things. There wasn't just one thing, the sexual abuse, my grandfather, family problems, it was everything... I really wanted attention from my friends. I'd never been really popular, but I never really cared about anyone else. .. The feelings of dirtiness and guilt were just overwhelming and I can't even explain it to you. I felt so disgusting. I would cry and cry and didn't know why I was crying. I would just sit there and cry my heart out. ...I still don't know why I was crying so much...There was nothing that could change the feelings I had I don't think. All the feelings were still there...." *Vera*

Clearly, the negative life events that contributed to a sense of loss, and social alienation, as identified by the majority of participants involved in this research, provided further evidence for the need for effective, perhaps longer term support systems. These events that led some participants on a path to self-destruction, may nave left a scar on their world view or disrupted their sense of safety within the world and within themselves.

9.4 Summary

Though not all of the participant interview transcripts were presented in this chapter, fundamental themes were elicited and presented thorough concise excerpts from interview material. These identified themes were categorised and offered support for the revised escape theory of suicide, and most importantly provide additional insight through a frame of reference which was grounded from the perspective of those who have faced suicide in full sincerity. As e. e. cummings (1947) wrote "i who have died am alive again today...(now the ears of my ears awake and/ now the eyes of my eyes are opened)" (p.480). Sharing unique and very painful experiences of deliberate self-harm and preceding traumatic life events was a process not to be taken for granted. The participants involved in this study demonstrated the highest level of bravery in facing the risk of exposure of their most intimate and arduous nightmares. They each shared perceptions about themselves and their experiences that required reflection on the most raw period of their lives. That is, a moment in which their own existence was in question. The information obtained from these portraits, in compilation, provided additional insights that were not necessarily anticipated by the investigator. However these experiences unfolded fresh, untrained avenues of awareness and contributed notably to the research

study as a whole. The themes extracted from these interviews offered insight to the results obtained in phase 1 of this investigation, and to a revised escape theory of suicide.

Chapter Ten: Discussion- Phase 2

10.1 Introduction

Results from phase 2 of this investigation illuminated the findings obtained in phase 1. Phase 2 results were beneficial in providing sufficient detail to explain the correlation's that were identified in phase 1, and offered an expanded scope of reference. Data obtained in phase 2 supplemented data obtained in phase 1 and aided in further building on interpretations of the revised escape theory of suicide. The aim of phase 2 was to more clearly define and interpret the significant relationship between fear of negative evaluation and emotion oriented coping, and also to examine participant descriptions of maladaptive coping to determine if avoidant strategies may be more readily defined than through the coping scale used in phase 1. The relationship between maladaptive coping and

fear of negative evaluation that was identified in phase 1, was more intensely reviewed through the process of interviewing participants who had a history of an incident of deliberate self-harm. The responses obtained through interviews were categorised by identified themes.

10.2 Fear of Negative Evaluation and Coping

Phase 2 results provided information regarding participant's perceptions of others prior to incidents of deliberate self-harm. The presence of fear of negative evaluation was identified along with maladaptive coping responses and depression or negative affect in participant responses. Information regarding fear of negative evaluation appeared to relate 1) to strategies involved in coping, e.g.: withdraw, 2) irrational thinking or cognitive distortions, and 3) symptoms of depression e.g.: a sense of feeling unworthy or less than others. Participant reflections that may have related to fear of negative evaluation were not directly articulated as such through the interview process. Findings identified issues related to shame, self-blame, isolation and a lack of ability to trust or communicate with others (Wiklander, Samuelsson, and Asberg, 1999). Participants, in descriptions of their relations toward to others, preceding an incident of deliberate self-harm, tended to describe symptoms associated with avoidant coping,

depression, and withdrawal. Narratives identified the belief that others would have been unable to help and cited an inability to engage with others. Several participants expressed a sense of shame, unworthiness or lack of self-worth that also interfered with connecting with others. These concepts supported the theoretical framework proposing that the presence of fear of negative evaluation or shame was a factor involved in cognitive distortions and negative affect that ultimately contributed to poor coping responses and depression. As in studies by Dean and Range, (1999) and Dean et. al. (1996), these factors suggest an interactional process leading to suicidal ideation. Conclusions regarding fear of negative evaluation suggested that factors related to fear of negative evaluation acted as specific cognitive distortions that were a component of maladaptive coping.

10.3 Support for an Interactional Model

The identification of factors of depression, emotion oriented coping and hopelessness associated with Baumeister's proposed model, also aided in answering questions regarding how these factors interact. Interview responses, consistently interrelated symptoms of depression, hopelessness, poor coping responses, and self refute. Participant descriptions though they

may not be widely generalised, and as second order data offered a subjective interpretation of events, supported the premise of interactional pathways towards suicide. Interviews did not conclusively substantiate an increase in one factor contributing to an increase in another, nor did the results of phase 2 suggest causation between these factors. However, participant descriptions of their experiences were consistently non-linear, multi-layered, and pointed to the interaction between multiple variables (e.g.: coping, hopelessness, and depression) which eventually culminated in an incident of deliberate self-harm. The overlap between factors of coping, depression, hopelessness and negative self-evaluation was evident in participant responses and reflections on their experiences.

10.4 Negative Life Events/Sexual Abuse

In addition to the general findings regarding aspects of Baumeister's revised theoretical framework and the factors under investigation, issues related to negative life events were highlighted. This data contributed to and supported Baumeister's theory and added additional avenues for future investigation. In phase 2 of this investigation, the role of sexual abuse emerged

a factor that was a common life experience for a number of participants. A number of participants related experiences of sexual abuse that contributed to the events that led to suicidal behaviours. This factor was not under investigation, nor previously targeted as a variable to be investigated. These life experiences were not intended to be a variable of focus through the interview process, but clearly emerged as a relevant theme in multiple interviews.

A history of sexual abuse has been a widely recognised negative life event that has been considered a long-term risk factor for both deliberate self-harm and completed suicide (Linehan, 1999, Brassard, Tyler, and Kehle, 1983). Peters and Range (1996), in their investigation of the role of self-blame and self-destruction in women who were sexually abused as children, identified that those women who had higher levels of self-blame, tended to be more depressed, suicidal and had weaker coping responses. The research further identified that these women, who were high in self-blame, were also more fearful of social disapproval. These findings were consistent with phase 2 results and supported the revised escape theory as proposed that would include the role of fear of negative evaluation as a risk factor for suicidal behaviour.

Linehan (1999) proposed another framework for understanding suicide,

which paralleled Baumeister's theory, and would further it by linking predispositional factors, family dynamics, and environments which would result in poor coping and poor emotional regulation. Linehan's (1999) theoretical framework stated:

> ...vulnerable individuals ...may invalidate their own affective experiences, look to others for accurate reflections of external reality, and oversimplify the ease of solving life's problems. This oversimplification leads inevitably to unrealistic goals... and self-hate following failure to achieve these goals. ...Intense shame as well as exacerbation of intense emotionality, may also be a natural result of a social environment that 'shames those who express emotional vulnerability' (p. 150).

Linehan's framework paralleled Baumeister's theory and further supported the efforts made through this research.

In vulnerable individuals, the development of depression may have been perpetuated through a lack of other available models or resources to cope with insufferable circumstances. As Herman (1992) stated:

> the child trapped in an abusive environment is faced

> with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness (p.96).

This description could also be applied to some situations of incidents of abuse or trauma in adults. Finkelhor (1986) described a sleeper effect pathology that emerges in late adolescence or adulthood in which survivors of sexual abuse manifest depression, self-destructive behaviour, anxiety, feelings of isolation, stigma, poor self-esteem, a tendency to experience further victimisation, and substance abuse. This sleeper effect pattern could be identified through the themes generated by participant descriptions.

The interviews also provided concrete support for Peters and Range (1996) conclusions regarding women with a history of childhood sexual abuse. The results of phase 2 of this investigation also gave a human voice to the individual experiences of deliberate self-harm and a context to the results of phase 1. The role of sexual abuse and the life long sense of shame, and isolation in which women cope warrants further research in the field of suicidology.

Results of phase 2 of this study provided an additional angle in approaching Baumeister's theory. This angle included a more specific definition to the term negative life events. The consideration of childhood trauma and the development of coping strategies in response to such trauma add another dimension or layer to the proposed theoretical framework. As previously stated, this framework was not intended to act as a panacea to theories of suicide or to be applied to all individuals. However, incorporating the results from phase 2 investigations into the theoretical model, specified and more accurately defined this model and established another direction for future exploration.

10.5 Loss

In reaching for death, participants who had experienced an episode of deliberate self-harm, may have been seeking a wider, more tangible, more immediate form of loss. They may have been reaching for an ultimate oblivion. In the book, Waking Up Alive: The Descent, the Suicide Attempt, and the Return to Life, Heckler (1994) presented the experiences of people who have attempted suicide. Heckler, in his exploration of personal histories identified loss as a significant precursor to suicide, and

outlined three forms of loss that emerged. These types of loss included: 1) traumatic loss, 2) extreme family dysfunction, and 3) alienation. Arguably, these forms of loss may have overlapped with one another. As in the results obtained from phase 2, the role of loss in relation to deliberate self-harm was an acute, perhaps universal reality. Coping with complicated, compounded or indescribable loss and pain, if not overcome or addressed, could overpower an individual.

Another type of loss to be considered is a loss of power or control. This type of loss would have a foothold in the lives of those who have experienced trauma or been the victim of violence. For these participants, there has existed a loss of trust in others, a loss of the self, and a loss of life(style) prior to trauma that the person once knew. For those who have endured incidents of childhood abuse or extreme family dysfunction, there also exists a loss of childhood. These losses, as with many other forms of pain, may go unnoticed, unspoken, unacknowledged for some time, but eventually would tend to manifest themselves in some manner. Culturally these losses have not been the source of outward bereavement for which flowers are sent, funerals are arranged, friends surface, and rituals are attached. These losses, like a cancer, may lie dormant until compounding circumstances would give them a voice, or they would become the natural

schema imposed upon the psyche of the person affected by them. Notably, within Western cultures, even for losses suffered through bereavement (e.g. the death of a loved one), mourners have suffered silently in the wake of restructuring their lives. Loss and grief have rarely been discussed in day to day living.

Notorious for her autobiographical book, The Bell Jar, which illustrated a young woman's deterioration into mental illness, the Pulitzer prize winning poet, Sylvia Plath, whose life sadly culminated in suicide, wrote haunting stanzas in several noted works about the darkness which weighed heavily upon her. From selected excerpts of the poem, "Elm", Plath (1966) wrote: " I know the bottom.../ I break in pieces.../ I am inhabited by a cry.../ I am terrified by this dark thing / That sleeps in me;/ All day I feel its soft, feathery turnings, its malignity..." (pp.1421-1422). These words captured both a lurking anxiety and depression that seemed to have overtaken the author. These utterances also communicated a sense of desperation, a type of weeping, internalised grief. Several participants described their emotional state as a "kind of grief". The pain, which was suffered through the sense of pervading hopelessness, and depression which arose in relation to suicide, also yielded a quietly encompassing sense of loss. This sense of loss may have been a by-product or an

escalating factor in the manifestation of hopelessness. Whatever it's origin, the presence of loss, in some form, seemed to compound the desperation leading to a bleak perception of limited alternatives. In relation to trauma, loss extended to a loss of memory, a loss of a known future and a lost of past life, pre-trauma.

Herman (1992) pointed to a concept that explained the experience of hopelessness. She indicated that reduction of time, as an endless presence occurred when thoughts of the future become unbearable, to the point of emotional desperation. She explained this perception of the past and future in relation to the perspective of prisoners. Eventually the past too was absolved in obliteration. This interpretation of perceptions of time was consistent with Beck's theory of depression that suggested that individuals develop distorted, negative perceptions of their future, the world, and themselves. Herman's inference to the concept of time and memory becoming negatively distorted complimented Beck's theory. Baumeister also cited this concept relating to a reduction in time in relation to the escape theory. Baumeister, in describing the process involved in the state of cognitive deconstruction referred to three signs that occur during this process, wherein the individual "tries to escape from negative affect by rejecting/avoiding meaningful thought". (p.99). These states included what

Baumeister describes as: time perspective, concreteness, and proximal goals. Baumeister defined each term as follows. Time perspective involved the narrowing of time into a tight sense of present, in which the past and future fall away. Concreteness involved a physical sense of numbing or lack of movement and a lack of sensation. Proximal goals were those goals conceived within a very short/heightened range of reflection, the thought of future or future goals were not within the range of the individual's perspective. Within this state of cognitive deconstruction, a numbing sense of press occurred, both emotionally and physically. This stage along the pathway of the escape theory seemed to relate to the concept of hopelessness. It also reflected a sense of oblivion that may inhabit the individual. Globally, all of life would become reduced to darkness.

Brison (2002) throughout her book, Aftermath: Violence and the Remaking of a Self, identified essential elements to overcoming trauma. Among the core components were 1) the need to retell or communicate the trauma, 2) the ability to integrate the traumatic episode into a comprehensive experience that relates to one's life both before and after, and 3) to gain control over memories, or sensory experiences that intrude with day to day living. Brison pointed to a need to integrate back into a new found familiarity with life and develop a formula for meaningful living.

Issues related to recovering from trauma and the prevention of suicide were further discussed in Chapter 11. The implications for suicide prevention in relation to the results of phase 2, suggested a need for therapeutic interventions which would aid the individual in: 1) resolving previous traumas, 2) coping with the challenge of living with painful memories, and 3) contextualising incidents of trauma within the whole of his/her life. This would also involve the need for the individual to gain perspective on the experience of deliberate self-harm, suicidal ideation or psychiatric disorders.

10.6 The Role of Feminism in Suicidology

Phase 2 of this study raised issues for addressing women's needs more comprehensively in the study of suicide. The majority of women participating in this study demonstrated underlying issues related to their experience of deliberate self-harm which uniquely and directly effect women. These issues included sexual abuse/rape, eating disorders, and motherhood. The experience of motherhood, and related stresses, was a secondary issue that remained unexplored in the interview format of phase 2. However, several participants pointed to their struggles with caregiving when in the throws of confronting their own anguish. These issues in

association with suicide research may require a feminist approach that warrants additional investigation.

Feminist theories and ideologies were developed by women for women to explain their experiences. Feminist principals have embraced 1) the defence of basic human rights and 2) individual empowerment. The focus of feminist theory has centralised on the imbalance of power within our society. Berrick and Gilbert, (1991) stated: "without an understanding of power relations between sexes (e.g.: male dominance) it is impossible to explain the epidemiology of sexual abuse" (p.10). If, as Berrick and Gilbert (1991) indicated, we can not explain the epidemiology of sexual abuse without understanding power relations between the sexes, how then can we explain higher rates of depression, eating disorders, (arguably another form of self-destruction, with a high comorbidity rate of depression) and higher incidents of deliberate self-harm in women without considering gender differences? Particularly when a significant risk factor, as demonstrated in this study, relates to sexual abuse.

Though suicide rates in women have been lower than suicide rates in men, the evidence of suicidal behaviour, physical violence, sexual abuse, and psychological oppression in women reflect higher rates of survival in

the face of misfortune. There has been a continued need to understand suicide through the reverse side of the primarily male oriented prism from which the majority of current research has been undertaken. As we progress the history of suicidology forward, there will be a need remain vigilant to of the needs of all individuals who experience suicidal behaviour.

Suicide research will need to reflect the full gamut of world culture and hold a space within that exploration that sensitively and straightforwardly explores the life experiences and needs of women. Range and Leach (1998) proposed that the field of suicidology needs to move beyond the traditional research approaches and consider alternative methodologies including a feminist approach. Range and Leach highlighted a feminist research framework which would also include the following guiding elements: a focus on women, consideration of power, acknowledging gender constructs, continued cognisance of the power of language, and the promotion of active practical applications for research outcomes.

The ultimate aim of a feminist approach in relation to suicide prevention would speak to adequate and competent care, intervention and prevention of suicide in all people, regardless of age, race or gender. A

prevention would speak to adequate and competent care, intervention and prevention of suicide in all people, regardless of age, race or gender. A feminist approach would also focus on the reduction of stigma for mental health issues including the scar of suicide and would focus on the valuation of the role of all people within society.

10.7 Summary

Results from phase 2 interviews revealed an additional layer of insight to research findings obtained through a quantitative approach in phase 1. Robert Bly (1967) wrote: "Come with me into those things that have felt this despair for so long" (p.1238). Phase 2 interviews allowed a first hand glimpse into human states of hopelessness, grief, despair, fear, sorrow, and anguish. Without the clear conscious human voices depicting their narratives, this insight into suicidal behaviour may not have been as illuminating. Results provided support for an interactional model for understanding suicide, the need to focus on women's issues related to suicide and evidence of negative cognitive distortions related to perceptions of self and others which tended to influence coping responses. Implications for intervention and prevention strategies in relation to these

findings were reviewed in the following chapter as they related to the whole of this study.

Chapter Eleven: Overview and Conclusions

11.1 Introduction

This study explored suicidal ideation and deliberate self-harm through the revision of one potential explanation of suicide, the escape theory. The escape theory of suicide (Baumeister, 1990), proposed that suicidal behaviours develop out of an attempt to escape from a state of aversive self-awareness. An examination of this theory was the basis of this investigation. The framework for investigation posed that: individuals respond to stress by demonstrating a maladaptive, specifically, avoidant style of coping. That individuals would then attribute this avoidant style of coping to themselves, blame themselves for negative events, and develop negative, internal attributions for negative life events, which would then have resulted in a state of self-aversion. The combination of an avoidant style of coping and the attribution of self-blame would also have led to an

avoidance or fear of others and contributed to further isolation.

Figure 1, presented in Chapter 3 outlined the pathways of a revised escape theory model. Though this model varied from research outcomes, in combination, the results from phase 1 and phase 2 supported elements of this revised theoretical framework. The impact of negative life events was not a factor under investigation in this study although was assumed to be significant. However precipitating negative life events emerged as a crucial factor. These negative life events which were frequently identified in association with incidents of deliberate self-harm as identified in phase 2, were compounded or heightened by incidents of rape, childhood sexual abuse and other traumatic events. The memories, and meanings attached or associated with these events became more powerful and painful than the event itself. Though the words from Bob Dylan's (2001) song "Sugar Baby" were not written in response to sexual abuse or suicide, his statement: "some of these memories, you can learn to live with and some of them you can't," expressed the collision which occurred between the memory (of trauma) and the inability to escape from these memories. Understanding the effects of trauma over time would have the potential to further our insight for preventative strategies. Factors, including the frequency, intensity, duration of the traumatic event or events, levels of

self-blame in relation to these events, initial stages of coping with trauma including disassociation, denial, or the articulation of the events to others when considered in relation to continuums of suicidal behaviour would warrant additional investigation.

Both qualitative (phase 2) and quantitative (phase 1) approaches to understanding the role of avoidance in relation to suicidal behaviour pointed to a framework for understanding the connection between these variables. Phase 1 results substantiated that fear of negative evaluation correlated with maladaptive coping, which correlated with depression. The connection between suicidal ideation, or deliberate self-harm and depression and hopelessness has been undisputed in the research literature. The proposed, revised framework for Baumeister's theory to include fear of negative evaluation as a relevant factor for understanding suicide has not been entirely supported by this investigation. However the results did provide further insight regarding the relationship between fear of negative evaluation and maladaptive coping strategies. Phase 2 of the investigation aimed at developing a more clear understanding of these factors. Though the findings related to this study may not be generalisable to the larger population, they did provide support to a theoretical framework that was multi-phased and interactional. The results of this research also provided an increased understanding of fear of negative evaluation and of avoidance

that may provide direction for future research.

11.2 Future Research

In this investigation, qualitative methodologies (phase 2 interviews) supplemented the quantitative methodologies employed in phase 1. The purpose for this integration of methods was to ensure that the qualitative methodology corresponded with quantitative results to elucidate contextual factors identified in phase 1. There is a need for multiple forms of research methodology in the development of comprehensive frameworks and intervention practices pertaining to suicidal behaviours. Research methodology that includes both a qualitative and quantitative approach provide variety and depth to the understanding of the multi-faceted aspects of suicidal behaviour. Directions for future research should also include a feminist focus. Though studies have indicated that men complete suicide at a higher rate, women have been identified to have higher rates of deliberate self-harm. Deliberate self-harm should not be underrated as a significant health, social, and psychological problem. Even though women have not completed suicide as frequently as do men, interventions and prevention would need also to concentrate on trends in deliberate self-harm, or suicidal

phenomena in women, including a research focus. There has also been a need to unravel the role of sexual abuse in relation to suicide. Future research concentrating on women, sexual abuse and deliberate self-harm should aim to examine effective interventions, and treatment outcomes. Undergraduate and post-graduate training in psychology needs to increase the emphasis on the psychological effects of sexual abuse including a feminist perspective on treatment strategies, the effects of which may offer direct suicide prevention applications.

Theoretical models of suicide should be the foundation for all research in suicide. In relation to Baumeister's revised escape theory of suicide, there would be merit in exploring this model base on specific populations of at risk individuals. Targeting individuals who demonstrated various anxiety disorders including social anxiety, social phobia, or post traumatic stress disorder may yield results that would directly address factors of shame, and avoidant coping and support the application of Baumeister's escape theory to a specific population. This would have implications for effective intervention and prevention strategies. Additionally, the identification of processes related to cognitive deconstruction may assist in understanding and applying specific interventions if research were undertaken to broaden current understanding

of this process and explore relevant therapeutic interventions.

11.3 Implications and Future Directions

In addressing therapeutic interventions to prevent suicide, both clinicians and researchers would need to adhere to best practice, biosocial treatment approaches. Pharmaceutical interventions have had a high efficacy rate in the treatment of depression, mood disorders and other psychiatric disorders, and should be included as one component of a comprehensive treatment approach. Therapeutic interventions including cognitive behavioural strategies for coping, interaction with others as a form of support, and alternative models of intervention, particularly for those who have experienced trauma such as sexual abuse and loss, would require further review to develop an integrated and eclectic approach to suicide prevention and intervention. The role of loss should not be overlooked in any therapeutic treatment model. In confronting the pain, isolation and distortion of rational thought that occurs in relation to suicidal behaviour, the role of loss, even in the most minimal of definitions, as a loss of an individual's sense of wellness in the world, should not be under emphasised.

Therapeutic interventions and the broader public health approaches to the prevention of suicide have ultimately aimed at developing psychological well being and these factors have tended to shape treatment goals, intervention and prevention strategies. Considering the complexities involved with suicide prevention, models for prevention and intervention would also require multiple approaches. Ryff (1989) developed criteria for defining psychological well being. This criterion was synthesized from multiple theoretical frameworks. Ryff's criteria for psychological well being included the following factors: Autonomy, Environmental Mastery, Positive Relations with Others, Purpose in Life, Personal Growth, and Self-Acceptance. Considering these domains as a standard toward which psychological health may be measured, the theoretical model proposed in this study mirrored a reverse of these factors. In comparing Ryff's model with Baumeister's revised theoretical framework: Autonomy and Environmental Mastery were replaced with Negative Life Events, and a perceived lack of control and disappointment in situational outcomes; Positive Relations with Others was replaced with Fear of Negative Evaluation by Others; Purpose in Life was replaced with hopelessness; Personal Growth was replaced with depression and Self-Acceptance was replaced with Self-loathing.

The overlay of Ryff's criteria of psychological well being and Baumeister's revised framework for a potential pathway to suicide, included the fundamental premise of this investigation, which was the inclusion of the role of social interactions, and perceptions of others. Herman (1992) cited that individuals who demonstrated an internal locus of control, engaged in task oriented coping strategies and demonstrated strong sociability were more resilient to developing post traumatic stress disorder in the face of trauma. Building resiliency has been a critical factor that underlies the root of complexity related to suicidal behaviour. One approach to building resiliency would be a community-wide strategy that would require generations of comprehensive education and include a focus on issues related to parenting, communication, and conflict resolution. Currently, creating resilient communities would be an insurmountable task. However, one method toward achieving psychological well being in individuals would begin through legislation that would mandate educational curriculum to include resilience- building programs into all levels of public education.

As this investigation demonstrated, fear of negative evaluation increased as maladaptive strategies for coping increased, and as maladaptive strategies for coping increased, levels of depression and

hopelessness increased. Negative life events that frequently included themes of loss precluded the stages that led to suicidal behaviour. There has been evidence that social supports are a critical protective factor for the prevention of suicide (Nisbet, 1996). Methods for sustained intervention for individuals who had experienced depression would need to be explored through alternative suicide prevention strategies that involve engaging with others. For example, Harris, Brown, and Robinson (1999), identified the protective factor of social support for women with depressive disorder and, though the study offered several limitations, satisfactory evidence regarding the role of befriending was offered as an effective intervention for chronically depressed women. This intervention of befriending was defined as volunteer's meeting with and listening to women with depression for one hour per week. This type of intervention mirrored the support, which the participants (phase 2) identified as a potential prevention for their own suicidal behaviours. The role of social isolation has been emphasised throughout this study. Social engagement may play a more pivotal role in the development of psychological well being than has been historically emphasised through therapeutic treatments for depression and the prevention of suicide.

Hackman (1997) emphasised the importance of working with images and memories in cognitive therapy. This therapeutic approach would be of specific relevance to individuals suffering from post-traumatic stress disorder or associated symptomology. In relation to the results obtained in phase 2, wherein traumas experienced in both adult life and childhood may have been contributing factors to incidents of deliberate self-harm for participants, the role of a cognitive behavioural framework that addresses intrusive images would be an important component of treatment. Hackman (1997) emphasised the importance of acknowledging recurrent images which may be accompanied by high affect and carry important meanings and examining frozen fragments of memory and images which would be linked to earlier traumatic experiences. Therapy or intervention would involve accessing meanings, including confronting whether these meanings were based in reality during the identified trauma in contrast to the present time. Therapy would also involve incorporating fragmented memories or images that may be avoided by the survivor and placing these images into a context of other autobiographical memories. The process of reframing or restructuring images and memories would also involve a physical-sensory response and may incorporate a spiritual viewpoint. The reliving of memories would involve the reliving of body memories including details of sights, sounds, smells, tastes or other bodily sensations. In a therapeutic

environment, the results would manifest as a reduction in disassociation from the memories, and an exploration of behavioural patterns that would have evolved into re-enactments of the original trauma in day to day life. The individual would begin to make sense of the impact of their experiences. These strategies have been applied to other forms of anxiety disorders including social phobia (Clark and Wells, 1995). In reference to suicide, these forms of therapy would aid an individual in the development of new coping skills and new patterns of behaviour. The individual would learn to safely expose, express and unravel their painful narrative. Connection to others would also be an important component to the process of suicide prevention and therapeutic support.

Rice, Jobes, Ansari, and FitzGerald (1999) proposed a need to move beyond the reliance on suicide risk factors as a means of assessing suicidal risk and the prevention of suicide. Rice, et.al. (1999) suggested that the prevention of suicide could be better targeted by examining prevention strategies directly articulated by the individual as a means of prioritising treatment. Results of their study categorised individual's responses as to the "one thing that would help me no longer feel suicidal". Responses included prevention strategies that involved 1) the self and 2) relations with others. This tactic of asking an individual what would assist him/her in no longer

feeling suicidal may be employed as a best practice approach that would aid the process of establishing a therapeutic alliance. This strategy would engage the individual in directing the treatment approaches, and in addressing explicit needs that may reduce the occurrence of an incident of deliberate self-harm or suicide. Engaging a suicidal individual in exploring what would help them no longer feel suicidal would also evaporate a sense of hopelessness. This would evolve through the reduction of alienation, a refocusing on future, and an elimination of the isolation that occurs in relation to the individuals' internal struggle to cope with problems. Thus the process would also facilitate his/her articulation of those things that would provide them with more hope for living.

Limitations to this approach were noted as individual's ambivalence toward suicide and difficulty articulating a resolution to their suicidal state of mind may interfere with obtaining a clear response. However, results of this study supported the theoretical framework of the revised escape theory and implied that resolution to psychological pain would involve the support of others. As individual's engage in an internal struggle to overcome their problems, resolutions to suicide would involve the self, however as individuals progress on the path towards self-acceptance, the role of others would become increasingly important as a source for sharing their

experiences and connecting with people. The results of phase 1 and phase 2 suggested that the role of others did impact the individual's sense of self. However, in relation to the revised escape theory pathways, this relationship was of significance on a peripheral basis, perhaps more early on in relation to coping, and negative self-evaluations that progressed toward negative affect, depression and hopelessness.

11.4 Implications for Prevention

The study of suicide, including interventions and the development of strategies to prevent suicide, has required an understanding of community and culture. Riger (2001) indicated that understanding feminist community psychology approaches required a focus on people, not programs and a comprehensive understanding of the range, depth and dimensionality of people's unique experiences. This perspective recognised the way in which people's lives intersect with larger social structures. Acknowledging and interpreting multiple points of view in evaluating the effectiveness of suicide prevention programs would result in the identification of additional unexpected factors such as individual methods for resisting suicide, or fundamental program failures, which, if modified, could greatly enhance

prevention strategies. This approach to evaluating suicide prevention programs would adapt a means for reviewing not only the fundamentals of program outcomes, but would also focus on the underside, or those meta-messages from an individual perspective.

Considering acts of deliberate self-harm as life threatening events or trauma, regardless of the methods employed, would provoke another dimension or perspective from which to consider the needs of individuals who have experienced incidents of deliberate self-harm. Incidents of deliberate self-harm could actually be characterised by similar features that have been associated with trauma survivors. Depending on the trauma experienced, shame reactions may be aroused and a heightened sense of loss may be encountered. Traumatic experiences could leave an individual in a state of feeling unconnected. The past would become too painful to contemplate and the future would seem unfathomable, and the survivor would become increasingly isolated as they lack connection with themselves, the world, and others who could understand their experience. Brison (2001) equated experiences of trauma with a loss of control and disintegration of the self. Wiklander, Samuelsson, and Asberg (1999) identified that shame reactions in individuals were common following an incident of deliberate self-harm. Wiklander et. al. (1999) suggested that this

sense of shame heightened their sensitivity to negative attitudes from others.

Understanding the scope of experiences would become an important step in overcoming and contextualising pain. Individuals who have experienced suicidal impulses whether suicidal ideation, or incidents of deliberate self-harm, may benefit from a framework for understanding their experience. For example, the grief recovery processes, though acknowledging that there has not been a prescribed, linear process to grief, identified stages of loss. These stages of grief were defined by Kubler-Ross (1969) to include Denial and Isolation, Anger, Bargaining, Depression, and Acceptance.

Similarly, traumatic recovery phases have outlined a profile for recovery, which included initial sense of shock, anger and depression. Herman (1992) identified stages that were critical to the healing process following trauma. These included: the Engagement of a Healing Relationship, Safety, Remembrance and Mourning, Reconnection and Commonality. Though these models were presented as linear processions, the authors acknowledged that healing can occur in waves and most importantly, have provided a context or reference point that furnishes a

sense of hope to those who are in the process of healing. Currently these recovery models could be applied to providing support for individuals suffering from psychiatric disorder or confronting suicidal behaviour. Such models would offer a cognitive framework for managing aspects of loss associated with pain, though it should be emphasised that these stages are not progressive or prescriptive. Creating a framework for understanding suicidal behaviours would reconnect an individual who has experienced disquieting emotional upheaval to find a place to pause, reflect and acknowledge a pattern or pathway that may become more bearable in time. A focus on developing and understanding of the aftermath of an incident of deliberate self-harm from a framework that combines the stages of grief or stages following recovery from loss may be warranted in assisting individuals to come to terms with their experiences. Such a framework may reduce shame, alienation, and isolation, and offer a semblance of reconnection with the self and others.

11.5 Role of community intervention and prevention

There has been a need to strengthen community and mental health services as a whole. That is, focusing not only on people known to be at high

risk, but a collaboration between services, providing early assertive identification, and potentially continued follow up care after discharge from hospital. There has also been a need for services to develop strategies to manage non-compliance. Service development with a wide community network focus, particularly in areas where services have been weak such as rural areas, would be critical in the prevention, intervention and management of suicide and associated psychological disorders (e.g.: depression, or substance abuse). The prevention of suicide would require sustained co-operation between government departments, a range of health services including community health, drug and alcohol services, mental health services, primary health care providers, hospital clinicians, social services, health promotion agencies, family services, correctional services education, the media and a wide range of non-government community service agencies. Strategies, plans policies and procedures for suicide prevention and intervention within all sectors of the community and at every level of service would need to be considered and such strategies should dovetail the national suicide prevention action plan.

Australia has developed a national suicide prevention strategy. Australia's National Action Plan for Suicide Prevention (1999) emphasised partnerships, whole population approaches, networking of community

based services, increasing service response for those at risk of suicide, providing support for bereaved, and enhancing evaluation and research components to provide education, ongoing review and awareness of effective reduction strategies for suicide. This approach has also had the potential of limiting levels of isolation. In considering the prevention of youth suicide, Poland (1995) identified several key areas including, but not limited to: 1) detection, 2) assessment, and 3) intervention and post-vention. These factors have been applicable to prevention strategies across the life span. The Center for Disease Control (1992) emphasised a number of recommendations regarding suicide prevention programs that would also be universal across the life span. Among these, recommendations emphasised: 1) collaboration between community services/resources, 2) programs focusing on reducing access to means, 3) linking programs to prevent suicide to other key programs e.g.: drug and alcohol and 4) effective evaluations of prevention programs.

The Australian Psychological Society (1999) highlighted key issues related to suicide intervention/prevention and service provision. These issues included:

- Availability of crisis intervention services, including options of hospitalisation and/or intensive support;

- The need for research and training in referral processes
- The need to assess for follow-up therapy/intervention
- Availability of ongoing mental health care
- Psychotherapy as a component of ongoing care
- Facilitating client engagement with ongoing therapy and follow-up
- Examining the processes which make multidisciplinary care a reality
- Emphasis on working with the family
- Dually diagnosed clients requirement for services that are oriented to a whole person
- Suicide contracts and their limitations

These factors have been critical in developing a dialogue with community service providers, evolving psychologist's response to the management of suicidal clients, and adhering to the guidelines that have been developed nationally.

Quality care for the intervention and prevention of suicide has not relied on one professional body or one service delivery model. The prevention of suicide has been as multifaceted and complex as the

actual suicidal behaviour. For this reason, community involvement and models of coordinated care have been essential in effective intervention and prevention.

11.6 Conclusion

Rotham-Borus, et. al. (1996) stated: "suicide remains a relatively rare and unpredictable event" (p.137). However, as Jamison (1999) claimed: "it is a societal illusion that suicide is rare" (p.310). She pointed out that those mental illnesses highly associated with suicide (affective disorders, schizophrenia, and substance abuse) have not been rare disorders, but highly prevalent. Suicide, particularly when considered across a spectrum of behaviours, has truly been much more widespread than public perception has acknowledged. However, the immediate, daily task of suicide prevention has continued to be an enigma that has baffled the best efforts of governments, eluded many esteemed medical and human services personnel and resulted in enormous and rippling pain for survivors or loved ones. It would seem that for many individuals, the pain which has been suffered through depression or other psychiatric illness', may be submerged, masked, untreated, unreported and unrecognised for many days

months or perhaps years. Ironically, the late poet John Berryman, who ended his life by throwing himself from a bridge in Minneapolis at the age of 57 (7 January, 1972), years earlier prophetically wrote in "The Ball Poem" (1950):

> ...Soon part of me will explore the deep and dark
> Floor of the harbour . . . I am everywhere
> I suffer and move, my mind and my heart move
> With all that move me, under the water..." (p.912)

Berryman's biological father committed suicide, and suicide was a topic that appeared thematically throughout a number of his poems. For many individuals, such as Berryman, it would appear that life long battles with suicide have been fought. Unfortunately, not all people have achieved victory in their efforts to cling to life.

This study of a revised escape theory of suicide was conceived out of an effort to understand the patterns of withdrawal, isolation and avoidance that appeared to exist in association with the behaviours leading to suicide. In unravelling the pathways that led to suicidal thinking and incidents of deliberate self-harm, this research resulted in several conclusions that enhance our current understanding of suicide. These contributions included:

1) The commitment to suicide research through the context of a theoretical

framework, thus supporting efforts to advance research practices in suicidology.

2) Support for an interactional, multi-factored pathway to understanding suicidal ideation and suicidal behaviours.
3) Reinforcing previous studies investigating significant associated risk factors of suicide including hopelessness, depression, sexual abuse, and emotion oriented coping
4) Potential support for the presence of a numbing effect described in Baumeister's original escape theory of suicide.
5) Identification of the factor of fear of negative evaluation not as an indicator of suicide, but as a correlate to emotion oriented coping.
6) The need to include and define women's issues or feminist approaches to the study of suicide.
7) The value for utilising qualitative research methods to increase our understanding of suicide.
8) Models of intervention and prevention strategies for suicidal behaviours need to be based on empirically sound, evidence based methods .

As suicide rates in Australia (and other countries) have continued to be a significant public health concern, it will be essential to examine the pathways to suicide, develop interventions to prevent suicide and consistently evaluate the

efficacy of these interventions or preventative strategies. This research sought to interpret one theory of suicide and examine contributing features along a theoretical pathway as a means of developing more effective intervention and prevention strategies and to understand suicide from a relatively unexplored framework.

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Appendices

Appendix A Demographic Results

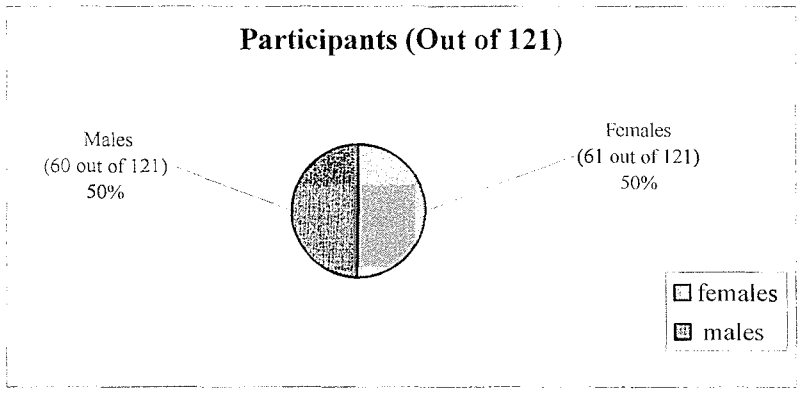


Figure 7 Number of Male/Female Participants

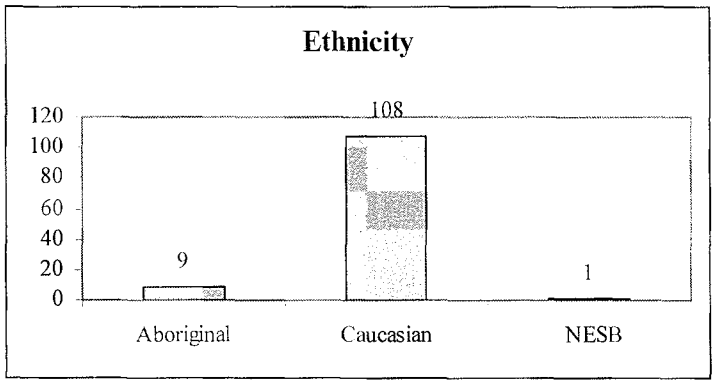
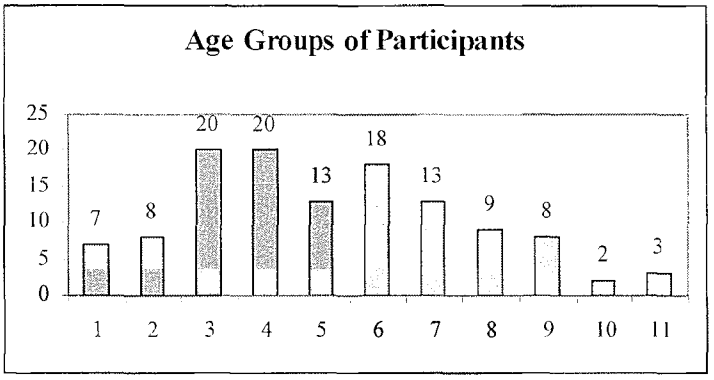


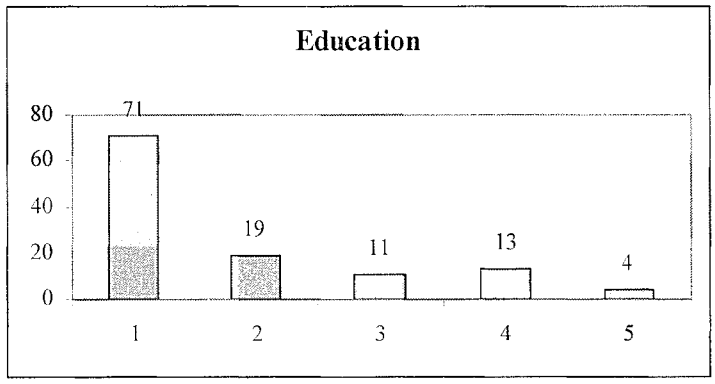
Figure 8 Ethnicity of Participants



KEY

1= Age 15-19
2= Age 20-24
3= Age 25-29
4= Age 30-34
5= Age 35-39
6= Age40-44
7= Age 45-49
8= Age 50-54
9= Age 55-59
10= Age 60-64
11= Age 60+

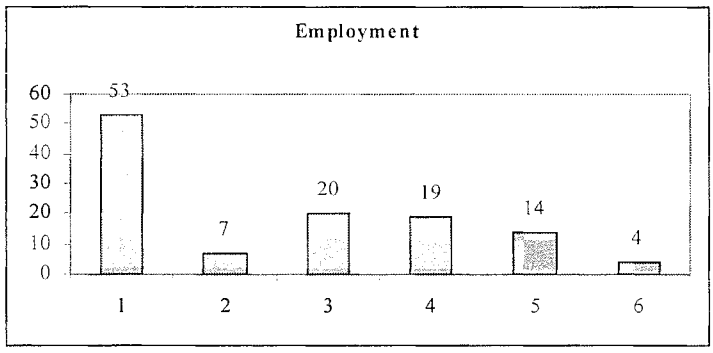
Figure 9 Age of Participants



KEY

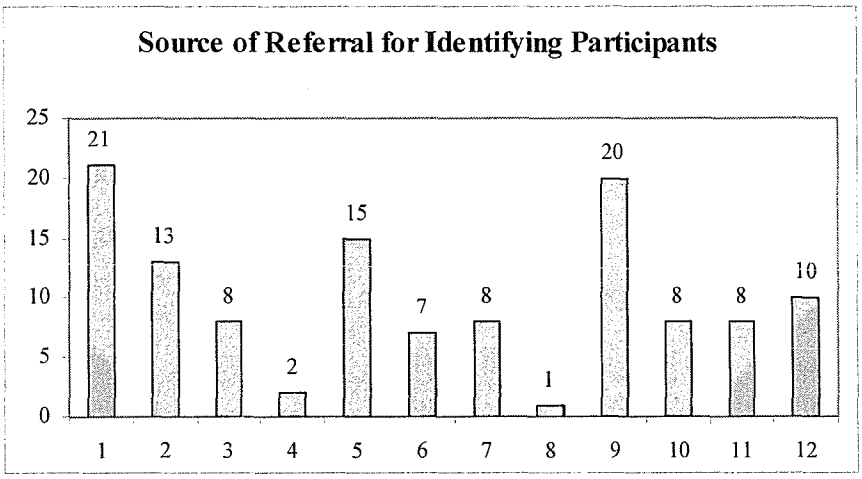
1= Did not complete High School
2= High School
3=Vocational Education
4= University
5= Postgraduate education

Figure 10 Participant's Level of Education



KEY
1=Unemployed
2= Student
3=Pensioner
4=Unskilled
5= Professional
6= Retired

Figure 11 Participant Employment Status



KEY

1= Hospital
2=Employee Assistance Program3= Privately Practicing Health Professional
4=Disability Support Service
5=Mental Health Education/Support Service
6=Women's Health Centre
7=Support Groups
8=Higher Education Counselling Service
9= Correctional Services
10= Alcohol and Drug Services
11=Community Shelter
12=Community Mental Health Services

Figure 12 Source of Participant Referral/Identification

Appendix B Questionnaires

Demographic Information

I.D #_____

Please circle the appropriate number corresponding to your answer, or print your answer in the space provided. Please answer all questions.

1.What is your gender? θ Male (1) θ Female (2)

2. What is your age?_____

Education level_____
Occupation_____

Do you live:

1θ alone
2θ at home with immediate family (father/mother/ brother etc.)
3θ with roommate(s) /housemate(s)/flatmate(s)
4θ with defacto boyfriend/girlfriend
5θ with husband/wife
6θ other(specify)_____

Brief Version of the Fear of Negative Evaluation Scale

Instructions: Read each of the following statements carefully and indicate how characteristic it is of you according to the following scale: 1= not at all characteristic of me, 2= slightly characteristic of me, 3 = moderately characteristic of me, 4= very characteristic of me, 5= extremely characteristic of me.

	Not at all	Slightly	Moderately	Very	Extremely
1) I worry about what other people will think of me even when I know it doesn't matter.	1	2	3	4	5
2) I am unconcerned even if I know people are forming an unfavourable impression of me.	1	2	3	4	5
3) I am frequently afraid of other people noticing my shortcomings	1	2	3	4	5
4) I rarely worry about what kind of impression I am making on someone.	1	2	3	4	5
5) I am afraid that others will not approve of me	1	2	3	4	5
6) I am afraid that other people will find fault with me.	1	2	3	4	5
7) Other people's opinions of me do not bother me.	1	2	3	4	5
8) When I am talking to someone, I worry about what they may be thinking about me.	1	2	3	4	5
9) I am usually worried about what kind of impression I make.	1	2	3	4	5
10) If I know someone is judging me, it has little effect on me.	1	2	3	4	5
11) Sometimes I think I am too concerned with what other people think of me.	1	2	3	4	5
12) I often worry that I will say or do the wrong things	1	2	3	4	5

Appendix C: Project Aims and Objectives

For Services and Service Provider Participation –SAMPLE COPY

Suicide is currently one of the leading causes death in young males. Australia has one of the highest rates of youth (age 15-24) suicide in the western world (Baume, 1996). Studies indicate that 60% of the population demonstrate suicidal thoughts. However suicide is difficult to predict.

The focus of this research is to examine the relationship between factors associated with avoidant behaviours and suicide and to test a revised, interactional model of suicide based on the escape theory of suicide (Baumeister, 1990).

The results of this investigation may lead to a more developed understanding of a potential indicator of suicide, and support and expand the escape theory of suicide as one possible model for the events leading to suicidal behaviour. This has applications for the identification, intervention, or the prevention of suicide. By understanding how suicidal individuals attribute life events, cope with stress, and develop a state of self-awareness and self-aversion, clinicians are in a better position to effectively intervene.

The aims of this study involve 1) the identification of individuals demonstrating thoughts of suicide and/or depression, 2) the administration a number of psychological scales through the process of an interview, and 3) the analysis of these results.

If you are interested in participating in the identification of young people at risk, please answer the following questions:

θ YES, I currently see/treat individuals aged 18 or over θ who demonstrate symptoms of depression OR θ who demonstrate suicidal thoughts

θ YES, I am willing to participate in the identification of participants for this study

Please return to:

Maureen Alsop, M.S., Ed.S.
[address/phone/ fax]

James Cook University currently supports the investigation undertaken by post- graduate Ph.D. student, Maureen Alsop, a fully registered psychologist within Queensland, a full member of the Australian Psychological Society, and a Nationally Certified School Psychologist. Supervisory support for this research has also been obtained from the Australian Institute of Suicide Research and Prevention, the Northern Queensland Rural Division of General Practice and the Anton Brienal Centre.

Appendix D Screening Questions for Service Agency

SAMPLE COPY

Thank you for your participation in the identification of participants for this study. For identified individuals to participate in this study, individuals will need to meet the following criteria:

Does the individual demonstrate the following signs or meet the following criteria required for participation in this study:

- θ Age 18 or older
- θ Report/indicate feeling depressed recently, or demonstrate symptoms of depression such as low energy or fatigue, poor concentration, poor appetite or overeating, sleeping too much or too little, low self-esteem, hopelessness, crying, sad
- θ Indicated any thoughts or wanting to hurt him/herself

If the individual meets requirements for criteria, please ask the individual if they would be interested in further interview for the purpose of research and provide them with form B (pink sheet)

Appendix E Information for Participants

The Department of Psychology at James Cook University is conducting research investigating depression and suicide risk in young people. Australia currently has one of the highest rates of youth suicide in the developed world. However, suicide remains a relatively unpredictable event. The results of this investigation may lead to a more developed understanding of a potential indicator of suicide, and support and expand current theories that have attempted to explain the events that contribute to suicidal behaviour. The information obtained thorough this study may be used to develop future treatments strategies to support young people's emotional health and well being.

In order to gather the information for this research, participants need to be willing to participate by answering a number of questionnaires. Participation is strictly voluntary, will require one hour with the researcher/psychologist, and will simply involve signing a letter of informed consent, and answering several (5) questionnaires.

This research has been reviewed and approved by the James Cook University Research Ethics Committee. In accordance with proper ethical conduct in investigations of this nature, the research has been designed to ensure the confidentiality of participants. The collected data will be secured in locked premises and accessed only by the researchers. As the aim of this research is to gather group data from which to draw general conclusions, no personal information is ever published. Further, the research is being conducted independently of the organisations that have been involved in the identification of participants for this study. Individual information will not be shared with referring agents. The outcomes of this study will not reveal any identifying information on the part of the individual participants, but will be used strictly for the purpose of research

Participants, if they desire, will be provided with a summary of results from this study. No individual details will be included or available. The following consent form will not be shared with any other individual. Names will not be used in this study and are required strictly for the purpose of initial contact and consent for participation. Individual confidentiality and identity will be maintained. If you have any questions or concerns about this research, please do not hesitate to telephone the researcher, Maureen Alsop on (07) 47 716 478. James Cook University Department of Psychology, Townsville QLD 4810.

Please fill out portion below, tear off and return to initial contact agent. You may keep the above information.

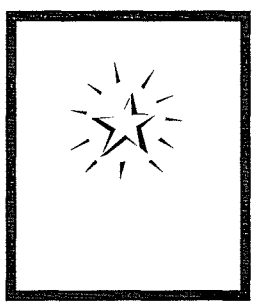
Yes, I,(name) _____ agree to be contacted for potential participation in the research study described above. I understand that I have the right not to participate or may discontinue participation at any time. I understand that by signing this form, I am permitting the researcher, Maureen Alsop to contact me. I understand that by signing this form, I am in no way obligated to participant in any further study unless I agree.

Signature_____

Phone number to be contacted _____ Preferred time: _____

Your participation in this study may help other people in the future.

Thank You for Your Consideration!



This research has been approved by the Townsville District Health Services Institutional Ethics Committee and by the James Cook University Human Ethics Committee.

For further information contact: Maureen Alsop
(07) 47 716 478 (h)
(07) 47 715 476 (w)
Maureen.Alsop@jcu.edu.au

Maureen Alsop, Chief Investigator, Psychologist, Post graduate Student
Jennifer Promnitz, Supervisor, Director Student Support Services
Christopher Cantor, Senior Researcher, Australian Institute of Suicide Research and Prevention

JAMES COOK UNIVERSITY
DEPARTMENT OF PSYCHOLOGY

Your Experiences are Important!

Maureen Alsop
(07) 47 716 478

Have you ever felt "blue"? Or "down in the dumps"?

Hello!

I am currently doing some research investigating how people cope and react towards others when they may be experiencing an emotionally difficult time in their lives.

The ultimate purpose of this investigation is to develop a better understanding of how

people feel so that psychologists and other professionals may develop stategies to more effectively support people when they are feeling extremely unhappy or hopeless about their future.

If you would like to participate. Please inform the service provider that gave you this brochure or contact me directly at:

(07) 47 716 478 (h)

(07) 47 715 476 (w)

THANK YOU FOR YOUR SUPPORT!

Maureen Alsop

What is Required?

If you decide to participate, you will be asked to complete 5 questionnaires. The reseacher, Maureen Alsop, will be present to work through these questionnaires with you if you need assistance or have any questions. The whole process can be completed within 30-45 minutes!

What Will Happen to My Information?

The information that you provide will not be shared with anyone. In fact, as soon as you complete the questionnaires, your name is separated from the information you provide.

Each participating agency and individual will be offered a summary of the results of the study. However, no individual or personal information will be shared. Furthermore, referring agencies will not have access to the information that you provide.

How Do I Participate?

If you would like to participate, simply inform the service provider who gave you this brochure and you will receive a call from the reseacher, Maureen Alsop within the next few days.

Alternatively, you can call Maureen directly on the phone number printed on this brochure.

Your Participation is Very Important!

For further information contact:

Maureen Alsop

(07) 47 716 478 (h)

(07) 47 715 476 (w)

Maureen.Alsop@jcu.edu.au

Appendix F Consent for Participation in Research Study

Research Topic: A Revision of the Escape Theory of Suicide Ideation

Researcher: Maureen Alsop
Post graduate student
Department of Psychology
James Cook University

Jenny Promnitz
Director of Counselling
Counselling Centre
James Cook University

Chris Cantor
Psychiatrist
Australian Institute of Suicide Research and Prevention

Instructions: Answer all questions to Section 1. Completion of section 2 is voluntary.

Section 1

I (name) _____ have read the "Information to Participants" which explains the research that I am about to participate in and I agree to the procedures set out in that information under the following terms:

- My data and personal details will be kept confidential with access restricted to the researcher and research supervisors.
- My participation in this research study is voluntary and I may withdraw my participation at any time, or refuse to answer any question without penalty.
- My data will be utilised anonymously in the researchers analyses.

Section 2

In return for you participation, the researcher is offering to provide feedback the final results (general findings) in a brief report. Would you like to request such feedback?
θYES θNO

If you answered YES, please provide your postal address below. These details will not be recorded, and will be destroyed after feedback is sent to you.
Name: _____
Postal Address: _____

Please note, no identifying information will be recorded on the psychometric answer sheets, this "Letter of Informed Consent" will be removed from the other research materials.

Signature_____Date_____

Appendix G- Summary of Results Distributed to Participants and Agencies

Hello!

Thank you for your recent participation in my research. Enclosed is a brief summary of the findings. If you have further questions or comments about this study, you may contact me through James Cook University Department of Psychology. If you would like further support or assistance, a number of services are available within the community including:

Community Health Services (47 221 350),

Mental Health Services (47 819 195),

Lifeline (131 114),

or contact the Australian Psychological Society for information regarding local psychologists (1 800 333 497)

Your participation is greatly appreciated. Thank you for your assistance!

Regards, Maureen Alsop

SUMMARY OF RESULTS

The focus of this research was to examine the relationship between factors associated with avoidance, depression and suicidal ideas. To date, researchers have identified a number or "risk factors" which may assist psychologists and other health professionals in identifying individuals who may be "at risk" of harming themselves. However, suicide remains an unpredictable event. Recent studies of the rates of suicide in Australia indicate significantly high increases in completed suicides for people of all ages over the last 30 years. This investigation aimed to expand current theories of suicide, namely the "Escape Theory of Suicide" (Baumeister, 1990), and to examine another potential risk factor associated with suicide.

121 individuals (60= men, 61 = women) participated in this research study. Participants were identified through a range of support services and health agencies in the community. Participants were identified as individuals who were experiencing depression or symptoms of depression. Each participant

completed 5 psychological scales. These scales were administered face to face with the researcher and included a period of debriefing.

The following psychological scales were used measure the following:

Beck Depression Inventory	Depression
Beck Scale For Suicidal Ideation	Suicidal Ideas
Coping Inventory for Stressful Situations	Coping Styles
Beck Hopelessness Scale	Feelings of Hopelessness
Brief Scale of Fear of Negative Evaluation	Feelings of Fear in relation to the negative judgements of other people

The initial results of this study support current literature in suggesting a strong relationship between hopelessness and emotion oriented styles of coping, depression and suicide. The relationship between 'fear of negative evaluation' and suicidal thinking has not been entirely resolved through this research. It appears that there does exist a relationship between depression and the fear of negative evaluation by others. These results suggest that there may be a "threshold effect" or other influences relating to these

emotional states. Further interpretation and analysis of these results will be required.

The researchers believe that the results of this investigation may lead to a more developed understanding of a potential indicator of suicide. This has applications for treatment and prevention. By understanding how people coping with depression, and experiencing suicidal ideas, cope with stress, and interact with others, clinicians are in a better position to effectively identify, intervene, or prevent suicide.

Appendix H: Semi-structured Interview- Phase 2

The purpose of this interview is to gain a better understanding of the events, emotions, and actions that lead up to a situation in which you hurt yourself and felt as if life was not worth living. First there are a few questions about that time in your life that I need to ask, then we can talk more in detail about that time in your life...

Interview Questions:

Have you attempted suicide? Yes/ No _____ (this question should have been identified prior to interview)

How many times have you attempted suicide?_____
How long ago did you (last)attempt suicide? _____ How old were you at that time?

The last time you attempted suicide, would you describe your wish to die as high, medium, or low?

Please describe the events that lead up to your suicide attempt.

How did you handle these events? What did you do? How did you react?

How would you describe the way that you coped?

How did you feel about your self at this time? (perception of own coping)...

How did you feel towards others?
Describe your relationship with others at that time.

How did your actions reflect your feelings toward people?

What, if anything, would have helped you at that time?

What would have stopped you from hurting yourself?